NHS Digital

Agenda

NHS Digital

Agenda: Part 1 (Public Session)

Wednesday 31 May 2017, 12:30 to 14:30

Venue: Diggory, Hill and Bevan, First Floor, 1 Trevelyan Square, Leeds, LS1 6AE

Apologies:

- Rachael Allsop, Director of Workforce
- Prof. David Hughes, Director of Information and Analytics
- Tamara Finkelstein, Director General for Community Care (Department of Health representative)

Ref No	Agenda Item	Time	Presented By
NHSD 17 02 01	***Chair's Introduction and Apologies*** **(oral)**	12:30 – 12:45	Chair
NHSD 17 02 02	***Declaration of Interests and Minutes*** (a) Register of Interests (paper) – **for information** (b) Minutes of the Statutory Board Meeting on 03 May 2017 (paper) – **to ratify** (c) Matters Arising (oral) – **for comment** (d) Progress on Action Points (paper) – **for information**		Chair
NHSD 17 02 03	**Strategic Delivery and Operational Performance** (a) Update on Cyber Attack (oral)	12:45 – 13:15	Interim CEO
NHSD 17 02 04	**Governance and Assurance** (a) 2016-17 Annual Report and Accounts (paper) - **for approval**	13:15 – 14:00	Director of Finance and Corporate Services
	(b) **Directions** (endorsed at EMT 11 May 2017): i. Establishment of Information Systems for NHS Services: Emergency Care Data Set Collection Directions 2017 (paper) – **for acceptance** ii. Community Services Dataset Direction (paper) – **for acceptance**	14:00 – 14:10	Medical Director and Caldicott Guardian
	(c) Committee Reports: i. Investment Committee (IC) Report: 09 May 2017 (oral) **- for information** ii. Assurance and Risk Committee (ARC) Report: 10 May 2017 (oral) **- for information**	14:10 – 14:20	Committee Chair
NHSD 17 02 05	***Any other Business*** (subject to prior agreement with Chair)	14:20 – 14:30	Chair
	Close	14:30	
NHSD 17 02 06	***Background Paper(s)*** (for information only) (a) Board Forward Business Schedule 2017-18 (paper) – **for information** (b) Forthcoming Statistical Publications (paper) – **for information**		

Date of next meeting: 06 September 2017, Rooms 102A and 124A, Skipton House, 80 London Road, London SE1 6LH

NHS Digital

Board meeting – Public Session

Title of paper:	**Register of Interests**
Board meeting date:	31 May 2017
Agenda item no:	NHSD 17 02 02 a
Paper presented by:	Chair
Paper prepared by:	Executive Office Secretariat
Paper approved by: (Sponsor Director)	Each Director is accountable for their declaration of interest
Purpose of the paper:	NHS Digital is required by its Standing Orders to maintain a publically available Register of Members' Interests. The Register contains, as they become available, the Declarations of Interest made by Board Members.
Key risks and issues:	N/A
Patient/public interest:	Corporate Governance Transparency and Openness
Actions required by the board:	For information

NHS Digital Board Register of Interests 2017-18

Name	Declared Interest
Non-Executive Directors	
Noel Gordon: Chair	**Directorships:** • Chairman, Healthcare UK • Non-Executive Director, NHS England • Non-Executive Director, PSR (Payments Services Regulator) • Chairman of Board of Trustees, Uservoice.org **Other Offices held:** • Member, Life Sciences Industrial Strategy Advisory Board • Member, Audit and Risk Committee, University of Warwick • Member, Development Board, Age UK **Shareholdings as defined in the NHS Digital Corporate Governance Manual:** • Accenture **Other relevant interests:** • Senior Advisor, Aleron
Dr Sarah Blackburn: Non-Executive Director Vice Chair	**Directorships:** • Director - The Wayside Network Limited • Board Director and Audit Committee member, RAC Pension Fund Trustee **Employment (other than with the NHS Digital):** The Wayside Network Limited **Other Offices held:** None **Contracts held in last 2 years:** • The Wayside Network Limited has: • a contract to supply GP and primary care nursing services to Avon and Wiltshire NHS Partnership • a zero hours contract with the Chartered Institute of Internal Auditors to provide an External Quality Assessment Reviewer and a viva voce examiner **Shareholdings as defined in the NHS Digital Corporate Governance Manual:** • 50% of The Wayside Network Limited

Name	Declared Interest
	Other relevant interests: • Husband has the other 50% of The Wayside Network Limited shares • Daughter is a trainee orthopaedic surgeon in Bristol
Sir Ian Andrews: Non-Executive Director Senior Independent Director	**Employment (other than NHS Digital):** • Partner in IMA Partners (formerly trading as IMA Partners Ltd until February 2016) providing legal and management consultancy services to government, academia (KCL[1]) and Transparency International UK. **Other Offices held:** • Conservator of Wimbledon and Putney Commons • Trustee Chatham Historic Dockyard • Member of UK Defence Academy Academic Advisory Board
Dr Marko Balabanovic: Non-Executive Director	**Employment (other than with NHS Digital):** • Chief Technology Officer, Digital Catapult **Shareholdings as defined in the NHS Digital Corporate Governance Manual:** • Equal Media Ltd
Daniel Benton: Non-Executive Director	**Directorships:** • Trustee, The Grange Festival **Other Offices held:** • Fundraising and Finance Committees , NSPCC **Shareholdings as defined in the NHS Digital Corporate Governance Manual:** • Accenture • Supercarers
Professor Soraya Dhillon MBE: Non-Executive Director	**Directorships:** • Non-Executive Director, The Hillingdon Hospital NHS Foundation Trust **Employment (other than with NHS Digital):** • Academic Manager, University of Hertfordshire **Other offices held:** • Senior Independent Sponsor Improvement Steering Group, Eastern Academic Health Science Network

[1] King's College London

Name	Declared Interest
	Contracts held in last 2 years: • Former Dean School of Life and Medical Sciences, University of Hertfordshire until 31 October 2016
Professor Sudhesh Kumar: Non-Executive Director	**Directorships:** • Institute of Digital Healthcare, Warwick Manufacturing Group **Employment (other than with NHS Digital):** • Dean, Warwick Medical School **Other offices held:** • Non-Executive Director, University Hospital of Coventry and Warwickshire (UHCW) NHS Trust • Honorary NHS Consultation Physician, (UHCW), Heart of England Foundation Trust and George Elliot Hospitals **Shareholdings:** • Medinova Research Limited **Other relevant interests:** • Member, Medical School Council
Rob Tinlin: Non-Executive Director	**Directorships:** • Director, Towler Tinlin Associates Ltd **Other Offices held:** • Member, Advisory Board, Queen Mary University of London Business School
Executive Members of the Board	
Rob Shaw: Interim Chief Executive Officer	• None
Rachael Allsop: Director of Workforce	• None
Beverley Bryant: Director of Digital Transformation	**Contracts held in last two years:** • Director of Digital Technology, NHS England (until 31 May 2015) **Other relevant interests:** • Silent Partner – Wildtrack Telemetry Systems Limited

Name	Declared Interest
Carl Vincent: Executive Director of Finance and Corporate Services	• None
Ex Officio Board Members	
Professor Martin Severs: Medical Director and Caldicott Guardian	• Trustee of Dunhill Medical Trust, a research charity • Professor of Health Care for Older People with University of Portsmouth (Honorary) **Other Offices:** • Member of National Data Guardian's Panel **Other relevant interests:** • Member of Royal College of Physicians, British Geriatrics Society, the Faculty of Public Health Medicine and British Medical Association (BMA)
Tamara Finkelstein: Director General for Community Care, Department of Health	• Department of Health**,** Director General for Community Care **Directorships:** • New North London Synagogue (as Tamara Isaacs) • The Jewish Community Secondary School (as Tamara Isaacs)
Professor Keith McNeil: Chief Clinical Information Officer, NHS England	Chief Clinical Information Officer, Health and Social Care **Directorships:** • Carers Queensland **Other Offices:** • Non-Executive Director Eastern Academic Health Science Network **Contracts held in last two years:** • Chief Executive, Addenbrookes Hospital Cambridge
Executive Management Team Directors	
Tom Denwood: Director of Provider Support and Integration	• British Computer Society (BCS) Health, Vice Chair Policy and Strategy (a voluntary role at this registered charity) • Senior Responsible Owner (SRO) for Local Service Provider (LSP) Programmes on behalf of Department of Health • Senior Responsible Owner (SRO) for the Health and Social Care Network (HSCN) Programme on behalf of Department of Health (DH)

Name	Declared Interest
James Hawkins: Director of Programmes	• Parent Governor at St Peters Church of England Primary School, Harrogate
Professor David Hughes: Director of Information and Analytics	• None

NHS Digital

NHS Digital

Minutes of Board Meeting
Held at Olympia London (Apex Room), Hammersmith Rd, London W14 8UX

03 May 2017

Part 1 - Public Session

Present:

Noel Gordon	Non-Executive Director (Chair)
Sir Ian Andrews	Non-Executive Director (Senior Independent Director)
Dr Marko Balabanovic	Non-Executive Director
Daniel Benton	Non-Executive Director
Prof. Soraya Dhillon, MBE	Non-Executive Director
Prof. Sudhesh Kumar	Non-Executive Director
Rob Tinlin	Non-Executive Director
Rob Shaw	Interim Chief Executive Officer
Rachael Allsop	Director of Workforce
Beverley Bryant	Director of Digital Transformation
Prof. David Hughes	Director of Information & Analytics
Carl Vincent	Director of Finance and Corporate Services
Prof. Keith McNeil	NHS Chief Clinical Information Officer (CCIO), (NHS England representative)
Prof. Martin Severs	Medical Director and Caldicott Guardian

In attendance:

Tom Denwood	Director of Provider Support and Integration from 10:00 – 11:45 am
Chris Jarvis	Secretary to the Board
Dean White	Head of Business & Operational Delivery attended as an observer

For Item NHSD 17 01 04 a

James Palmer	Programme Head

Apologies

Dr Sarah Blackburn	Non-Executive Director (Vice Chair)

1. Chair's Introduction and Apologies **NHSD 17 01 01 (P1)**

1.1 The Chair convened a meeting of the NHSD Digital Board.

1.2 The Chair reported that he had received apologies from Dr Sarah Blackburn, Non-Executive Director,

The Chair confirmed that the meeting was quorate. He also made reference to the period of Purdah that was in place during the election period, noting the Cabinet Office guidance in place in this respect.

2. Declaration of Interests and Minutes **NHSD 17 01 02 (P1)**

2.1 (a) Register of Interest (paper) NHSD 17 01 02 (a) (P1)

The Board agreed that the register of interests was correct.

The Chair asked Board members to make declarations of interest for the Agenda items listed.

2.2 (b) Minutes of Board Meeting on 28 March 2017 (paper) NHSD 17 01 02 (b) (P1)

The Board ratified the minutes of the meeting Part 1 held on 28 March 2017.

2.3 (c) Matters Arising (oral) NHSD 17 01 02 (c) (P1)

There were no matters arising not covered on the agenda.

2.4 (d) Progress on Action Points (paper) NHSD 17 01 02 (d) (P1)

The Board noted the progress on action points resulting from the previous meetings.

3. Strategic Delivery and Operational Performance **NHSD 17 01 03 (P1)**

3.1 (a) Board Performance Pack (paper) NHSD 17 01 03 (a) (P1)

The Interim CEO presented this item the purpose being to provide the Board with a summary of NHS Digital's performance for March 2017. He noted that a comprehensive review of KPIs was due to be carried out at the end of June.

General issues were noted as follows;

- The importance of the NHS England document; *Next Steps on the NHS Five Year Forward View,* in shaping and providing context to the future environment.
- Identifying the commitments that NHS Digital has made to NHS England. The Director of Finance and Corporate Affairs noted that this could be included in the progress tool through the quarterly Business Plan review and this principle was agreed.
- Determining the Digital Delivery Board (DDB) view of progress within NHS Digital

Performance during March was noted, with particular reference to;

1. **Programme Achievement;** reported as amber green with overall delivery confidence across all programmes as 64.3%, with a recent go live noted as Widening Digital Participation

2. **IT Service Performance**; reported as green with 98.1% of services (53 out of 54) achieved their availability target. It was recognised that this is a significant

step forward

3. **Organisational Health**; reported as amber, noting that the "path to green" is dependent on workforce planning actions including alternative sourcing models. Areas of particular discussion were as follows;

    I. Graduate recruitment and the step improvement that is being achieved
    II. The important role of apprenticeships
    III. The relevance of Masters' Programmes in creating an awareness of the environment
    IV. How the recruitment value proposition is developed
    V. The Interim Chief Executive confirmed that these issues are being addressed and developed

4. **Financial Management**; reported as red. It was noted that the budget for the year was materially restated at M9 to recognise funding realignment from DH and NHS England into NHS Digital. Areas of particular discussion were as follows;

    I. The reasons for the projected underspend for the year, noting that the delivery timescale of some programmes has slipped
    II. The challenge on programme delivery undertaken taken through Business Plan reviews
    III. The extent to which the forecast underspend constitutes a material issue, in the particular context of acceptable tolerance levels
    IV. The importance of being advised of projected underspends as soon as possible, together with the ability to have a prioritised pressures list
    V. It was noted that further detail would be provided in the next report.

Having regard to the points discussed, the Board noted the report.

4 Strategy and Capability — NHSD 17 01 04 (P1)

4.1 (a) Child Protection Information Sharing (CP-IS) (paper) — NHSD 17 01 04 (a) (P1)

Beverley Bryant, Director of Digital Transformation presented this item. The purpose was to brief the board on recent progress on the Child Protection – Information Sharing project.

By way of background, it was noted that the Child Protection – Information Sharing (CP-IS) project links information about vulnerable children between social care and unscheduled NHS care settings via the NHS Spine.

A review of the programme by NHS Digital and NHS England, recognised that new milestones should be set for the project and the approach to delivery reconsidered.

Accordingly, improvements and changes to the approach to implementation have been introduced to improve implementation uptake namely, (i) stakeholder management (ii) co-ordinated deployment across Health and Social Care and Health (iii) Local Authority Funding (iv) Engaging with suppliers (v) communications and (vi) support from other NHS Digital Teams.

Key issues raised through wide ranging discussion were as follows;

- The publicity associated with the programme
- The importance of providing a visual trajectory
- In answer to a question from the Chair, the Director of Digital Transformation confirmed that there was a high level of confidence for delivery of the new schedule

- It was noted that there is a comprehensive Child Protection training System in place
- A comment was made that it would be helpful to get a sense of the incidence of children at risk, although it was noted that it was early in the process to establish that information.
- In response to a question concerning delivery milestones, the Director of Digital Transformation said that the figures identified represented significant levels of ambition
- The importance of ensuring effective mobilisation on the ground and recognising the impact of human factors
- In terms of keeping pace with the programme, the Interim Chief Executive made reference to the high priority being accorded to the programme
- Possible impediments to implementation were noted with particular reference to software suppliers prioritising making the required changes to their systems.

Following discussion, the Board;

I. Noted the progress and actions in hand outlined in the paper to accelerate progress in CP-IS deployment
II. Noted the revised delivery milestones, reflecting a more realistic deployment
III. Noted there would be more frequent and detailed reporting within the Performance Dashboard.

4.3 (b) NHS Digital Social Care – update briefing (paper) NHSD 17 01 04 (b) (P1)

Tom Denwood, Director of Provider Support and Integration introduced this item. James Palmer, Programme Head, attended the meeting to present. The purpose was to brief the Board on the ongoing work of NHS Digital and the National Social Care Advisory Group to support social care priorities across the Paperless 2020 portfolio.

Through the report presented, it was noted that this initial work and investment includes specific project delivery for a clearly defined set of projects, including;

I. A structured messaging exchange service to streamline discharge from acute settings to local authority social care
II. An innovation investment fund for Local Authorities
III. Support for Care Homes to improve Information Governance to access NHS Mail.

Discussion took place on a number of issues;

- The significance of Integrated Care, and the importance of including children's services in this work
- The importance of maintaining public trust
- Working in conjunction with Social Care in considering Dame Fiona Caldicott's report
- The significant piece of work to be carried out in relation to Child Health
- Cyber Security guidance for Care Homes, including Penetration Testing
- The Interim Chief Executive emphasised the importance attached to the continued development of social care priorities
- The Chair made reference to ensuring that this was placed in the bigger context of Integrated Care, within a holistic approach.

Having been advised that this issue would be brought back to the September Board Meeting, the Board noted the report.

5 Governance and Assurance

5.1 **(a) Directions for Acceptance:** **NHSD 17 01 05 (a) (P1)**

(i) Personal Health Budget Data Set (paper) NHSD 17 01 05 (a)(i) (P1)

The Director of Information & Analytics presented this item.

The Board, being satisfied with the information and assurances provided, accepted the Direction.

5.2 (b) Board assurance of Investment Decisions. Proposal to establish an Investment Committee NHSD 17 01 05 (b) (P1)

Carl Vincent, Director of Finance and Corporate Services presented this item. The purpose was to secure approval for the Board to establish a sub-Committee to oversee the assurance of investment decisions.

The Board noted the expectation that the volume and value of investment proposals arising from the P2020 portfolio would increase over the coming months, making difficult the provision of timely approvals within the scheduling of Board Meetings.

Having noted that (i) the Digital Delivery Board (DDB) was comfortable with the proposal and (ii) the Investment Committee (IC) would report to each statutory meeting of the NHS Digital Board, the Board approved the establishment of an Investment Committee as a sub-committee of the NHS Digital Board, to be chaired by Noel Gordon, Chair of NHS Digital, and also approved the Terms of Reference as presented.

5.3 (c) Modern Slavery Act 2015 – Implications for NHS Digital (paper) NHSD 17 01 05 (c) (P1)

Carl Vincent, Director of Finance and Corporate Services presented this item. The purpose was to provide the Board with a summary of changes in UK law relating to supply chain transparency brought about by the Modern Slavery Act 2015 (Act) and the need for NHS Digital to take appropriate and proportionate action to ensure slavery and human trafficking is not taking place in its business or its supply chains.

Mr Vincent reported that NHS Digital commits to ensuring that the necessary measures are in place to complete and enact the required Statutory Statement, which will then be published on the NHS Digital web site. It was further noted that compliance to the Act will be reporting annually in the Annual Report and Accounts, commencing in 2017/18.

The Board noted the current position and supported the proposed actions going forward.

5.4 (d) National Back Office (NBO) Review Position (oral) NHSD 17 01 05 (d) (P1)

Sir Ian Andrews, Senior Independent Director reported that no further action would be taken on this issue until the period of Purdah had concluded.

6 Any Other Business (subject to prior agreement with chair) **NHSD 17 01 06 (P1)**

6.1 There was no other business.

7 Background Papers (for information) NHSD 17 01 07 (P1)

7.1 (a) Board Forward Business Schedule (paper) NHSD 17 01 07 (a) (P1)

The Board noted this paper for information.

7.2 (b) Forthcoming statistical Publications (paper) NHSD 17 01 07 (b) (P1)

The Board received this paper for information, having noted the Chair’s comment that the publications listed were not impacted by the Purdah arrangements in place.

8 Date of Next Meeting

8.1 The next statutory Board meeting will take place on 31 May 2017.

The Board resolved that pursuant to the Public Bodies (Admission to Meetings) Act 1960 that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest’ (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).

Table of Actions:

Paper Ref	Action Reference	Action Owner
NHSD 17 01 03	Board Performance Pack; comprehensive review of KPIs due to be carried out at the end of June	Carl Vincent; Director of Finance and Corporate Services
NHSD 17 01 04 (a) P1	CP-IS paper; implementation of actions identified to ensure that milestones are met	Beverley Bryant, Director of Digital Transformation
NHSD 01 04 (b) (P1)	NHS Digital Social Care – update briefing	Tom Denwood, Director of Provider Support and Integration

Agreed as an accurate record of the meeting	
Date:	
Signature:	
Name:	Noel Gordon
Title:	NHS Digital Chair

NHS Digital

Board meeting – Public Session

Title of paper:	**Progress on Action Points**
Board meeting date:	31 May 2017
Agenda item no:	NHSD 17 02 02 d
Paper presented by:	Chair
Paper prepared by:	Executive Office Secretariat
Paper approved by: (Sponsor Director)	Each action update is submitted and approved by the relevant Executive Director
Purpose of the paper:	To share an update on open action points from previous meetings for information. To ensure the completion of Board business.
Key risks and issues:	As stated in the action and commentary
Patient/public interest:	Corporate Governance best practice
Actions required by the board:	To note for information

Progress against Board meeting actions

Green = completed
Amber = on-going
Red = overdue

Meeting Date	Status	Summary of Action	Responsible Director	Commentary	Next Steps	Target Completion Date
07/09/2016	Amber	**Information Assurance and Cyber Security Committee:** The COO said that there was recognition that the Information Assurance and Cyber Security Committee terms of reference would need to evolve to reflect changes in the informatics governance landscape and across Whitehall, including the formation of the National Cyber Security Centre (NCSC). The Chair asked that the Board have sight of any proposed change to the Committee and its terms of reference prior to implementation.	Chief Operating Officer	**Update 28 March 2017:** Work with NCSC has begun to identify linkages and requirements on the IACSC Terms of Reference. However, the work is also looking to bring input from the recommendations within the NHS Digital Capability review which has not yet been approved. **Update 03 May 2017:** Work is progressing but we have yet to fully define the impact and impact as a consequence of the Capability Review.	**Update 28 March 2017:** Capability review to be approved within NHS Digital to be approved and released in March 2017. Once released, ToR to be update accordingly and circulated to the Board. **Update 03 May 2017:** Work is in progress to determine the impact of the Capability Review aspects. This will be completed by end May 2017	May 2017

Meeting Date	Status	Summary of Action	Responsible Director	Commentary	Next Steps	Target Completion Date
				Update 31 May 2017: IACSC TOR to be retrospectively updated to include NCSC as committee member, no further changes are required at this time. Progression of the Capability Review recommendations may result in the need to further review the groups Terms Of Reference (ToR), should this requirement be identified a further paper will be submitted.	**Update 31 May 2017:** Paper highlighting the inclusion of NCSC within the TOR to be submitted to September board. Should progression of Capability Review requirements results in the need for further changes an additional paper can be submitted to the board.	
28/03/2017	Amber	**Progress Towards a Patient Centric Digital Health and Care System:** It was agreed that further updates on progress towards a Patient –Centric Digital Health and Care System detailing successes and challenges, be brought to a future Board meeting.	Director of Programmes	**Update 03 May 2017:** Further update on the 30 May Development Board Agenda. **Update 31 May 2017:** Further update will be bought to the 04 July Board Timeout meeting**.**	**Update 03 May 2017:** To present a further update to the Board at the 30 May 2017 meeting. **Update 31 May 2017:** To present a further update to the Board at the 04 July Timeout meeting**.** It was subsequently agreed to defer this item to the September meeting	May 2017

Meeting Date	Status	Summary of Action	Responsible Director	Commentary	Next Steps	Target Completion Date
28/03/2017	Green	**Stop Smoking Service Data Collection:** A note will be sent to the Board on the validity of the process of collecting data	Director of Programmes	**Update 03 May 2017:** Action being progressed with a completion date target by 5th May. **Update 31 May 2017:** A note was circulated to the Board on 23 May 2017 as follows: "Systems are used for the collection of this data by recording patient details and interaction with them. At the end of the quarter, the user runs a report that allows the user to manually validate breaches, eg. quit rates outside our expected limits, before submitting the collection. NHS Digital also compares returns to those submitted in previous quarters and flags any unexpectedly high or low values with the Local Authority."	**Update 03 May 2017:** Action in progress. **Update 31 May 2017:** Action Closed	May 2017

Meeting Date	Status	Summary of Action	Responsible Director	Commentary	Next Steps	Target Completion Date
03/05/2017	Amber	**Board Performance Pack:** comprehensive review of KPIs due to be carried out at the end of June	Director of Finance and Corporate Services	**Update 31 May 2017:** Work is underway to review the corporate KPIs reported to EMT and the Board. The main focus is the Programmes Achievement KPI and the Workforce/Organisational Health KPI. In addition the Financial information reported in the pack is being reviewed, and other elements of the pack will be freshened up.	**Update 31 May 2017:** Proposals for the main KPI developments will be considered by EMT in June/July and the changes incorporated into the Performance Pack for the next statutory Board meeting	June 2017
03/05/2017	Amber	**Child Protection Information Sharing (CP-IS) paper:** implementation of actions identified to ensure that milestones are met. ie. I. Noted the progress and actions in hand outlined in the paper to accelerate progress in CP-IS deployment II. Noted the revised delivery milestones, reflecting a more realistic deployment Noted there would be more frequent and detailed reporting within the Performance Dashboard.	Director of Digital Transformation	**Update 31 May 2017:** CP-IS will be added to the quarterly performance dashboard from September	**Update 31 May 2017:** CP-IS will be added to the quarterly performance dashboard from September	September

Meeting Date	Status	Summary of Action	Responsible Director	Commentary	Next Steps	Target Completion Date
03/05/2017	Amber	**NHS Digital Social Care – update briefing:** to be bought back to the September Board meeting for a further update, with particular reference to the broader context of Integrated Care, within an holistic approach.	Director of Provider Support and Integration	**Update 31 May 2017:** • Guidance sought from relevant Non-Executive Director on framing. • Discussion with NHS England National Director: Operations and Information on link to Accountable Care Systems.	**Update 31 May 2017:** • Board development day agenda item scheduled for further discussion. • Work with NHS England and other partners to understand full remit of Integrated Care requirements. • Opportunity for testing at National Social Care Advisory Group.	September 2017

NHS Digital

Board Meeting – Private Session

Title of paper:	**Cyber Attack Briefing**
Board meeting date:	31 May 2017
Agenda item no:	NHSD 17 02 04 (P2) a
Paper presented by:	Rob Shaw, Interim CEO
Paper prepared by:	Sean Walsh, Director, Operations and Assurance Services & Systems & Service Delivery
Paper approved by: (Sponsor Director)	Rob Shaw, Interim CEO
Purpose of the item:	Verbal update to brief the Board on the NHS Digital response to the May Cyber Attack.
Additional Documents and or Supporting Information:	N/A
Please specify the key risks and issues:	Briefing only
Patient/public interest:	N/A
Supplementary papers:	N/A
Actions required by the Board:	To note the briefing and planned next steps.

NHS Digital

Board Meeting – Public Session

Title of paper:	**2016-17 Annual Report and Accounts**
Board meeting date:	31 May 2017
Agenda item no:	NHSD 17 02 04 a
Paper presented by:	Carl Vincent, Director of Finance and Corporate Service
Paper prepared by:	Stephen Leathley, Deputy Director of Finance – Financial Accounts
Paper approved by: (Sponsor Director)	Carl Vincent, Director of Finance and Corporate Service
Purpose of the paper:	To approve the 2016-17 Annual Report and Accounts
Additional Documents and or Supporting Information:	2016-17 Annual Report and Accounts
Please specify the key risks and issues:	Satisfactory completion of the National Audit Office review
Patient/public interest:	Statutory document – may be some press and public interest.
Supplementary papers:	None
Actions required by the Board:	To approve the 2016-17 annual Report and Accounts and provide the Accounting Officer (Interim CEO) with approval to make minor changes and sign on behalf of NHS Digital

Official

2016-17 Annual Report and Accounts

Published 26 May 2017

Information and technology
for better health and care

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Executive Summary

The purpose of this briefing paper is to:

- Enable the Board to approve the 2016-17 Annual Report and Accounts
- To recommend delegation of further minor changes to Accounting Officer

Background

The Annual Report and Accounts presented reflect the latest known position including the NAO observations made to date. We still need to undertake a final thorough drafting review to ensure grammatical presentation and numerical accuracy, although we do not expect there to be significant redrafting. We are also aware that the NAO have not completed all their internal reviews. We are aware of a number of minor changes to be made to structure including:

- Page number references to be checked
- The numbers in the accounts have negatives in red, need to be changed to black
- The para called "Preparation of the Accounts" needs to be relocated as part of the Finance section.
- Photos for directors

The content of the Annual Report and Accounts is largely governed by various guidance including HM Treasury's Financial Reporting Manual, the Department of Health Group Accounting Manual, the "Green Book" and various other guidance and statutory notices. This sets the basic content framework against which we are able to tailor to our specific organisation and reader.

We have made significant progress from last year in terms of the year end accounts process having arrived at this stage a full week ahead of last years' equivalent Board (6th June 2016). We believe the audit has been undertaken relatively smoothly compared to previous years, although some work is still to be completed.

The principle areas affecting the audit included:

- The transfer of the former Department of Health (DH) programmes and assets on the 1st December 2016, in particular
    - evidencing the existence of the asset transfers, justifying their cost and incorporating into the NHS Digital accounting policies. A number of adjustments have been made, including a reassessment of the revaluation value. The NAO audit ultimately supported the due diligence work undertaken
    - agreeing with the Department of Health the accounting entries in respect of inter group transactions. Some of these were agreed late, and there is still a further entry to put through once the NAO have also confirmed their agreement, which will not materially change the substance of the Accounts presented
    - that appropriate disclosures have been made within the accounts to reflect the in-year transactions

- Our provider of transactional services, SBS, had a "limited" rating for their ISAE3402 report of payroll services undertaken by PwC. We were able to mitigate this by

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demonstrating that we had sufficient alternative internal controls on the key areas. The equivalent report on financial services was satisfactory.

- Despite our efforts to avoid this, there were a large number of transactions close to the year end - both invoices to customers, and receipt of goods and suppliers from suppliers, which inevitable created some cut off challenges. Several errors were identified as part of the audit.

- Final decision as to whether prior year comparatives in the Statement of Financial Position are restated for prepayments over one year, materiality being considered with the National Audit Office.

Subject to the NAO final review, we believe the Report and Accounts represent a fair reflection of the position.

Recommendation

To approve the Annual Report and Accounts with a caveat that the Accounting Officer is mandated to undertake minor amendments as required.

Implications

Strategy Implications

There are no strategy implications. The Annual Report and Accounts is a statutory requirement.

Financial Implications

There are no financial implications.

Stakeholder Implications

All content has been drafted in consideration of the likely readers of the report. We have shared an earlier draft with the Department of Health.

Handling

The production of the content has been a joint effort from various teams, primarily Finance and the Communications team.

The approximate timetable to complete the remaining process is as follows:

- ARC approve the Accounts to the Board subject to any particular caveats (31st May)
- Board approve and direct the Accounting Officer to make minor changes to content (31st May)
- Draft accounts to DH (6th June)
- We have made considerable strides on the recording of fixed assets, and believe the controls are substantially robust and the risk of material misstatement is low. However we all acknowledge that the processes are inefficient and disproportionately complex. This remains a challenging area for ourselves and the NAO, both to manage and to

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ensure that a full and complete audit trail exists. We have further work planned to address this area.
- NAO complete their review process and we finalise any adjustments (by last week of June – to be confirmed)
- Agree a date for NAO signature (probably last week of June/first week of July)
- Produce a final version for Accounting Officer signature with the letter of representation. Submit to NAO (last week of June)
- Signed by NAO enter final dates / auto signatures and lay to Parliament, print put on website etc. (mid-July latest).

Risks and Issues

The National Audit Office audit is not yet complete and they have not yet had the opportunity to undertake a full review of the whole document. There may thus be some amendments to make.

Corporate Governance and Compliance

It is best practice that the NHS Digital Board approve the Annual Report to provide assurance to the Accounting Officer that he is able to sign them on NHS Digital's behalf.

Management Responsibility

Carl Vincent, Director of Finance and Corporate Services.
Rob Shaw, Interim Chief Executive (and Accounting Officer).

Actions Required of the Board

To approve the 2016-17 annual Report and Accounts and provide the Accounting Officer (Interim CEO) with approval to make minor changes and sign on behalf of NHS Digital.

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Board Meeting – Public Session

Title of paper:	**Establishment of Information Systems for NHS Services: Emergency Care Data Set Collection Directions 2017**
Board meeting date:	31 May 2017
Agenda item no:	NHSD 17 02 04 b i
Paper presented by:	Prof. Martin Severs Medical Director and Caldicott Guardian
Paper prepared by:	Sam Sibeko, Lead Business Analyst, Domain H Data Content
Paper approved by: (Sponsor Director)	David Hughes, Director of Information and Analytics
Purpose of the paper:	Acceptance of NHS England ECDS Directions
Additional Documents and or Supporting Information:	ECDS Directions HSCIC Issue 1 Draft v0.2 Annex A – Specification Annex B – Technical Output Specification
Please specify the key risks and issues:	The ECDS standard was published on the 19th April 2017, with an outstanding Condition raised by SCCI that Directions were required to provide the legal basis for NHS Digital to collect and process the data.
Patient/public interest:	Indirect public interest supporting improved quality and accuracy of emergency care data
Supplementary papers:	No supplementary Papers
Actions required by the Board:	Acceptance of Directions

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NHS Digital

Establishment of Informatics Systems for NHS Services: Emergency Care Data Set Collection Directions 2017

Published 31 May 2017

Information and technology
for better health and care

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Executive Summary

Direction has been received from NHS England to support the Emergency Care Data Set. Implementing ECDS will facilitate better and timelier access to data on Emergency Department activity. The Direction covers the transmission of ECDS data to NHS Digital and the subsequent dissemination of the data.

Initially the sponsor for the ECDS Impact Assessment was DH. As the project has moved forward into the delivery phase for ECDS, sponsorship of the Direction has transferred to NHS England.

The Board is asked to consider and accept the Direction.

Background

Commissioning Data Set (CDS) Type 010 was developed in the late 1970s. At that time the work of A&E 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 sustained increase in the volume, scope and complexity of Emergency Care. The main factors driving the change in provision and delivery of 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 choose to access services and their expectations of the care that they receive.

CDS 010 has not evolved to keep pace with these changes and this has resulted in an ‘information gap’ in the data collected from A&E. 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’.

NHS Digital has been commissioned to deliver the capability to collect and disseminate the Emergency Care Data Set (ECDS) by the ECDS project board, chaired by Professor Jonathan Benger, National Clinical Director for Urgent Care at NHS England.

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The ECDS work, to date:

- facilitated the widespread agreement of the data set changes required, defining the data items to be collected, in partnership with the Royal College of Emergency Medicine (RCEM) and other bodies;
- proposed updating the currently mandated Accident and Emergency data flow within CDS 010, introducing a new CDS Type 011 ECDS which will eventually replace CDS 010;
- has received SCCI assurance with Conditions (dependent on acceptance of the Direction) of the ECDS Standard (SCCI0092-2062, CDS6.2.1, Amendment (Amd) 17/2015) to support the collection of patient emergency care data.

A meeting with key stakeholders chaired by DH (David Williams) on 21 October 2016 confirmed support for the implementation of ECDS and asked that NHS Digital begin implementation. This approach has the support of NHS Digital Information and Analytics senior management, Domain H SRO Tim Donohoe, NHS England CCIO Prof. Keith McNeil and NHS England CIO Will Smart.

Recommendation

Accept the Directions in order to facilitate the legal basis for collecting ECDS from relevant providers.

The data will flow into The Secondary Uses Service (SUS), with the very first “early adopter” sites coming on-line from early August 2017.

Implications

Strategy Implications

The ECDS aligns most closely with Paperless 2020 domain H: ‘Data Outcomes for Research and Oversight’ and also the work of the Urgent and Emergency Care Review within NHS England.
Unplanned care is one of the top priorities for the health and care system. The scope of unplanned care includes all unplanned care across the NHS including Ambulance, NHS111 and type 1,2,3,4 emergency care settings.

Financial Implications

Funding for the ECDS has been aligned with Paperless 2020 – Strategic Data Content (Domain H) and specifically Programme 26: Data Content and New Data Collections. ECDS is part of the Investment Justification for Programme 26 with approval anticipated during Q1 17/18.

Stakeholder Implications

Key stakeholders include NHS England, the Department of Health and the Royal College of Emergency Medicine as initiators of the project. NHS Digital is acting in the capacity of a delivery partner.

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There is strong support for the new data set from Emergency Care clinicians across the service, and care has been taken to ensure good engagement at trust level. The Royal College of Emergency Medicine has played a major part in this.
If the Direction is delayed then there will be an impact on the ability for ECDS to collect live data as this is a key Condition stipulated by SCCI as part of standard assurance.

Handling

The potential changes to CDS 010 have been and continue to be communicated through stakeholder engagement by the Royal College of Emergency Medicine, NHS Digital, NHS England and SCCI. Previous versions of the ECDS have been widely consulted on, and the ECDS team is proactively engaging with internal and external parties that may be affected by this change. There is no anticipated media or public engagement beyond normal legal obligations.

Risks and Issues

There are no anticipated risks associated with doing this work appropriately and within the legal and governance frameworks within NHS Digital. There are potential risks associated with delay:

- If the Direction is not accepted then NHS Digital cannot legally collect the data;
- The key project deliverable will not be met, causing damage to the reputation of NHS Digital amongst key stakeholders;
- Data Co-ordination Board will have to retract the Information Standard Notice (ISN) and collection of A&E data will continue under CDS 010 (A&E).

Corporate Governance and Compliance

This project follows the usual corporate governance protocols as part of Programme 26 (Data Content and New Data Collections). Programme 26 highlight reporting contains all KPIs for this data set implementation and this is available to the Board in the usual manner.

Management Responsibility

Peter Sherratt is the Programme Manager with day to day responsibility for the ECDS work package. Jago Taylor is the Programme Head responsible for ECDS, with Jackie Shears providing director level oversight. Prof. David Hughes is the EMT Director with accountability for this work.

Actions Required of the Board

Accept the Directions.

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DIRECTIONS

NATIONAL HEALTH SERVICE, ENGLAND

The Health and Social Care Information Centre (Establishment of Information Systems for NHS Services: Emergency Care Data Set Collection) Directions 2017

The National Health Service Commissioning Board gives the following Directions to the Health and Social Care Information Centre in exercise of the powers conferred by sections 254(1), (3) and (6) of the Health and Social Care Act 2012.

In accordance with section 254(5) of the Health and Social Care Act 2012, the National Health Service Commissioning Board has consulted the Health and Social Care Information Centre before giving these Directions[1].

Citation, commencement and interpretation

1. These Directions may be cited as The Health and Social Care Information Centre (Establishment of Information Systems for NHS Services: Emergency Care Data Set Collection) Directions 2017 and shall come into force on **[date].**

2. In these Directions–

"The 2012 Act"	means the Health and Social Care Act 2012[2];
"The Board"	means the National Health Service Commissioning Board[3];
"HSCIC"	means the Health and Social Care Information Centre[4];

[1] S.I. 2013/259
[2] 2012 c7
[3] The National Health Service Commissioning Board was established by section 1H of the National Health Service Act 2006 (2006 c 41.), and operates as NHS England.
[4] The Health and Social Care Information Centre is a body corporate established under section 252(1) of the Health and Social Care Act 2012

"Relevant Organisation"	means Accident and Emergency Department;
"Specification"	means the Commissioning Data Set v6.2.1 Introduction of CDS Type 011 Emergency Care Data Set version 1.0 (Document Reference: SCCI0092-2062, CDS6.2.1, Amd 17/2015) issued on 19/04/2017 and annexed to these Directions at Annex A or any subsequent amended version of the same document approved by the Board which supersedes version 1.0;
"Technical Output Specification"	means the CDS Type 011 - ECDS v1.0 Technical Specification version 1.0 dated 19/04/2017 and annexed to these Directions at Annex B or any subsequent amended version of the same document approved by the Board which supersedes version 1.0

Establishing and Operating the Emergency Care Data Set Collection Information System

3. – (1) Pursuant to its powers under sections 254(1) and 254(6) of the 2012 Act, the Board directs the HSCIC to establish and operate a system for the collection of the information described in sub-paragraph (2) from Relevant Organisations, such system to be known as "the Emergency Care Data Set Collection Information System".

(2) The information referred to in sub-paragraph (1) is set out in the Technical Output Specification.

(3) The Board directs HSCIC to carry out the activities described in sub-paragraph (1) in accordance with the Specification and generally in such a way as to enable and facilitate the purposes that are described in the Specification.

S254(3) - Requirement for these Directions

4. In accordance with section 254(3) of the 2012 Act, the Board confirms that it is necessary or expedient for it to have the information which will be obtained through the HSCIC complying with these Directions in relation to the Board's functions in connection with the provision of NHS Services.

Fees and Accounts

5. Pursuant to sub-section 254(7) of the 2012 Act, HSCIC is entitled to charge a reasonable fee in respect of the cost of HSCIC complying with these Directions.

DRAFT

6. The HSCIC must keep proper accounts, and proper records in relation to the accounts, in connection with the Emergency Care Data Set Collection Information System.

Review of these Directions

7. These Directions will be reviewed by the Board when the Specification or Technical Output Specification are amended. This review will include consultation with the HSCIC as required by sub-section 254(5) of the 2012 Act.

Signed by authority of the NHS Commissioning Board

Sir Bruce Keogh
Caldicott Guardian

[INSERT DATE]

Annex A – Specification

Annex A – Technical Output Specification

ECDS Technical Output Spec v6.2.xls

DRAFT

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Document filename:	Introduction of CDS Type 011 – Emergency Care Data Set - Requirements Specification		
Project / Programme	**ECDS Impact Assessment Team**	Project	**ECDS**
Document Reference	**SCCI0092-2062, CDS6.2.1, Amd 17/2015**		
Project Manager	**Aaron Haile**	Status	**Final**
Owner	**Aaron Haile**	Version	**1.0**
Author	**Sam Sibeko**	Version issue date	**19/04/2017**

Commissioning Data Set v6.2.1

Introduction of CDS Type 011 Emergency Care Data Set

Requirements Specification

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Document management

Revision History

Version	Date	Summary of Changes
0.1	28/09/2016	First draft for comment to include ECDS
0.2	04/10/2016	SCCI and NHS Digital Rebranding
0.3	10/10/2016	Confirmation of new CDS Type 011 Emergency Care Dataset
0.4	01/11/2016	ECDS requirements included
0.5	04/11/2016	Additional review
0.6	09/11/2016	Further review
0.7	09/11/2016	Further review
0.8	17/11/2016	Comments addressed following SCCI Review
0.9	09/12/2016	Comments addressed following 6/12/2016 ISAS Review
0.10	13/12/2016	Additional comments following ISAS Review
0.11	16/01/2017	Further comments addressed following ISAS Review
0.12	19/01/2017	Developer review and comment prior to Advanced Notification publication
0.13	23/01/2017	Final review prior to Advance Notification
0.14	13/02/2017	Additional review
0.15	14/02/2017	Final review
0.16	23/02/2017	Update following comments from SCCI Development (AH)
0.17	23/02/2017	Final update following comments from SCCI Development (SS)
0.18	30/03/2017	Final SCCI comments
0.19	04/05/2017	Development team review
0.20	06/04/2017	Inclusion of data flow
0.21	12/04/2017	Updated following SCCI final review feedback
1.0	19/04/2017	Publication copy

Reviewers

This document must be reviewed by the following people:

Reviewer name	Title / Responsibility	Date	Version
Aaron Haile	RCEM ECDS Project Manager	06/05/2017	0.20
Tom Hughes	ECDS Clinical Lead	06/05/2017	0.20
Jonathan Benger	National Clinical Lead Urgent Care, NHS England/ SRO ECDS Project	19/01/2016	0.12
Peter Sherratt	NHS Digital Programme Manager	06/05/2017	0.20

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Approved by

This document must be approved by the following people:

Reviewer name	Title / Responsibility	Date	Version
Aaron Haile	RCEM ECDS Project Manager	04/05/2017	0.20
Peter Sherratt	NHS Digital Programme Manager	04/05/2017	0.20

NHS England has approved this information standard (SCCI0092-2062) for publication under section 250 of the Health and Social Care Act 2012.

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

This information standard comprises the following documents:

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

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

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

Date of publication: 19 April 2017

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Glossary of Terms

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

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		commissioners provide best value to their patients. https://www.gov.uk/government/publications/nhs-national-tariff-payment-system-201617
Public Health England	**PHE**	An executive agency, sponsored by the Department of Health to protect and improve the nation's health and wellbeing, and reduce health inequalities
Role Based Access Control	**RBAC**	RBAC is the process through which a national set of job roles, activities and workgroups can be applied to grant users access to functionality and indirectly to data within NHS national (Spine) services. https://digital.nhs.uk/article/311/Registration-Authorities-and-Smartcards
Referral to Treatment	**RTT**	Waiting Times measurement policy for consultant led and Allied Health Professional activity, which monitors the waiting time between the referral of a patient to a service, to the time they receive first definitive treatment for their condition
Standardisation Committee for Care Information	**SCCI**	The Committee that oversees the development, assurance and approval of information standards, data collections and data extractions
Secondary Uses Service	**SUS**	Single source of comprehensive data to enable a range of reporting and analysis managed by NHS Digital. SUS supports the NHS and its partners in the areas of planning, commissioning, management, research, audit, public health and a number of national initiatives, such as National Tariff and the reimbursement mechanism for acute care.
Treatment Function Code	**TFC**	A division of clinical work based on Main Specialty, but incorporating approved sub-specialties and treatment interests used by lead care professionals including but not limited to Consultants
Extensible Markup Language	**XML**	XML is a markup language designed to carry data, not to display data. It is the CDS XML schemas which carry data in the Commissioning Data Set format between health care providers and the Secondary Uses Services (SUS)

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1 Purpose

The purpose of this document is to precisely define the introduction of Commissioning Data Set (CDS) Type 011 – Emergency Care Data Set (ECDS) which will replace the current CDS Type 010 A&E within the existing Commissioning Data Set v6.2, outlining what it is and how it should be implemented.

CDS is an existing, approved information standard with version CDS 6.2 currently operational across the health service, and will continue to be in use. This specification will focus upon the inclusion of the new CDS Type 011 within the existing CDS 6.2.

This specification and other supporting documentation such as the Change Specification and Implementation Guidance is intended to provide necessary information to support the following uses for different types of user:

- Existing users of CDS 6.2 and submitting CDS Type 010 A&E
- New users who will be specifically submitting CDS Type 011 - ECDS

It is not the intention of this document to detail the existing requirements for CDS v6.2, but only those pertinent to the introduction of the new CDS Type 011 and associated CDS Type 011 XML schema.

1.1 Background

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

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

These include:

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

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

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

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

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

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

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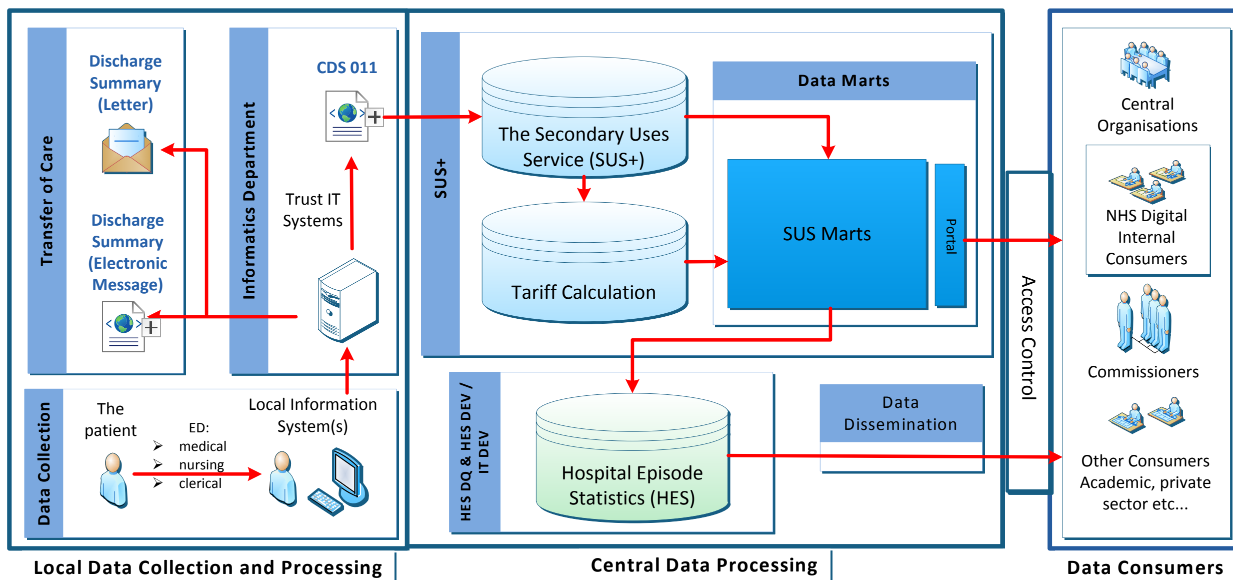
In ECDS (CDS v6.2.1) the developers have sought to align data collection for primary and secondary uses wherever possible as this ensures data quality that benefits patients, staff, commissioners, researchers and the wider NHS.

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

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



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

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

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

The Emergency Care Data Set project team, which consists of representatives from the Royal College of Emergency Medicine NHS England and NHS Digital have identified the following issues in the current data:

- A need for **accurate and relevant information regarding patients presenting to Accident and Emergency Departments** in England, and the quality of care delivered. The current CDS Data Set Type 010 A&E does not capture all the information relating to a patient's attendance at an Accident and Emergency Department, resulting in gaps in the record of the patient journey such as:
  - There is no accurate record of the source of the patient's referral to the Accident and Emergency Department.
  - The patient's chief complaint (the primary clinical reason for the attendance) is not captured consistently or submitted centrally.
  - There is no detailed information capturing what happens to patients during their Accident and Emergency attendance, e.g. when patients are referred to inpatient services for assessment or admission.

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

Commissioning Data Set Data Flow Definitions

The Commissioning Data Set is the basic structure used for the submission of commissioning data to the Secondary Uses Service (SUS) and is designed to be capable of individually conveying many different Commissioning Data Set structures encompassing Accident and Emergency Attendances, Outpatient Attendances, Future Attendances, Admitted Patient Care and Elective Admission List data.

Commissioning Data Set Messages have been defined in specific components known as a CDS type. Each Commissioning Data Set Type as configured into the Commissioning Data Set Message carries only one specific Commissioning Data Set Type, an example being the Finished Consultant Episode Commissioning Data Set Type.

CDS v6.2.1 Type 011 - ECDS will eventually replace the current CDS Type 010 A&E. CDS Type 010 A&E will cease to be supported from April 2019.

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Full details of the current baseline Commissioning Data Sets (CDS) including the specification for the CDS types outlined above, definitions and supporting guidance, XML schemas and submission rules are available from
http://www.datadictionary.nhs.uk/web_site_content/navigation/commissioning_data_sets_menu.asp

A provider will be required to continue submitting CDS Type 010 A&E, until they start submitting CDS Type 011 ECDS, please see the tables below.

Providers will not be expected to submit both CDS types simultaneously unless they implement across different department types in a phased approach e.g. Type 1 or 2 Departments from October 2017 and Type 3 or 4 Departments from October 2018. CDS Type 010 A&E will be withdrawn in April 2019.

CDS Type	CDS Title	CDS Description	Status	Minimum Frequency for Submission
Accident and Emergency Commissioning Data Set Type 010 A&E:				
010	Accident and Emergency CDS	Contains details of all Accident and Emergency Attendances.	Mandatory	Monthly

Or;

CDS Type	CDS Title	CDS Description	Status	Minimum Frequency for Submission
Accident and Emergency Commissioning Data Set Type 011 - ECDS				
011	Emergency Care Data Set	Contains details of all Accident and Emergency Attendances	Mandatory	Weekly/ Daily

Supporting CDS Types
The table below lists the Commissioning Data Set Interchange and Message Controls to support the national flow of CDS information. These headers and trailers help to specify the data items used for data handling and management within the Secondary Uses Service.

CDS Type	CDS Title	CDS Description	Status	
Commissioning Data Set Interchange and Message Controls				
001	CDS Interchange Header	Contains the metadata that describes the identity and addressing information for the Commissioning Data Set submission and signals the start of a CDS submission.	Mandatory	Must be submitted for every CDS Interchange
002	CDS Interchange Trailer	Contains the metadata that describes the identity and addressing information for the Commissioning Data Set submission and signals the end of a CDS submission.	Mandatory	Must be submitted for every CDS Interchange
003	CDS Message Header	Contains the metadata that describes the content of the message and signals the start of CDS message.	Mandatory	Must be submitted for every CDS Message

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004	CDS Message Trailer	Contains the metadata that describes the content of the message and signals the end of CDS message.	Mandatory	Must be submitted for every CDS Message
Commissioning Data Set Transaction Header Group				
005B	CDS Transaction Header Group - Bulk Update Protocol	Contains the metadata that describe the controls for a bulk submission.	Mandatory	Must be submitted for every bulk CDS submission

Or;

005N	CDS Transaction Header Group - Net Change Protocol	Contains the metadata that describe the controls for a net submission.	Mandatory	Must be submitted for every net CDS submission

For further details on the mandated CDS data sets, please visit:
http://www.datadictionary.nhs.uk/web_site_content/cds_supporting_information/commissioning_data_sets_overview.asp?shownav=1?query=%22Commissioning+Data+Sets%22&rank=62.5&shownav=1

The current CDS v6.2 uses the Electronic Data Transfer (EDT) mechanism to transport and submit XML files to the Secondary Uses Service. EDT will continue to be used for CDS Types including CDS Type 010, but for CDS v6.2.1 Type 011 - ECDS, the Messaging Exchange for Social Care and Health (MESH) will be used as the mechanism to transport and submit files to the Secondary Uses Service.

Further details about MESH is available from: https://digital.nhs.uk/messaging-exchange-social-care-health, and is detailed further within this document.

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2 Overview

2.1 Summary

Standard	
Standard Number	SCCI0092-2062
Standard Title	Commissioning Data Sets (CDS)
Release	
Release Number	Amd 17/2015
Release Title	Version 6.2.1: Addition of CDS Type 011 - ECDS
Description	This change outlines the introduction of CDS v6.2.1 Data Set Type 011 Emergency Care Data Set, within the existing CDS v6.2. The submission of CDS v6.2.1 Type 011 - ECDS will apply to all Accident and Emergency Department Types, explicitly, Types 1, 2, 3 and 4. Providers must continue to submit all other CDS Types within the current CDS v6.2, using the existing mechanisms to do so, but replace the current submission of CDS Type 010 A&E, with the new CDS v6.2.1 Type 011 - ECDS. Once CDS v6.2.1 Type 011 - ECDS has been implemented by a particular site, CDS Type 010 A&E will no longer be accepted by SUS for that site. CDS v6.2 will continue to be supported via the Secondary Uses Service (SUS), and any changes to SUS will also be applicable for CDS v6.2.1 Type 011 - ECDS, as and when this occurs. CDS v6.2.1 Type 011 - ECDS will initially be a weekly feed at least, from October 2017, moving ultimately to a daily feed from April 2018. When submitting CDS v6.2.1 Type 011 - ECDS on a daily basis, this should be automated from the Emergency Department Information System. CDS v6.2.1 Type 011 - ECDS data set includes code sets represented as NHS Data Dictionary-defined National Codes or SNOMED CT concepts. The changes outlined following this introduction will support the following areas: • Continued support for National Tariff • Accident and Emergency Clinical Quality Indicators (CQIs) • Mental Health • Improving Quality and Value of Hospital Data • Injury Surveillance • Changes to support local analysis by providers and commissioners • Maintenance updates to ensure alignment with NHS Data Dictionary editorial policy and to address known issues The current CDS Type 010 A&E data will be withdrawn from 1st April 2019.
Implementation Completion Date	ED Types 1, 2, 3 and 4 **MAY** flow CDS Type 011 ECDS from 1st August 2017 ED Types 1 and 2 **MUST** flow CDS Type 011 ECDS from 1st October 2017 ED Types 3 and 4 **MUST** flow CDS Type 011 ECDS from 1st October 2018

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2.2 Supporting Products

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

2.3 Related Standards

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

2.4 Contacts

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3 Requirements

3.1 Overview

The 'CDS v6.2 Addition of CDS Type 011 – ECDS Change Specification', outlines the changes from the existing baseline CDS 6.2 Information Standard.

Providers which currently submit CDS v6.2 must continue to do so, but will need to discontinue submission of CDS Type 010 A&E and replace this with CDS v6.2.1 Type 011 - ECDS.

Therefore all current providers submitting CDS v6.2 will submit either:

- CDS v6.2 including CDS Type 010 A&E as they do currently, until their implementation of this standard, when they will then submit;
- CDS v6.2 excluding CDS Type 010 A&E, but in addition, the new CDS v6.2.1 Type 011 - ECDS

Providers who deliver urgent and emergency care services, but do not currently submit CDS v6.2 will need to ensure they submit:

- CDS v6.2.1 Type 011 - ECDS

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

Providers current CDS 6.2 Submission Status	Expected Change for Providers
Providers submitting CDS 6.2, within one file, including CDS Type 010, via EDT	• Separate the CDS Type 010 elements from current CDS 6.2 file pack where submissions are made including all CDS Types within one file • Continue to submit remaining CDS Types within CDS 6.2 via Electronic Data Transfer (EDT) • **Submit CDS Type 011, instead of CDS Type 010, via Message Exchange for Social Care and Health (MESH)**
Providers submitting CDS 6.2, within separate files or independently of each other, including CDS Type 010, via EDT	• Stop submitting CDS Type 010 as a separate file • Continue to submit remaining CDS Types within CDS 6.2 via EDT • **Submit CDS Type 011, instead of CDS Type 010, via MESH**
Providers only submitting CDS Type 010 via EDT	• Stop submitting CDS Type 010 via EDT • **Submit CDS Type 011, instead of CDS Type 010, via MESH**
Providers not required to submit CDS Type 010, but submit other CDS Types within CDS 6.2	• No change, continue to submit CDS Types (all others excluding CDS Type 010) via EDT
Accident and Emergency Departments that currently do not submit any CDS Types within CDS 6.2	• **Submit CDS Type 011 via MESH**

Corresponding NHS Data Dictionary changes from CDS Type 010 A&E to CDS Type 011 will be available from: http://www.datadictionary.nhs.uk/web_site_content/cds_supporting_information/commissioning_data_set_version_6-2_type_list.asp?shownav=1

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3.2 Information Specification

All requirements in relation to the CDS Types within the CDS 6.2 Requirement Specification will remain as is, with the exception of CDS Type 010 A&E which will be replaced by the new requirements specific to the submission of CDS Type 011 ECDS.

#	Requirement [1]
	Healthcare Providers
1	All providers of emergency care including Type 1, 2, 3 and 4 Accident and Emergency Department Types **MAY** submit the new CDS v6.2.1 Type 011 - ECDS to the Secondary Uses Service (SUS) **from 1st August 2017** on a weekly or daily basis. This will require all providers to ensure their suppliers of relevant clinical systems, patient administration systems and/or XML Middleware suppliers can incorporate the required changes in order to meet this capability.
2	Providers of emergency care specifically Types 1 and 2 Accident and Emergency Department Types **MUST** submit the new CDS v6.2.1 Type 011 - ECDS to the Secondary Uses Service (SUS) **from 1st October 2017** on a weekly basis at least. This will require all providers to ensure their suppliers of relevant clinical systems, patient administration systems and/ or XML Middleware suppliers can incorporate the required changes in order to meet this capability.
3	Providers of emergency care specifically Types 1 and 2 Accident and Emergency Department Types MUST submit the new CDS Type 011- ECDS to the Secondary Uses Service (SUS) **from 1st April 2018** on a daily basis. This will require all providers to ensure their suppliers of relevant clinical systems, patient administration systems and/ or XML Middleware suppliers can incorporate the required changes in order to meet this capability.
4	Providers of emergency care specifically Types 3 and 4 Accident and Emergency Department Types **MUST** submit the new CDS v6.2.1 Type 011 - ECDS to the Secondary Uses Service (SUS) **from 1st October 2018** on a daily basis. This will require all providers to ensure their suppliers of relevant clinical systems, patient administration systems and/ or XML Middleware suppliers can incorporate the required changes in order to meet this capability.
5	All providers of CDS v6.2.1 Type 011 - ECDS **SHOULD** automate their data submission processes to provide weekly and then daily data. This will require all providers to ensure their suppliers of relevant clinical systems, patient administration systems and/ or XML Middleware suppliers can incorporate the required changes in order to meet this capability.
6	All providers of CDS v6.2.1 Type 011 - ECDS **SHOULD** submit changes using the Data Set Net Change Protocol. This will require all providers to ensure their suppliers of relevant clinical systems, patient administration systems and/ or XML Middleware suppliers can incorporate the required changes in order to meet this capability.

3.3 Conformance Criteria

This section describes the tests that can be measured to indicate that the information standard is being used correctly by an organisation (conformance criteria). These may be different depending upon the Emergency Care type.

[1] https://www.ietf.org/rfc/rfc2119.txt

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The conformance criteria outlined below are directly linked to the CQUIN Indicator Specification Information on CQUIN 2017/18 - 2018/19[1], Supporting Proactive and Safe Discharge.

Healthcare Providers

#	Conformance Criteria
1	By 30th June 2017 Accident and Emergency Department Type 1 and 2 providers to: • have demonstrable and credible planning in place to make the required preparations (e.g. by upgrading IT systems and training staff) so that ECDS can be collected and returned from 1st October 2017.
2	By 31st December 2017 Accident and Emergency Department Type 1 and 2 providers to: • return data at least weekly **AND**; • 95% of patients have both a valid Chief Complaint and a Diagnosis (unless that patient is streamed to another service) so that 95% of patients have a diagnosis. - Chief Complaint shall be any value from the ECDS Chief Complaint code set (SNOMED CT). - Diagnosis shall be any value from the ECDS Diagnosis code set (SNOMED CT).
3	By 30th June 2018 Accident and Emergency Department Types 1 and 2 providers to: • return data daily **AND**; • 99% of patients have both a valid Chief Complaint and a Diagnosis (unless that patient is streamed to another service) so that 99% of patients have a diagnosis - Chief complaint shall be any value from the ECDS Chief Complaint code set (SNOMED CT) - Diagnosis shall be any value from the ECDS diagnosis code set (SNOMED CT), **AND**; • 99% of patients have a measure of acuity recorded - Acuity shall be any value from the ECDS acuity set.
4	By 30th September 2018 Accident and Emergency Department Types 1 and 2 providers to: • return data daily **AND**; • 100% of patients have both a valid Chief Complaint and a Diagnosis (unless that patient is streamed to another service) so that 100% of patients have a diagnosis, **AND**; • 100% of patients have a measure of acuity recorded, **AND** • 100% of patients record the discharging clinician (using the GMC/NMC/HCPC number).
5	By 31st December 2018 Accident and Emergency Department Types 1 and 2 providers to: • Return data daily **AND**; • 100% of patients have both a valid Chief Complaint and a Diagnosis (unless that patient is streamed to another service) so that 100% of patients have a diagnosis, **AND** • 100% of patients have a measure of acuity recorded, **AND**; • 100% of patients record the discharging clinician (using the GMC/NMC/HCPC number), **AND**

[1] https://www.england.nhs.uk/wp-content/uploads/2016/11/cquin-indicator-spec-04-11-16.docx

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	• 100% of patients have the referral source recorded. (Referral source should be any value from the EDCS referral source set).
6	By 31st March 2019 Accident and Emergency Department Types 1 and 2 providers to: • return data daily, **AND**; • 100% of patients have both a valid Chief Complaint and a Diagnosis (unless that patient is streamed to another service) so that 100% of patients have a diagnosis, **AND**; • 100% of patients have a measure of acuity recorded, **AND**; • 100% of patients record the discharging clinician (using the GMC/NMC/HCPC number), **AND;** • 100% of patients have the referral source recorded, **AND** • 100% of patients have discharge status recorded. (Discharge status should be any value from the EDCS Discharge Status set).
7	By 1st October 2018 all Type 3 and Type 4 Emergency Departments (including Urgent Care Centres) MUST be submitting CDS v6.2.1 Type 011 – ECDS.

Conformance with the CDS Type 011 XML schema will be enforced through the CDS 6.2.1 schema and validation upon landing within Secondary Uses Service (SUS) of correct use of associated SNOMED CT code sets and other necessary validation rules including correct format/ length, enumerated national codes where applicable, and mandation of the fields (Mandatory, Required or Optional), all of which are published from: https://isd.hscic.gov.uk/trud3/user/guest/group/0/home.

All CDS v6.2.1 Type 011 - ECDS submissions will need to adhere to the restrictions enforced by the XML schema.

Upon translation any interchanges containing records that do not conform to the XML schema or other necessary validation rules, i.e. field length and format, will be rejected. In these cases a validation report will be provided to assist the sender in the identification and resolution of issues.

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4 Concept of Operation

4.1 Data Users

4.1.1 Data Collectors and Providers

- Healthcare Professionals: will be responsible for capturing information as part of the ongoing care of the patient, i.e. for primary use purposes as they do currently.
- Administrative Staff: will be responsible for capturing clerical information such as demographics.
- If the trust use clinical coders to support the recording of clinical information from Emergency Departments coders must ensure that they collect information which is either specified in the CDS v6.2.1 Type 011 - ECDS Technical Output Specification or that arrangements are put in place to map what they collect to the required CDS v6.2.1 Type 011 - ECDS SNOMED CT subsets.
- XML/Middleware Suppliers: will continue to support CDS v6.2 and will develop tools and/or services to process submissions in conformant XML for submission to SUS, specifically for CDS v6.2.1 Type 011 - ECDS and other CDS types as necessary.
- Suppliers of Patient Administration (PAS) and Emergency Department Information Systems: will develop systems ensuring that ECDS data items can be captured electronically and output the required CDS 6.2 Type 011 - ECDS submission.
- Trust informatics staff: will be responsible for the collation of ECDS information and the submission of this via MESH (to submit CDS v6.2.1 Type 011 - ECDS) to SUS via XML Middleware Suppliers or in-house products licensed from XML/Middleware Suppliers. This will include ensuring completeness and addressing any data quality issues identified with the information within the data set.

4.1.2 Secondary Users

Information generated through implementation of this standard will continue to be analysed and used by the existing users of CDS v6.2 data.

The data collected via CDS Type 011 – ECDS will enable users to analyse and compare more granular, higher quality data for reporting, audit, research and for service delivery. It will provide vital information which will support the following:

- The provision of an accurate and relevant record of why patients attend emergency departments in England, the quality of care that they receive and what happens to them after the attendance. This in turn will enable a greater understanding of patient outcomes and the value added by emergency care services.
- A greater understanding of the complexity of patients who attend emergency departments and the services required to treat them appropriately.
- A better understanding of how people access urgent and emergency care services particularly in relation to overall patient flow in the urgent care system.
- More information to help understand who is doing what and where, with the aim of achieving more effective and efficient resource deployment across urgent and emergency care services.
- A national picture of the number of patients attending emergency departments as a result of injury which will support the development of targeted prevention strategies which would in turn reduce the number of emergency department attendances and improve the lives of patients.
- Public Health syndromic surveillance via the Emergency Department Syndromic Surveillance System (EDSSS) which collects information on patient illnesses presenting to Emergency Departments and is consistently monitored to provide public health situational awareness, as well as early warning of emerging population health threats.

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4.2 Use of SNOMED CT

4.2.1 What is SNOMED CT

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

SNOMED CT provides the content for health and care related data items in software applications to enable representation of clinically relevant information consistently and reliably in a way that is processable by the computer system. This enables applications to exchange processable data across the health and care environment; provide clinical decision support tools and undertake enhanced analytics to support effective delivery of high quality healthcare to individual people and populations.

SNOMED CT is managed and maintained internationally by SNOMED International[2] and in the UK by the UK Terminology Centre (UKTC)[3].

SNOMED CT is specified as the single terminology to be used across the health system in 'Personalised Health and Care 2020: A Framework for Action'.

4.2.2 SNOMED CT and Paperless 2020

As the NHS moves towards being paperless by 2020 it is critical that all systems share the same clinical vocabulary.

Providers of health and care are required to be paperless at the point of care before 2020: such systems must incorporate SNOMED CT as the clinical terminology to provide the content for structured data within scope of the terminology. The SNOMED CT standard was approved by the Information Standards Board in 2011; providers implementing electronic health and care related systems must ensure those systems are SNOMED CT enabled at the point of implementation. The following is a summary of conformance dates for appropriate implementation of SNOMED CT that all providers and standards developers must be aware of when planning new, or making changes to existing IT systems or relevant operational information standards:

- Systems used by, or communicating coded clinical data to, General Practice service providers must use SNOMED CT as the clinical terminology within the system before 1 April 2018. SNOMED CT must be utilised in place of the Read codes before 1 April 2018.
- Systems used within Secondary Care, Acute Care, Mental Health Services, Community Services, Dentistry and Optometry - for the direct management of care of an individual - must use SNOMED CT as the clinical terminology standard within all electronic patient level recording and communications before 1 April 2020.
- Systems used by all other providers of health related services where the flow of information for the direct management of patient care comes into the NHS must use SNOMED CT by 1 April 2020.

Further details in relation to the SNOMED CT Standard is available from: http://content.digital.nhs.uk/media/22807/0034352016req-spec/pdf/0034352016req-spec.pdf

In support of the use of SNOMED CT as outlined above, ECDS mandates the use of SNOMED CT. This will support adoption of SNOMED CT in line with Paperless 2020 and will help to properly capture and represent the full extent and granularity of Emergency Department activity, and therefore:

- enable an accurate understanding of the cost and value of emergency care

[2] http://www.snomed.org/

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

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- facilitate improved healthcare commissioning
- improve the quality of patient care in England's Emergency Departments
- provide more effective delivery of healthcare strategy and policy

Further details of how SNOMED CT should be implemented to support ECDS are available from the ECDS User Guidance, available from: http://content.digital.nhs.uk/ECDS

4.3 Working Practices

Full guidance, including changes to working practices, is available in the CDS 6.2 Implementation Guidance available from: http://content.digital.nhs.uk/isce/publication/SCCI0092-2062

4.4 Information Governance

4.4.1 Background

The Chief Medical Officer of England commissioned the 'Department of Health - The Caldicott Committee Report on the Review of Patient-Identifiable Information' (Dec 1997)[4] report, to review the transfer of patient-identifiable information from NHS organisations to other NHS and non-NHS organisations. The report included 16 recommendations and suggested six principles be applied to current flows and any flows proposed in the future. 'Information: To share or not to share? The Information Governance Review' (March 2013)[5] followed. Known as Caldicott2, it was an independent review of information sharing by Dame Fiona Caldicott at the request of the Secretary of State for Health (March 2013). This review was to ensure an appropriate balance between protection of patient information, and its use and sharing. The Government subsequently accepted the recommendations from this report (September 2013), and the 'National Data Guardian for Health and Care Review of Data Security, Consent and Opt-Outs' (June 2016)[6] outlines the recommendations of the new data security standards.

4.4.2 Overview

Commissioning Data Sets 6.2 currently has section 251[7] approval from the Confidentiality Advisory Group to allow the flow and storage of patient identifiable data without patient consent within the national, strategic data warehouse as part of the SUS application.

As a result of the introduction of CDS 6.2.1 Type 011 - ECDS , a Direction will support the legal flow of the data. The Direction will not cover the entire CDS v6.2 as this will remain subject to the section 251 approval.

NHS Digital (the operating name for the Health and Social Care Information Centre) is exempt from having to apply for section 251 support from the Confidentiality Advisory Group (CAG) when mandated to collect data via directions from NHS England or the Department of Health and when acting as data controller. This is set out in sections 254 and 255 of the Health and Social Care Act 2012.

As a result explicit consent is not required; however, providers are required to inform patients that their information will be used to support secondary uses, and to act on any objections raised in line with their local policy.

If consent is sought and not given, then this information must not be shared and other legal routes for sharing are not available.

[4] http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationspolicyandGuidance/DH_4068403

[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf

[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/535024/data-security-review.PDF

[7] http://www.legislation.gov.uk/ukpga/2006/41/section/251

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Where a patient explicitly objects to their data being used for secondary purposes, the provider has the option of not flowing the records for this patient, as directed by their local Caldicott Guardian.

Further information on a patient's personal information choices can be found at NHS Digital's, "How we look after information"

A Data Provision Notice (DPN), produced by NHS Digital will be prepared confirming the structure and content of the collection and will be used to confirm NHS Digital's legal requirement to collect the data.

4.4.3 Type 1

If a patient does not want information that identifies them to be shared outside their GP practice, for purposes beyond their direct care then the patient can register a type 1 opt-out with their GP practice. This prevents their personal confidential information from being used other than in particular circumstances required by law, such as a public health emergency like an outbreak of a pandemic disease.

4.4.4 Type 2

NHS Digital collects information from a range of places where people receive care, such as hospitals and community services. If a patient does not want their personal confidential information to be shared outside of NHS Digital, for purposes other than direct care then the patient can register a type 2 opt-out with their GP practice.

A direction from the Secretary of State sets out the Department of Health policy as to how type 2 opt-outs must be applied and instructs NHS Digital to apply type 2 opt-outs.

However, Type 2 opt-outs do **not** apply in the following circumstance, where information is made available in anonymised form (so that individuals are not identified in the data). For example the data are either aggregate such as counts of information or it complies with the ICO's Anonymisation: managing data protection risk code of practice

Where a patient objects, the NHS has the option to flow the data without patient identifiers such as the NHS Number or not flow the data at all, as directed by the local Caldicott Guardian. This remains the same as currently applies to CDS Type 010 A&E.

4.4.5 Patient Identifiable Data Items

Commissioning Data Sets (CDS) include several patient identifiable items, e.g.

- NHS Number
- Local Patient Identifier
- Name
- Address
- Date of Birth
- Postcode of Usual Address.

CDS necessarily includes patient identifiers to support the linkage of activity to create a complete picture of the patient pathway, for example across A&E, Admitted Patient Care and Outpatient Appointments, and also to support commissioning of health services and remuneration for activity undertaken by providers.

4.4.6 Secondary Care Use

Any secondary care uses of data must be subject to compliance with the appropriate legal basis, and service providers should review their own information governance standards to ensure they are complying accordingly.

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4.4.7 Direct Care

ECDS can be used for direct care, but the information for direct care would be shared before the data has become the ECDS.

4.5 Ethics

There are not considered to be any ethical issues associated with the move to CDS v6.2.1 Type 011 - ECDS. The Ethics and Confidentiality Committee (ECC) have not raised any concerns about the changes to CDS 6.2.

4.6 Clinical Safety

Commissioning Data Sets (CDS) utilise information already routinely collected in a variety of Trust systems and collated in a non-clinical setting for secondary uses. There are minimal patient safety or clinical risk implications or potential adverse effects for patients in the application of these changes to implement CDS v6.2.1 Type 011 - ECDS within this existing standard. Any risks identified have been mitigated.

A clinical safety report was produced following a hazard assessment workshop and the consensus was that there were minimal clinical safety risks associated with the implementation of the ECDS as the data set is not primarily used as a tool to support clinical decision making but rather to record information about specific episodes of care. In support of this standard the ECDS Clinical Safety Report has been approved by the NHS Digital Clinical Safety Group.

4.7 Clinical Governance

Commissioning Data Sets support clinical governance by maintaining and improving the quality of patient care within the health system through the national reporting of comparable primary use data for secondary use purposes to standardised definitions to support transparency. This supports (a) the audit of providers by organisations such as Care Quality Commission, Public Health Observatories (PHOs) and other research and commercial organisations and (b) the identification of outliers to indicate areas to focus limited resources for investigation purposes.

4.8 Data Quality

The ECDS does not mandate design of local systems or specific local data quality measures. However, highlighted below, are areas the data set developers recommend should be considered by data providers within their local governance arrangements to ensure good data quality in respect of the extracted submission.

4.8.1 Corporate Data Quality Framework

Each organisation will have its own corporate framework for managing data quality in respect to data collection, submission and publication. Such a framework is likely to involve a number of components such as leadership and direction from a senior officer, organisational and departmental data quality objectives, data quality audits and a performance management framework. It is recommended that appropriate components of the corporate data quality framework include the ECDS, so that data quality relating to the data set is at the heart of the organisation’s data quality framework.

4.8.2 Data Quality Risks

At organisational, departmental and individual levels, risks related to data quality should be identified and mitigated. Examples of risks which could be considered, are:

- Organisational - does the organisation have corporate policy and objectives for managing data? Is there a senior officer with overall responsibility for data quality?

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- Team - are all relevant staff aware of the purpose and importance of collecting data for the national data set? Are there sufficient resources available to continue data collection during staff absences?
- Individuals - do staff have sufficient time within their work routine to collect the data? Is there a need for additional training so staff can possess appropriate skills to collect the data (especially where systems are upgraded)?

4.8.3 Organisational and Departmental Objectives

In any organisation, resources will be deployed towards organisational and departmental objectives.

The organisation's performance management framework will identify the extent to which objectives are met, and, where necessary, revised.

Where the data set is used to monitor progress towards objectives, there will be greater emphasis on collecting good quality data. It may be necessary to embed the data set subject area into the organisation's performance management framework (and therefore set local objectives) to ensure data is collected in a reliable and timely manner.

The structure and internal processes of each data provider will vary and, to a certain extent, depend on the priority given to IT and informatics. Some organisations will have well developed processes and systems that, with minimum effort, will accommodate ECDS. Other organisations, for who processes and systems are underdeveloped, or who will be new to the submission of ECDS may require significant changes. In such instances, organisations may choose to plan the implementation of this Information Standard as a priority to ensure sufficient resources are deployed for conformance.

The implementation of a new or re-engineered process may be more successful where organisations use peer organisations to identify and replicate areas of good practice.

4.8.4 Timeliness

The data should be entered in local systems and submitted in a timely manner, so that the data set can deliver meaningful, relevant and timely reports for stakeholders. This should be followed by a review of data quality to implement improvement actions.

4.8.5 National Data Quality

The submission of CDS Type 011 – ECDS encourages a move towards an automated daily submission.

In all cases a submission will be expected to meet the necessary CDS 6.2.1 XML schema validation, which will go some way to ensure that only valid formats and codes are submitted. The validations, which are described in the ECDS Technical Output, only relate to the structure and validity of the submitted data.

Further validation will involve the continued analysis of submitted CDS Type 011 – ECDS, to identify potential data quality issues for an individual provider or nationally. This will result in NHS Digital working with the provider to ensure that they are aware of potential data quality issues and identifying appropriate resolutions. It will also result in the publication of improved guidance or consideration of future changes to CDS.

VODIMN (Valid, Other, Default, Invalid, Missing, Not Applicable) Reports will be made available to providers to flag potential data quality issues with submitted data.

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5 Implementation and Use

5.1 Guidance

Full guidance is available in the CDS 6.2 Addition of CDS Type 011 ECDS Implementation Guidance, which will specifically reference the continued use of CDS 6.2 in conjunction with the introduction of the new CDS v6.2.1 Type 011 - ECDS, which is available from:
http://content.digital.nhs.uk/isce/publication/SCCI0092-2062

5.2 Governance

NHS Digital will have overall executive responsibility for implementation of changes to CDS.

Implementation of changes to SUS will be managed through the SUS Programme. This will be overseen by the SUS Programme Board.

Ongoing maintenance of CDS will be undertaken by NHS Digital. Users and stakeholders can submit requests for change to: ecds@nhs.net.

Change requests will be prioritised by the sponsor, in conjunction with the SUS User Group (SUG), and will only be progressed where a sponsor and funding can be identified and where a suitable implementation mechanism is available e.g. a SUS release.

The SUS User Group (SUG), comprising key stakeholders representing providers, system suppliers and commissioners, fulfils the role as CDS Expert Working Group.

5.3 Technical Architecture

5.3.1 Providers who currently submit CDS 6.2

Providers currently submitting CDS 6.2 must continue to submit CDS 6.2 for all CDS Types, **except CDS Type 010 – A&E,** using current mechanisms (EDT, at time of writing).

A new schema is available for CDS v6.2.1 Type 011 - ECDS (CDS 6.2.1.), which must be used to submit the new Emergency Care Data Set.

When an Emergency Department implements the ECDS it will no longer submit a CDS Type 010 – A&E, it will submit CDS v6.2.1 Type 011 - ECDS, instead.

CDS Type 011 will be submitted via the Messaging Exchange for Social Care and Health (MESH) service – see Using the MESH Service. This is the primary messaging service used across the NHS. MESH is used to transfer electronic messages, directly and securely from one application to another.

Note that if a Healthcare Provider has more than one Emergency Department then it will be allowable to upgrade units at different times, and send CDS 011 to SUS for one unit and CDS 010 to SUS for the other(s) if necessary for local deployment reasons. If this is the case, remember that CDS 011 must be sent via MESH and CDS 010 must be sent via EDT.

5.3.2 Data Validation CDS v6.2.1 Type 011 - ECDS

The EDT service carries out a range of XML data validation processes on files, giving automated feedback to the submitter on the quality of data before it is transmitted onwards to SUS.

The MESH service does not carry out this sophisticated range of data validation processes, but a validation client that can be used locally, before submission to MESH, is possible.

Full data validation is carried out on receipt of the XML file at NHS Digital. Automated feedback is generated, in a similar way as with the EDT service, and made available to the user.

In this way, the migration from using EDT to using MESH closely replicates the services familiar to the historic CDS 6.2 submitter whilst adding additional features useful to the submitter that are built into the MESH service.

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5.4 Providers who currently do not submit CDS 6.2

Providers who do not currently flow CDS 6.2 will need to ensure they can submit the CDS Type 011 xml schema to the Messaging Exchange for Social Care and Health (MESH) service – see below.

5.5 Using the MESH service

There are three main steps required by providers to install the MESH client:

1. Setting up a MESH account by completing the MESH application form: https://digital.nhs.uk/article/912/MESH-application-form
2. Setting up a MESH end point certificate
3. Installing MESH as a service.

For installation guidance of MESH, please visit: https://digital.nhs.uk/messaging-exchange-social-care-health/technical-information.

This information will then be available to the Secondary Uses Services (SUS).

SUS to reduce the use of person identifiable information for purposes other than that of direct patient care. SUS has significantly improved the security and confidentiality of data managed through a combination of:

- Comprehensive and rigorous access controls (Role Based Access Control).
- Anonymisation of data and the use of encrypted pseudonyms to replace information that could be used to identify individuals, which is accessed or transferred from the SUS environment.
- Enabling the linkage of data from different sources relating to the same care pathway.

Full details and guidance relating to submission of CDS to SUS is available from: http://content.digital.nhs.uk/sus

SUS has a robust Information Governance process to ensure that the data is protected from unauthorised access. Approval to access SUS and view patient data is required from the Ethics and Confidentiality Committee (ECC).

Users of SUS are issued with an NHS Care Records Service Smartcard, a pass code and Unique User Identification (UUID) to ensure data is kept secure. SUS will provide access and outputs in clear or pseudonymised form dependent upon each user's access rights. Where access to pseudonymised data is appropriate, elements which could identify a patient are encoded in order to provide greater protection of privacy.

Access to the Spine and SUS is via a connection to Health and Social Care Network (HSCN), the secure private national network for the NHS.

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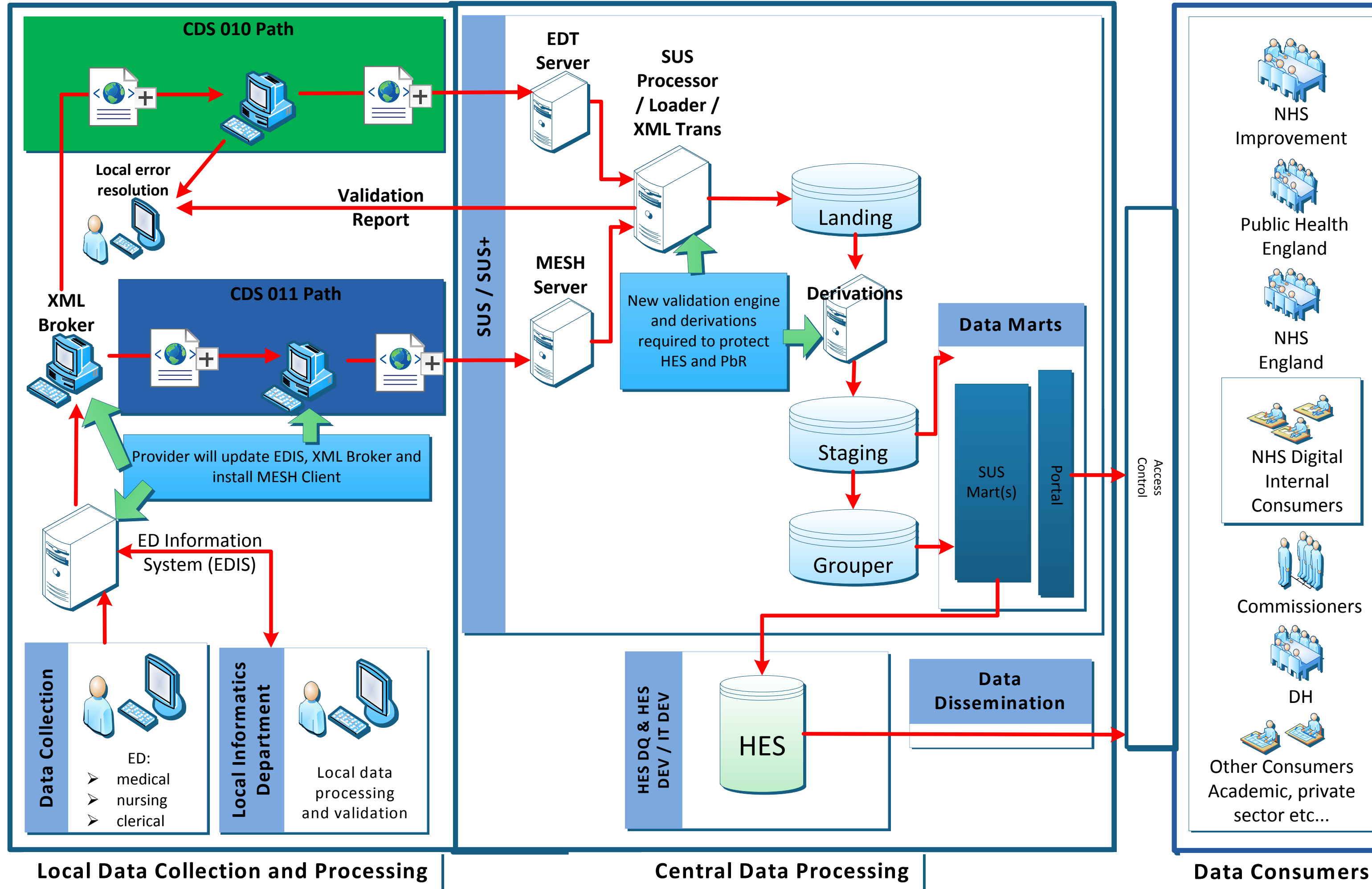
5.5.1 CDS 6.2 and CDS 6.2.1 XML schema flow

The following diagram outlines the data flow for submitting both CDS Type 010 A&E in addition to the CDS v6.2.1 Type 011 - ECDS flows:



5.5.2 CDS 6.2.1 XML Schema

The CDS 6.2.1 XML schema will be published to coincide with the publication of the standard via the Terminology Reference Data Update Distribution (TRUD) Service: https://isd.hscic.gov.uk/trud3/user/guest/group/0/home.

TRUD provides a mechanism for the UK Terminology Centre to license and distribute reference data to interested parties.

5.5.3 CDS 6.2 and CDS 6.2.1 XML Schema support

Upon implementation of CDS 6.2.1 support will continue to be provided by the SUS support teams via enquiries@nhsdigital.nhs.uk.

5.5.4 CDS Type 010 A&E Withdrawal

SUS will continue to support CDS Type 010 A&E submissions from those providers currently doing so until its withdrawal on 31st March 2019.

The current CDS Type 010 A&E will cease to be supported from 1st April 2019, so all providers will need to pay due regard to the standard and transition to using the new CDS v6.2.1 Type 011 - ECDS before this time.

5.5.5 XML/ Middleware Suppliers

All XML / Middleware suppliers will be required to complete appropriate assurance for submission of CDS 6.2.1 xml schema. Information on this assurance approach will be provided by NHS Digital.

All XML / Middleware suppliers will be required to submit the CDS Type 011 ECDS XML schema including the ECDS data to the Messaging Exchange for Social Care and Health (MESH) service (which will transmit the ECDS data to SUS).

For general guidance about MESH, please visit: https://digital.nhs.uk/messaging-exchange-social-care-health

CDS 6.2 will continue to use the EDT client for transmission of data to SUS.

Where changes take place to upgrade the existing SUS version, it is anticipated that the new CDS Type 011 ECDS will also be included within any future delivery and transition road map.

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CDS Type 011 - Emergency Care Data Set (ECDS) Technical Output Specification v1.0

Technical Output Specification

NHS Digital

Purpose of this document

The CDS Type 011 - ECDS v1.0 Technical Output Specification (TOS) is intended to provide a comprehensive technical view of the provider submission (18 data set tables and 39 code sets). It has been accepted by SCCI for publication under section 250 of the Health and Social Care Act 2012. It should be used alongside the requirements specification and implementation guidance, available on the NHS Digital website: www.content.digital.nhs.uk/isce/publication/scci0092-2062.

This technical specification presents the ECDS data item groups and their constituent data items as 'final'.

The 18 data set tables include data item level detail necessary to construct an output data set suitable for submission. The data set tables also include additional information explaining:
- which records should be included in a submission
- the justification for inclusion of new items in the data set
- validation rules
- format
- provenance

ECDS Data Groups

- Patient Pathway
- Patient Identity
- Patient Characteristics
- Mental Health Act Legal Status
- GP Registration
- Emergency Care Attendance Location
- Ambulance Details
- Emergency Care Attendance Characteristics
- Injury Characteristics
- Patient Clinical History
- Service Agreement Details
- Care Professionals (Emergency Care)
- Emergency Care Diagnosis (SNOMED CT)
- Emergency Care Investigations (SNOMED CT)
- Emergency Care Treatments (SNOMED CT)
- Referral to Other Services
- Discharge from Emergency Care
- Research and Outbreak Notification

Background

The Emergency Care Data Set (ECDS) is a new national data set for urgent and emergency care which will be implemented across all Emergency Departments Types (1-4). The ECDS will replace CDS Type 010 A&E with a data set which can properly capture and represent the full extent and granularity of emergency care activity across England.

Related Documents

A comprehensive set of documentation is being developed by the project team which will be published with the ECDS Information Standard Notice in Spring 2017.

This draft document should be read in conjunction with the following documents:
• CDS Type 011 - ECDS Information Standards Notice
• CDS Type 011 - ECDS Requirements Specification
• CDS Type 011 - ECDS Change Request
• CDS Type 011 - ECDS Implementation Guidance
• CDS Type 011 - ECDS User Guidance
• CDS Type 011 - ECDS Technical Guidance

Document Version History

Version	Status	Date Published	Brief Summary of Change
1.0	Draft	May-15	Published in support of the first ECDS development consultation
2.0	Draft	Oct-15	Published following feedback from ECDS May 2015 consultation
3.0	Draft	Apr-16	Published in support of ECDS Impact Assessment and ECDS pilots
4.0	Draft	Oct-16	Published following feedback from Impact Assessment and ECDS pilots
5.0	Draft	Dec-16	Published to provide early view of changes to structure in order to replace the current CDS Type 010 - A&E CDS.
6.0	Draft	Jan-17	Published in support of the ECDS ISN Advanced Notification
6.1	Draft	Feb-17	Submitted as part of ECDS SCCI documentation
6.2	Draft	Feb-17	Updated following schema development
6.3	Draft	Mar-17	Updated following schema testing, inclusion of change log and presentation of amended SNOMED CT ECDS subsets. .
1.0	Final	Apr-17	ECDS v6.3 updated to 'CDS Type 011 - ECDS v1.0' following approval by SCCI.

For more information on the status of this document, please contact:	ECDS Implementation Team NHS Digital 1 Trevelyan Square Boar Lane Leeds, LS1 6AE Tel: 0300 303 5678 Internet: www.digital.nhs.uk Email: ecds@nhs.net

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CDS Type 011 - Emergency Care Data Set (ECDS) Technical Output Specification v1.0

NHS Digital

Technical Output Specification

How to read the ECDS Technical Output Specification

Output Data Set

The table below describes the fields included in the ECDS Output Data Set which follows.

N.B. Blue tabs represent individual ECDS Data Groups

Column Name	Definition
Data Group	The Data Group name is highlighted in the yellow box at the top. This name (or a truncated version of it) will be used to name the corresponding element structure in the Data Dictionary.
Group Status	The group status describes whether or not this group (as a whole) is mandatory or optional and how this group may relate to other groups in the transmission. Link to CDS Notation
Group repeats	The group repeat describes how the group may repeat in the transmission. 0..1 This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 0 to a maximum of 1. 0..9 This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 0 to a maximum of 9. 0..* This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 0 to an unlimited maximum. 1..1 This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 1 to a maximum of 1. 1..97 This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 1 to a maximum of 97. 1..* This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 1 to an unlimited maximum.
DATA GROUP	The Data Group name (see above)
DATA ITEM NAME	The unique title or name of the data item. A link to the NHS Data Model & Dictionary data item page will be added when available.
DATA ITEM DEFINITION	Provides a description and explains in detail what information the data item is requiring the user to capture.
DATA ITEM STATUS	Whether individual data items are Mandatory, Required or Optional. Mandatory: These data items MUST be reported. Failure to submit these items will result in the rejection of the record. Required: These data items SHOULD be reported where they apply. Failure to submit these items will not result in the rejection of the record but may affect the derivation of national indicators or national analysis. (Please note that the purpose of the data set is not to change clinical practice.) Optional: These data items MAY be submitted on an optional basis at the submitters discretion.
CQUIN DATA ITEM REQUIRED (Y/N)	Describes whether the data item is required in the 2017/2019 CQUIN - Indicator 8a
DATA ITEM REPEATS	Describes how the many times this data item may repeat in the transmission. 0..1 This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 0 to a maximum of 1. 0..9 This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 0 to a maximum of 9. 0..* This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 0 to an unlimited maximum. 1..1 This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 1 to a maximum of 1. 1..97 This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 1 to a maximum of 97. 1..* This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 1 to an unlimited maximum.
FORMAT	The format of the data item expressed in data type and length. For dates and times it specifically refers to the exact formatting. For other fields it describes the data type required and the max/min field lengths.
SNOMED CT/DM&D/ODS	Whether the data item should be captured in SNOMED CT, as per the Data Model and Dictionary or via the Organisation Data Service (ODS) service.
JUSTIFICATION	Why the data item has been included.
ECDS CODE SET	A link to the proposed code set. N.B. When available these links will be replaced with internet links for live hosting of sub sets
LINK TO CURRENT CDS Type 010	For information only. Provides a link to the CDS Type 010 which this data item originates from.
VALIDATION RULES: POPULATION VALIDATION	Where the data item format will validated in the schema or where the data item will be validated against an explicit list of permitted values as defined in the NHS Data Dictionary.
VALIDATION RULES: POST SCHEMA VALIDATION	Where the data item will be validated further following submission to the Secondary Uses Service (SUS)
DATA ITEM PROVENANCE	Indicates whether the data item originates from CDS Type 010 or is a new data item.
NOTES	ADDITIONAL INFORMATION

Code Sets

Some of the information provided in the code set tabs is specifically intended for system suppliers to maximise usability and will help minimise time spent searching for codes. User guidance will make specific reference to ECDS Unique ID, flags, grouping and the sort codes.

N.B. Providers and Suppliers should be aware that the CDS Type 011 - ECDS SNOMED CT subsets will be under constant review and some changes may be required following the initial release of these subsets in April 2017. If any amendments/changes to the CDS Type 011 - ECDS SNOMED CT subsets are required they will be available in the October 2017 SNOMED CT release.

SNOMED CT ECDS subsets for human reading and spreadsheet download will be available when the ISN is published. Please note that these have not yet been updated.	https://isd.hscic.gov.uk/trud3/user/authenticated/group/0/pack/40/subpack/296/releases
System suppliers are advised to use ECDS SNOMED CT subsets from the UK Edition of SNOMED CT when this has been updated in line with publication of the ECDS ISN.	https://isd.hscic.gov.uk/trud3/user/authenticated/group/0/pack/26
SNOMED additional information	For more information on the SNOMED CT standard and format information please look at the NHS Digital SNOMED CT Change Specification

N.B. Yellow Tabs represent accompanying code sets for each ECDS data group.

Column Name	Definition
ECDS_UniqueID	A unique number for that data item that incorporates the sort codes, and allows this single number to be used • to identify that code • as a single number to allow those data items to be ordered (e.g. if returning items in a search box)
Sort1/Sort2/Sort3	Together with the ECDS 'Group code', the ECDS 'Sort Codes' enable sequential sorting e.g. to support the use of linked dropdown boxes.
ECDS_Group	Can be used to support implementation of sequential sorting of longer code sets to improve usability.
ECDS_Description	The ECDS description of the DM&D or SNOMED CT term.
ECDS_Code (SNOMED CT)	The ECDS code, this will either be SNOMED CT or NHS Data Dictionary
SNOMED CT_TERM	The full SNOMED CT term where relevant
ECDS_Notes	Supporting information

Flags	The flags appear both in the Diagnosis and Chief Complaint code sets and specifically for injury are intended to identify which Chief Complaints and Diagnoses should indicate that the injury data items should be completed. The flags in the Chief Complaint and Diagnosis code sets are meant as guidance for suppliers and providers during implementation. Injury flag (Chief Complaint and Diagnosis)- Helps to identify whether an attendance is likely to be the result of an injury and could be used to trigger the injury data group. AEC – This could indicate that this is an Ambulatory Emergency Care condition Notifiable Disease – Indicates that this is a Notifiable disease and should be restrained Allergy – Identifies that the chief complaint and/or diagnosis are allergy related and that this information should flow as part of the ED Discharge summary Male – Indicates when a chief complaint and/or diagnosis is specifically a male condition (should mean that you get fewer pregnant males recorded) and that you would not expect to see this in a female record. Female – Indicates when a chief complaint and/or diagnosis is specifically a female condition and that you would not expect to see this in a male record.

Investigations and Treatments

The Investigation and Treatment code sets are listed here specifically because there are extra columns which relate to the mapping which will be used for Tariff calculation (HRG) purposes. Please see the Technical User Guidance document for further detail.

Column Name	Definition
ECDS_UniqueID	A unique number for that data item that incorporates the sort codes, and allows this single number to be used • to identify that code • as a single number to allow those data items to be ordered (e.g. if returning items in a search box)
Sort1/Sort2	Together with the ECDS 'Group code', the ECDS 'Sort Codes' enable sequential sorting e.g. to support the use of linked dropdown boxes.
ECDS_Group	Can be used to support implementation of sequential sorting of longer code sets to improve usability.
ECDS_Description	The ECDS description of the SNOMED CT term
SNOMED_Code	The ECDS code, in SNOMED CT
SNOMED_Description	The full SNOMED CT term where relevant
CDS code mapping used for HRG Grouping	This is the Data Dictionary code that will be used for HRG Grouping when the associated SNOMED code is submitted. This is also the value which should be used for local grouping.
PbR category	This is the PbR category of the Data Dictionary code used for HRG Grouping
CDS Investigation/Treatment mapping that is used for HRG Grouping	This is the name of the investigation or treatment associated with the Data Dictionary code to be used for HRG Grouping
Notes	Supporting information

CDS Type 011 - Emergency Care Data Set (ECDS) Technical Output Specification v1.0

NHS Digital

Technical Output Specification - Change Control

This Summary of Changes tab aims to highlight changes to the Technical Output Specification as part of the transition to new versions of the data set.

This tab includes changes from ECDS v6.0 to CDS Type 011 - ECDS Technical Output Specification.

Date	Stage	Previous document version number	Document Version Number	Group/Table	Item Name	Item Type	Item Amend Type	Previous	New	Change Reason(s)
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT PATHWAY IDENTITY GROUP	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	Data item	Format change	an20	n12	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT PATHWAY IDENTITY GROUP	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	Data item	Definition change	A unique identifier for an ORGANISATION.	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER) is the ORGANISATION IDENTIFIER of the Organisation issuing the PATIENT PATHWAY IDENTIFIER.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT PATHWAY IDENTITY GROUP	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	Data item	Format change	min an5 max an9	min an3 max an5	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT PATHWAY IDENTITY GROUP	NHS NUMBER STATUS INDICATOR CODE	Data item	Definition change	The status of the NHS number.	The trace status of the NHS number.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT PATHWAY IDENTITY GROUP	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	Data item	Definition change	An ORGANISATION CODE is a code which identifies an Organisation uniquely.	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) is the ORGANISATION IDENTIFIER derived from the PATIENT's POSTCODE OF USUAL ADDRESS, where they reside within the boundary of a: •Clinical Commissioning Group •Care Trust •Local Health Board (Wales) •Scottish Health Board •Northern Ireland Local Commissioning Group •Primary Healthcare Directorate (Isle of Man) •Local Authority.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT PATHWAY IDENTITY GROUP	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	Data item	Format change	min an5 max an9	min an3 max an5	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT PATHWAY IDENTITIY - WITHHELD IDENTITY STRUCTURE	WITHHELD IDENTITY REASON	Data item	Definition change	WITHHELD IDENTITY REASON is used in Data Group 'Withheld Identity Structure' in the Commissioning Data Sets (version 6-2 onwards). It allows suppliers of Commissioning Data Set records to indicate to recipients of the record (for example, the Commissioner of the activity) that the record has been purposely anonymised for a valid reason.	WITHHELD IDENTITY REASON allows suppliers of data set records to indicate to recipients of the record (for example, the Commissioner of the activity) that the record has been purposely anonymised for a valid reason.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT PATHWAY IDENTITIY - VERIFIED IDENTITY STRUCTURE	LOCAL PATIENT IDENTIFIER (EXTENDED)	Data item	Name change	LOCAL PATIENT IDENTIFIER	LOCAL PATIENT IDENTIFIER (EXTENDED)	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT PATHWAY IDENTITIY - VERIFIED IDENTITY STRUCTURE	LOCAL PATIENT IDENTIFIER (EXTENDED)	Data item	Definition change	A number used to identify a PATIENT uniquely within a Health Care Provider. It may be different from the PATIENT's case note number and may be assigned automatically by the computer system. 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.	A number used to identify a PATIENT uniquely within a Health Care Provider. It may be different from the PATIENT's case note number and may be assigned automatically by the computer system.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT PATHWAY IDENTITIY - VERIFIED IDENTITY STRUCTURE	LOCAL PATIENT IDENTIFIER (EXTENDED)	Data item	Format change	an10	max an20	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT PATHWAY IDENTITIY - VERIFIED IDENTITY STRUCTURE	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	Data item	Definition change	An ORGANISATION CODE is a code which identifies an Organisation uniquely.	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) is the ORGANISATION IDENTIFIER of the Organisation that assigned the LOCAL PATIENT IDENTIFIER.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT PATHWAY IDENTITIY - VERIFIED IDENTITY STRUCTURE	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	Data item	Format change	min an5 max an9	min an3 max an5	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT PATHWAY IDENTITIY - VERIFIED IDENTITY STRUCTURE	NHS NUMBER STATUS INDICATOR CODE	Data item	Definition change	The status of the NHS number.	The trace status of the NHS number.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT PATHWAY IDENTITIY - VERIFIED IDENTITY STRUCTURE	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	Data item	Format change	min an5 max an9	min an3 max an5	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT PATHWAY IDENTITIY - UNVERIFIED IDENTITY STRUCTURE	LOCAL PATIENT IDENTIFIER	Data item	Format change	an10	max an20	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT PATHWAY IDENTITIY - UNVERIFIED IDENTITY STRUCTURE	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	Data item	Format change	An ORGANISATION CODE is a code which identifies an Organisation uniquely.	min an3 max an5	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT PATHWAY IDENTITIY - UNVERIFIED IDENTITY STRUCTURE	NHS NUMBER STATUS INDICATOR CODE	Data item	Definition change	The status of the NHS number.	The trace status of the NHS number	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT PATHWAY IDENTITIY - UNVERIFIED IDENTITY STRUCTURE	PATIENT NAME - PERSON NAME STRUCTURED OR PATIENT NAME - PERSON NAME UNSTRUCTURED	Data item	Format change	an70	max an70	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT PATHWAY IDENTITIY - UNVERIFIED IDENTITY STRUCTURE	PATIENT USUAL ADDRESS - ADDRESS STRUCTURED (Label format Postal Address) OR PATIENT USUAL ADDRESS - ADDRESS UNSTRUCTURED (Character string)	Data item	Format change	an175 (5 lines each an35)	max an175 (5 lines each an35)	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT PATHWAY IDENTITIY - UNVERIFIED IDENTITY STRUCTURE	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	Data item	Definition change	An ORGANISATION CODE is a code which identifies an Organisation uniquely.	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) is the ORGANISATION IDENTIFIER derived from the PATIENT's POSTCODE OF USUAL ADDRESS, where they reside within the boundary of a: •Clinical Commissioning Group •Care Trust •Local Health Board (Wales) •Scottish Health Board •Northern Ireland Local Commissioning Group •Primary Healthcare Directorate (Isle of Man) •Local Authority.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	UNVERIFIED IDENTITY STRUCTURE	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	Data item	Format change	min an5 max an9	min an3 max an5	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT CHARACTERISTICS (EMERGENCY CARE)	PERSON STATED GENDER CODE	Data item	Definition change	The classification is phenotypical rather than genotypical, i.e. it does not provide codes for medical or scientific purposes.	The gender of a PERSON. PERSON STATED GENDER CODE is self declared or inferred by observation for those unable to declare their PERSON STATED GENDER.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT CHARACTERISTICS (EMERGENCY CARE)	ETHNIC CATEGORY	Data item	Format change	an2	max an2	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT CHARACTERISTICS (EMERGENCY CARE)	ACCOMMODATION STATUS (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT CHARACTERISTICS (EMERGENCY CARE)	PREFERRED SPOKEN LANGUAGE (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT CHARACTERISTICS (EMERGENCY CARE)	ACCESSIBLE INFORMATION PROFESSIONAL REQUIRED CODE (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT CHARACTERISTICS (EMERGENCY CARE)	INTERPRETER LANGUAGE (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT CHARACTERISTICS (EMERGENCY CARE)	OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE	Data item	Definition change	A classification of OVERSEAS VISITOR STATUS.	The charging category relating to an OVERSEAS VISITOR STATUS.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	MENTAL HEALTH ACT LEGAL STATUS	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE	Data item	Definition change	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE is required for all PATIENTS who have a Hospital Provider Spell which includes the care of a CONSULTANT in the psychiatric specialties or have been discharged from such a Hospital Provider Spell and are required to receive supervised aftercare under the provisions of the Mental Health (Patients in the Community) Act 1995.	A code which identifies the MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION. Note that the National Code 'Informal' is used for those PATIENTS who are neither formally detained nor receiving supervised aftercare.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	GP REGISTRATION	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	Data item	Format change	min an5 max an9	an6	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	EMERGENCY CARE ATTENDANCE LOCATION	EMERGENCY CARE DEPARTMENT TYPE	Data item	Definition change	An Emergency Care Department is a Department. An Emergency Care Department may be either: • an Accident and Emergency Department or • an Ambulatory Emergency Care Service.	The type of Emergency Care Department	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	AMBULANCE DETAILS	ORGANISATION CODE (CONVEYING AMBULANCE TRUST)	Data item	Format change	min an5 max an9	min an3 max an5	Update required following schema development

1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ATTENDANCE IDENTIFIER	Data item	Format change	an12	max an12	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ARRIVAL MODE (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE)	Data item	Definition change	An ORGANISATION SITE CODE is a code which identifies an Organisation Site uniquely.	ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE) is the ORGANISATION IDENTIFIER of the Organisation Site from which a PATIENT arrived at an Emergency Care Department.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ARRIVAL DATE	Data item	Definition change	An Emergency Care Arrival Date is an ACTIVITY DATE TIME. An Emergency Care Arrival Date may be either: • the Arrival Date At Accident and Emergency Department or • the Ambulatory Emergency Care Arrival Date. An Arrival Date At Accident and Emergency Department is the date the PATIENT self presented at the Accident and Emergency Department or arrived in an Ambulance at the Accident and Emergency Department.	An Emergency Care Arrival Date may be either: • the Arrival Date At Accident and Emergency Department or • the Ambulatory Emergency Care Arrival Date. An Arrival Date At Accident and Emergency Department is the date the PATIENT self presented at the Accident and Emergency Department or arrived in an Ambulance at the Accident and Emergency Department.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ARRIVAL TIME	Data item	Definition change	An Arrival Time At Accident and Emergency Department is an ACTIVITY DATE TIME. Page 21 of 73 The Emergency Care Arrival Time may be either: • the Arrival Time At Accident and Emergency Department or • the Ambulatory Emergency Care Arrival Time. An Arrival Time At Accident and Emergency Department is the date the PATIENT self presented at the Accident and Emergency Department or arrived in an Ambulance at the Accident and Emergency Department.	The Emergency Care Arrival Time may be either: • the Arrival Time At Accident and Emergency Department or • the Ambulatory Emergency Care Arrival Time. An Arrival Time At Accident and Emergency Department is the date the PATIENT self presented at the Accident and Emergency Department or arrived in an Ambulance at the Accident and Emergency Department.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE INITIAL ASSESSMENT DATE	Data item	Definition change	An Emergency Care Initial Assessment Date is an ACTIVITY DATE TIME. The Emergency Care Initial Assessment Date may be either: • the Accident and Emergency Initial Assessment Date or • the Ambulatory Emergency Care Initial Assessment Date. An Accident and Emergency Initial Assessment Date is the date that the PATIENT is first assessed in the Accident and Emergency Department.	The Emergency Care Initial Assessment Date may be either: • the Accident and Emergency Initial Assessment Date or • the Ambulatory Emergency Care Initial Assessment Date. An Accident and Emergency Initial Assessment Date is the date that the PATIENT is first assessed in the Accident and Emergency Department.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE INITIAL ASSESSMENT TIME	Data item	Definition change	An Emergency Care Initial Assessment Time is an ACTIVITY DATE TIME. The Emergency Care Initial Assessment Time may be either: • the Accident and Emergency Initial Assessment Time or • the Ambulatory Emergency Care Initial Assessment Time. An Accident and Emergency Initial Assessment Time is the time, recorded using the 24 hour clock, that the PATIENT is first assessed in the Accident and Emergency Department for first attendances and unplanned follow-up attendances.	The Emergency Care Initial Assessment Time may be either: • the Accident and Emergency Initial Assessment Time or • the Ambulatory Emergency Care Initial Assessment Time. An Accident and Emergency Initial Assessment Time is the time, recorded using the 24 hour clock, that the PATIENT is first assessed in the Accident and Emergency Department for first attendances and unplanned follow-up attendances.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ACUITY (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE DATE SEEN FOR TREATMENT	Data item	Definition change	Accident and Emergency Date Seen For Treatment is the date, that the PATIENT is seen by a clinical decision maker (someone who can define the management plan and discharge the PATIENT) to diagnose the problem and arrange or start definite treatment as necessary.	The Emergency Care Date Seen For Treatment may be either: • the Accident and Emergency Date Seen For Treatment or • the Ambulatory Emergency Care Date Seen For Treatment Accident and Emergency Date Seen For Treatment is the date, that the PATIENT is seen by a clinical decision maker (someone who can define the management plan and discharge the PATIENT) to diagnose the problem and arrange or start definite treatment as necessary.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE TIME SEEN FOR TREATMENT	Data item	Definition change	An Accident and Emergency Time Seen For Treatment is the time, recorded using the 24 hour clock, that the PATIENT is seen by a clinical decision maker (someone who can define the management plan and discharge the PATIENT) to diagnose the problem and arrange or start definite treatment as necessary.	The Emergency Care Time Seen For Treatment may be either: • the Accident and Emergency Time Seen For Treatment or • the Ambulatory Emergency Care Time Seen For Treatment An Accident and Emergency Time Seen For Treatment is the time, recorded using the 24 hour clock, that the PATIENT is seen by a clinical decision maker (someone who can define the management plan and discharge the PATIENT) to diagnose the problem and arrange or start definite treatment as necessary.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	INJURY CHARACTERISTICS	EMERGENCY CARE PLACE OF INJURY (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	INJURY CHARACTERISTICS	EMERGENCY CARE INJURY INTENT (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	INJURY CHARACTERISTICS	EMERGENCY CARE INJURY ACTIVITY STATUS (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	INJURY CHARACTERISTICS	EMERGENCY CARE INJURY ACTIVITY TYPE (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	INJURY CHARACTERISTICS	EMERGENCY CARE INJURY MECHANISM (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	INJURY CHARACTERISTICS	EMERGENCY CARE INJURY ALCOHOL OR DRUG INVOLVEMENT (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	PATIENT CLINICAL HSITORY	COMORBIDITY (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	SERVICE AGREEMENT DETAILS	COMMISSIONING SERIAL NUMBER	Data item	Format change	an6	max an6	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	SERVICE AGREEMENT DETAILS	NHS SERVICE AGREEMENT LINE NUMBER	Data item	Format change	an10	max an10	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	SERVICE AGREEMENT DETAILS	PROVIDER REFERENCE NUMBER	Data item	Format change	an17	max an17	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	SERVICE AGREEMENT DETAILS	COMMISSIONER REFERENCE NUMBER	Data item	Format change	an17	max an17	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	SERVICE AGREEMENT DETAILS	ORGANISATION IDENTIFIER (CODE OF PROVIDER)	Data item	Definition change	An ORGANISATION CODE is a code which identifies an Organisation uniquely.	ORGANISATION IDENTIFIER (CODE OF PROVIDER) is the ORGANISATION IDENTIFIER of the Organisation acting as a Health Care Provider.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	SERVICE AGREEMENT DETAILS	ORGANISATION IDENTIFIER (CODE OF PROVIDER)	Data item	Format change	min an5 max an9	min an3 max an5	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	SERVICE AGREEMENT DETAILS	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	Data item	Definition change	An ORGANISATION CODE is a code which identifies an Organisation uniquely.	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) is the ORGANISATION IDENTIFIER of the Organisation commissioning health care.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	SERVICE AGREEMENT DETAILS	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	Data item	Format change	min an5 max an9	min an3 max an5	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	CARE PROFESSIONALS (EMERGENCY CARE)	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER	Data item	Format change	an12	max an32	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	EMERGENCY CARE DIAGNOSIS (SNOMED CT)	EMERGENCY CARE DIAGNOSIS (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	EMERGENCY CARE DIAGNOSIS (SNOMED CT)	CODED CLINICAL ENTRY SEQUENCE NUMBER	Data item	Format change	an2	max n5	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	EMERGENCY CARE DIAGNOSIS (SNOMED CT)	EMERGENCY CARE DIAGNOSIS QUALIFIER (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	EMERGENCY CARE CLINICAL INVESTIGATION (SNOMED CT)	EMERGENCY CARE CLINICAL INVESTIGATION (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	EMERGENCY CARE TREATMENTS (SNOMED CT)	EMERGENCY CARE PROCEDURE (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	REFERRALS TO OTHER SERVICES	REFERRED TO SERVICE (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	REFERRALS TO OTHER SERVICES	ACTIVITY SERVICE REQUEST DATE (EMERGENCY CARE)	Data item	Definition change	The DATE that a SERVICE REQUEST for an ACTIVITY was made.	The DATE that a PATIENT was referred to another SERVICE during an Emergency Care Attendance.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	REFERRALS TO OTHER SERVICES	ACTIVITY SERVICE REQUEST TIME (EMERGENCY CARE)	Data item	Definition change	The TIME that a SERVICE REQUEST for an ACTIVITY was made.	The TIME that a PATIENT was referred to another SERVICE during an Emergency Care Attendance.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	REFERRALS TO OTHER SERVICES	REFERRED TO SERVICE ASSESSMENT DATE	Data item	Definition change	A Referred To Service Assessment Date is an ACTIVITY DATE TIME. A Referred To Service Assessment Date is the date that a CARE PROFESSIONAL from a SERVICE which a PATIENT has been referred to, assesses the PATIENT.	A Referred To Service Assessment Date is the date that a CARE PROFESSIONAL from a SERVICE which a PATIENT has been referred to, assesses the PATIENT.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	REFERRALS TO OTHER SERVICES	REFERRED TO SERVICE ASSESSMENT TIME	Data item	Definition change	A Referred To Service Assessment Time is an ACTIVITY DATE TIME. A Referred To Service Assessment Date is the time that a CARE PROFESSIONAL from a SERVICE which a PATIENT has been referred to, assesses the PATIENT.	A Referred To Service Assessment Date is the time that a CARE PROFESSIONAL from a SERVICE which a PATIENT has been referred to, assesses the PATIENT.	Update required following schema development

1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	DISCHARGE FROM EMERGENCY CARE	DECIDED TO ADMIT DATE	Data item	Definition change	The date at which the decision is made to admit the person.	The date a DECISION TO ADMIT was made.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	DISCHARGE FROM EMERGENCY CARE	DECIDED TO ADMIT TIME	Data item	Definition change	The time at which the decision is made to admit the person.	The time a DECISION TO ADMIT was made.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	DISCHARGE FROM EMERGENCY CARE	ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT)	Data item	Definition change	ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT) is the same as attribute TREATMENT FUNCTION CODE. ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT) is the TREATMENT FUNCTION CODE of the SERVICE to which a PATIENT is to be admitted.	ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT) is the TREATMENT FUNCTION CODE of the SERVICE to which a PATIENT is to be admitted.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DISCHARGE STATUS (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE ATTENDANCE CONCLUSION DATE	Data item	Definition change	An Emergency Care Attendance Conclusion Date is an ACTIVITY DATE TIME. The Emergency Care Attendance Conclusion Date may be either: • the Accident and Emergency Attendance Conclusion Date or • the Ambulatory Emergency Care Attendance Conclusion Date. Where the PATIENT dies in the Emergency Care Department, the Emergency Care Attendance Conclusion Date is the same as the PERSON DEATH DATE.	The Emergency Care Attendance Conclusion Date may be either: • the Accident and Emergency Attendance Conclusion Date or • the Ambulatory Emergency Care Attendance Conclusion Date. Where the PATIENT dies in the Emergency Care Department, the Emergency Care Attendance Conclusion Date is the same as the PERSON DEATH DATE. An Accident and Emergency Attendance Conclusion Date is the date that a PATIENT's Accident and Emergency Attendance concludes or when treatment in the Accident and Emergency Department is completed (whichever is the later). For those PATIENTS admitted into hospital, the ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE is recorded as the date when the DECISION TO ADMIT was made.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE ATTENDANCE CONCLUSION TIME	Data item	Definition change	An Emergency Care Attendance Conclusion Time is an ACTIVITY DATE TIME. The Emergency Care Attendance Conclusion Time may be either: • the Accident and Emergency Attendance Conclusion Time or • the Ambulatory Emergency Care Attendance Conclusion Time. Where the PATIENT dies in the Emergency Care Department, the Emergency Care Attendance Conclusion Time is the same as the PERSON DEATH TIME.	The Emergency Care Attendance Conclusion Time may be either: • the Accident and Emergency Attendance Conclusion Time or • the Ambulatory Emergency Care Attendance Conclusion Time. Where the PATIENT dies in the Emergency Care Department, the Emergency Care Attendance Conclusion Time is the same as the PERSON DEATH TIME. An Accident and Emergency Attendance Conclusion Time is the time, recorded using a 24 hour clock: • that a PATIENT's Accident and Emergency Attendance concludes or • when treatment in an Accident and Emergency Department is completed (whichever is the later). For those PATIENTS admitted into hospital, the A and E ATTENDANCE CONCLUSION TIME is recorded as the time when the DECISION TO ADMIT was made.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DEPARTURE DATE	Data item	Definition change	An Accident and Emergency Departure Date is the date that a PATIENT leaves an Accident and Emergency Department after an Accident and Emergency Attendance has concluded. An Emergency Care Departure Date is an ACTIVITY DATE TIME. The Emergency Care Departure Date may be either: • the Accident and Emergency Departure Date or • the Ambulatory Emergency Care Departure Date.	The Emergency Care Departure Date may be either: • the Accident and Emergency Departure Date or • the Ambulatory Emergency Care Departure Date. An Accident and Emergency Departure Date is the date that a PATIENT leaves an Accident and Emergency Department after an Accident and Emergency Attendance has concluded.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DEPARTURE TIME	Data item	Definition change	An Accident and Emergency Departure Time is the time recorded using a 24 hour clock that a PATIENT leaves an Accident and Emergency Department after an Accident and Emergency Attendance has concluded. An Emergency Care Departure Time is an ACTIVITY DATE TIME. The Emergency Care Departure Time may be either: • the Accident and Emergency Departure Time or • the Ambulatory Emergency Care Departure Time.	The Emergency Care Departure Time may be either: • the Accident and Emergency Departure Time or • the Ambulatory Emergency Care Departure Time. An Accident and Emergency Departure Time is the time recorded using a 24 hour clock that a PATIENT leaves an Accident and Emergency Department after an Accident and Emergency Attendance has concluded.	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	DISCHARGE FROM EMERGENCY CARE	SAFEGUARDING CONCERN (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DISCHARGE INFORMATION GIVEN (SNOMED CT)	Data item	Format change	n18	min n6 max n18	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	DISCHARGE FROM EMERGENCY CARE	CLINICAL TRIAL IDENTIFIER	Group/Data item	Deletion	CLINICAL TRIAL IDENTIFIER	Deleted	Update required following schema development
1/31/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6	Emergency Care Data Set (ECDS) Technical Output Specification v6.1	DISCHARGE FROM EMERGENCY CARE	DISEASE OUTBREAK NOTIFICATION	Group/Data item	Deletion	DISEASE OUTBREAK NOTIFICATION	Deleted	Update required following schema development
2/28/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	Headers	Inclusion of Headers	n/a	Addition	n/a	Inclusion of: CDS Interchange Header CDS Interchange Trailer CDS Message Header CDS Message Trailer CDS Trans Header BULK CDS Trans Header NET	Update required following schema development
3/3/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	INJURY CHARACTERISTICS	EMERGENCY CARE PLACE OF INJURY (LATTITUDE AND LONGITUDE)	Data item	Deletion	EMERGENCY CARE PLACE OF INJURY (LATTITUDE AND LONGITUDE)	Deleted	Update required following schema testing
3/3/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	INJURY CHARACTERISTICS	EMERGENCY CARE PLACE OF INJURY (LATTITUDE)	Data item	Addition	EMERGENCY CARE PLACE OF INJURY (LATTITUDE AND LONGITUDE)	EMERGENCY CARE PLACE OF INJURY (LATTITUDE)	Update required following schema testing
3/3/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	INJURY CHARACTERISTICS	EMERGENCY CARE PLACE OF INJURY (LONGITUDE)	Data item	Addition	EMERGENCY CARE PLACE OF INJURY (LATTITUDE AND LONGITUDE)	EMERGENCY CARE PLACE OF INJURY (LONGITUDE)	Update required following schema testing
3/3/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	INJURY CHARACTERISTICS	EMERGENCY CARE PLACE OF INJURY (LATTITUDE)	Data item	Format change	an50	max n2 n6	Update required following schema testing
3/3/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	INJURY CHARACTERISTICS	EMERGENCY CARE PLACE OF INJURY (LONGITUDE)	Data item	Format change	an50	max n3 n6	Update required following schema testing
3/3/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	RESEARCH AND OUTBREAK NOTIFICATION	CLINICAL TRIAL IDENTIFIER	Group/Data item	Addition	DISCHARGE FROM EMERGENCY CARE	RESEARCH AND OUTBREAK NOTIFICATION	Update required following schema testing
3/3/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	RESEARCH AND OUTBREAK NOTIFICATION	DISEASE OUTBREAK NOTIFICATION	Group/Data item	Addition	DISCHARGE FROM EMERGENCY CARE	RESEARCH AND OUTBREAK NOTIFICATION	Update required following schema testing
3/3/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	RESEARCH AND OUTBREAK NOTIFICATION	CLINICAL TRIAL IDENTIFIER	Group/Data item	Format change	an20	max an20	Update required following schema testing
3/3/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	RESEARCH AND OUTBREAK NOTIFICATION	DISEASE OUTBREAK NOTIFICATION	Group/Data item	Format change	an20	max an20	Update required following schema testing
3/3/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	Document Guidance	n/a	n/a	Addition	n/a	Inclusion of 'flag' information	Update required following feedback from SUS users
3/3/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	Document Guidance	n/a	n/a	Addition	n/a	Inclusion of group and data item repeat information.	Update required following feedback from SUS users
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	PATIENT CHARACTERISTICS (EMERGENCY CARE)	PERSON STATED GENDER CODE	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	PATIENT CHARACTERISTICS (EMERGENCY CARE)	ETHNIC CATEGORY	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	PATIENT CHARACTERISTICS (EMERGENCY CARE)	ACCOMMODATION STATUS (SNOMED CT)	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	PATIENT CHARACTERISTICS (EMERGENCY CARE)	PREFERRED SPOKEN LANGUAGE (SNOMED CT)	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	PATIENT CHARACTERISTICS (EMERGENCY CARE)	ACCESSIBLE INFORMATION PROFESSIONAL REQUIRED CODE (SNOMED CT)	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	PATIENT CHARACTERISTICS (EMERGENCY CARE)	INTERPRETER LANGUAGE (SNOMED CT)	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	PATIENT CHARACTERISTICS (EMERGENCY CARE)	OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	GP REGISTRATION	GENERAL MEDICAL PRACTITIONER (SPECIFIED)	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	GP REGISTRATION	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	EMERGENCY CARE ATTENDANCE LOCATION	ORGANISATION SITE IDENTIFIER (OF TREATMENT)	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	EMERGENCY CARE ATTENDANCE LOCATION	EMERGENCY CARE DEPARTMENT TYPE	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ATTENDANCE IDENTIFIER	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ARRIVAL MODE (SNOMED CT)	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback

3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ATTENDANCE CATEGORY	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT)	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE)	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ARRIVAL DATE	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ARRIVAL TIME	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	AGE AT CDS ACTIVITY DATE	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE INITIAL ASSESSMENT DATE	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE INITIAL ASSESSMENT TIME	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ACUITY (SNOMED CT)	Data item	Addition	n/a	Addition of more detailed justification and notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT)	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE DATE SEEN FOR TREATMENT	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE TIME SEEN FOR TREATMENT	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	INJURY CHARACTERISTICS	INJURY DATE	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	INJURY CHARACTERISTICS	INJURY TIME	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	INJURY CHARACTERISTICS	EMERGENCY CARE PLACE OF INJURY (SNOMED CT)	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	INJURY CHARACTERISTICS	EMERGENCY CARE PLACE OF INJURY (LATITUDE)	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	INJURY CHARACTERISTICS	EMERGENCY CARE PLACE OF INJURY (LONGITUDE)	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	INJURY CHARACTERISTICS	EMERGENCY CARE INJURY INTENT (SNOMED CT)	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	INJURY CHARACTERISTICS	EMERGENCY CARE INJURY ACTIVITY STATUS (SNOMED CT)	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	INJURY CHARACTERISTICS	EMERGENCY CARE INJURY ACTIVITY TYPE (SNOMED CT)	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	INJURY CHARACTERISTICS	EMERGENCY CARE INJURY MECHANISM (SNOMED CT)	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/20/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	INJURY CHARACTERISTICS	EMERGENCY CARE INJURY ALCOHOL OR DRUG INVOLVEMENT (SNOMED CT)	Data item	Addition	n/a	Addition of more detailed notes to support collection of data.	Update required following feedback
3/23/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	PATIENT CHARACTERISTICS (EMERGENCY CARE)	ACCOMMODATION STATUS (SNOMED CT)	Code set	Code change	414418009 - Housed (finding)	242711000000100 - Lives in house (finding)	Updated following terminology review
3/23/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	PATIENT CHARACTERISTICS (EMERGENCY CARE)	ACCOMMODATION STATUS (SNOMED CT)	Code set	Addition	n/a	1066881000000100 - Residence and accommodation circumstances unknown (finding)	Updated following terminology review
3/23/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	PATIENT CHARACTERISTICS (EMERGENCY CARE)	ACCESSIBLE INFORMATION PROFESSIONAL REQUIRED CODE (SNOMED CT)	Code set	Tab name change	LANGUAGE PROFESSIONAL REQUIRED	ACCESSIBLE INFO PROF REQ	Updated following terminology review
3/23/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	PATIENT CHARACTERISTICS (EMERGENCY CARE)	INTERPRETER LANGUAGE (SNOMED CT)	Code set	Addition	n/a	343671000000102 - English	Updated following terminology review
3/23/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT)	Code set	Code change	309774006 - weakness of limb (finding)	713514005 - Muscle weakness of limb (finding)	Updated following terminology review
3/23/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT)	Code set	Code change	81102000 - Injury of back (disorder)	450724008 - Injury of cervical region of back (disorder) 282765009 - Upper back injury (disorder) 282766005 - Lower back injury (disorder)	Updated following terminology review
3/23/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	EMERGENCY CARE DIAGNOSIS (SNOMED CT)	EMERGENCY CARE DIAGNOSIS (SNOMED CT)	Code set	Code change	312403005 - legionella pneumonia (disorder)	195889001- legionella pneumonia (disorder)	Updated following terminology review
3/23/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	EMERGENCY CARE DIAGNOSIS (SNOMED CT)	EMERGENCY CARE DIAGNOSIS (SNOMED CT)	Code set	Code change	371332008 - abortion with complication (disorder)	609446006 - induced termination of pregnancy with complication (disorder)	Updated following terminology review
3/23/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	EMERGENCY CARE DIAGNOSIS (SNOMED CT)	EMERGENCY CARE DIAGNOSIS (SNOMED CT)	Code set	Addition	n/a	274204004 - Corneal burn (disorder)	Updated following terminology review
3/23/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ACUITY (SNOMED CT)	Data item	Change to notes	This data item will required providers to map current triage scores or allocation of a patients intended treatment area to a three point acuity score. Please refer to ECDS FAQ's.	This data item will required providers to map current triage scores or allocation of a patients intended treatment area to a **five** point acuity score. Please refer to ECDS **User Guidance**.	Updated following publication review.
3/23/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	CARE PROFESSIONALS (EMERGENCY CARE)	CARE PROFESSIONAL TIER (EMERGENCY CARE)	Data item	Deletion from notes	This data item will required providers to map Electronic Staff Record (ESR) data relating to employment grade to the appropriate tier as per the Royal College of Medicine Guidance. Please refer to ECDS FAQ's.	n/a	To be updated following User Guidance development.
3/23/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	DISCHARGE FROM EMERGENCY CARE	DECIDED TO ADMIT DATE	Data item	Change to notes	This data item should be recorded when a patient is referred to a service.	This data item should be recorded **in the ED record on the occasion whereby a decision is made to refer a** patient to a service.	To be updated following User Guidance development.
3/23/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	DISCHARGE FROM EMERGENCY CARE	DECIDED TO ADMIT TIME	Data item	Change to notes	This data item should be recorded when a patient is referred to a service.	This data item should be recorded **in the ED record on the occasion whereby a decision is made to refer a** patient to a service.	To be updated following User Guidance development.
3/24/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	Document Guidance	n/a	Guidance	Addition	n/a	Inclusion of explanation of additional columns in Investigations and Treatments code set tabs.	Updated following publication review.
3/8/2017	Requirement to Full	Emergency Care Data Set (ECDS) Technical Output Specification v6.2	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ATTENDANCE CATEGORY	Code set	Change to DM&D Definition	Not Applicable/Dead on arrival : no intent / attempt to resuscitate in Emergency Care facility	Not Applicable (Patient dead on arrival at Emergency Care Department)	Updated following publication review.
4/5/2017	Full Approval	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	CDS Type 011 - ECDS Technical Output Specification v1.0	Document Guidance	Output data set	Guidance	Addition	n/a	Additon of definition of new data item column heading ''CQUIN DATA ITEM REQUIRED (Y/N)'.	Missing from previous version.
4/5/2017	Full Approval	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	CDS Type 011 - ECDS Technical Output Specification v1.0	EMERGENCY CARE TREATMENTS (SNOMED CT)	EMERGENCY CARE PROCEDURE	Data item	Addition	EMERGENCY CARE PROCEDURE	Addition of (SNOMED CT) to date item group name.	Missing from previous version.
4/5/2017	Full Approval	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	CDS Type 011 - ECDS Technical Output Specification v1.0	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	CDS Type 011 - Emergency Care Data Set (ECDS) Technical Output Specification v1.0	Guidance	Change to specification name	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	CDS Type 011 - Emergency Care Data Set (ECDS) Technical Output Specification v1.0	Change of name for ISN publication.
4/18/2017	Full Approval	Emergency Care Data Set (ECDS) Technical Output Specification v6.3	CDS Type 011 - ECDS Technical Output Specification v1.0	EMERGENCY CARE DIAGNOSIS (SNOMED CT)	EMERGENCY CARE DIAGNOSIS (SNOMED CT)	Code set	Spelling corrections	Multiple code set spelling errors corrected.		Following publication review

CDS V6-2-1 Type 001 - CDS Interchange Header

Name	Format	DD Allowed Values / Additional Validation Applied	Allowed Repeats (Mandation)	Notes/Queries
CDS INTERCHANGE SENDER IDENTITY	min an1 max an15	None	1..1	
CDS INTERCHANGE RECEIVER IDENTITY	min an1 max an15	None	1..1	
CDS INTERCHANGE CONTROL REFERENCE	min an1 max an14	None	1..1	
CDS INTERCHANGE DATE OF PREPARATION	Date	None	1..1	
CDS INTERCHANGE TIME OF PREPARATION	Time	None	1..1	
CDS INTERCHANGE APPLICATION REFERENCE	min an1 max an14	NHSCDS	1..1	
CDS INTERCHANGE TEST INDICATOR	an1	1, 0	0..1	

CDS V6-2-1 Type 002 - CDS Interchange Trailer

Name	Format	DD Allowed Values / Additional Validation Applied	Allowed Repeats (Mandation)	Notes/Queries
CDS INTERCHANGE CONTROL REFERENCE	min an1 max an14	None	1..1	
CDS INTERCHANGE CONTROL COUNT	max n7	None	1..1	
CDS INTERCHANGE SENDER IDENTITY	min an1 max an15	None	0..1	
CDS INTERCHANGE RECEIVER IDENTITY	min an1 max an15	None	0..1	

CDS V6-2-1 Type 003 - CDS Message Header CDS

Name	Format	DD Allowed Values / Additional Validation Applied	Allowed Repeats (Mandation)	Notes/Queries
CDS MESSAGE TYPE	an6	NHSCDS	1..1	
CDS MESSAGE VERSION NUMBER	max an6	CDS062	1..1	Hard coded in schema - no change
CDS MESSAGE REFERENCE	max an14	None	1..1	
CDS RECORD IDENTIFIER	min an1 max an35	None	0..1	

CDS V6-2-1 Type 004 - CDS Message Trailer CDS

Name	Format	DD Allowed Values / Additional Validation Applied	Allowed Repeats (Mandation)	Notes/Queries
CDS MESSAGE REFERENCE	max an14	None	1..1	

CDS V6-2-1 Type 005B - CDS Transaction Header Group - Bulk Update Protocol

Name	Format	DD Allowed Values / Additional Validation Applied	Allowed Repeats (Mandation)	Notes/Queries
CDS TYPE CODE	an3	010, 011, 020, 021, 030, 040, 050, 060, 070, 080, 090, 100, 110, 120, 130, 140, 150, 160, 170, 180, 190, 200	1..1	011 added to enumeration
CDS PROTOCOL IDENTIFIER CODE	an3	010, 020	1..1	
CDS UNIQUE IDENTIFIER	min an1 max an35	None	0..1	
CDS BULK REPLACEMENT GROUP CODE	an3	010, 020, 030, 040, 050, 060, 070, 080, 090, 100, 110, 120, 130, 140, 150, 160	1..1	160 added to enumeration
CDS EXTRACT DATE	Date	None	1..1	
CDS EXTRACT TIME	Time	None	1..1	
CDS REPORT PERIOD START DATE	Date	None	1..1	
CDS REPORT PERIOD END DATE	Date	None	1..1	
CDS ACTIVITY DATE	Date	None	1..1	
CDS SENDER IDENTITY	min an3 max an12	None	1..1	
CDS PRIME RECIPIENT IDENTITY	min an3 max an12	None	1..1	
CDS COPY RECIPIENT IDENTITY	min an3 max an12	None	0..7	

CDS V6-2-1 Type 005N - CDS Transaction Header Group - Net Change Protocol

Name	Format	DD Allowed Values / Additional Validation Applied	Allowed Repeats (Mandation)	Notes/Queries
CDS TYPE CODE	an3	010, 011, 020, 021, 030, 040, 050, 060, 070, 080, 090, 100, 110, 120, 130, 140, 150, 160, 170, 180, 190, 200	1..1	011 added to enumeration
CDS PROTOCOL IDENTIFIER CODE	an3	010, 020	1..1	
CDS UNIQUE IDENTIFIER	min an1 max an35	None	1..1	
CDS UPDATE TYPE	an1	1, 9	1..1	
CDS APPLICABLE DATE	Date	None	1..1	
CDS APPLICABLE TIME	Time	None	1..1	
CDS ACTIVITY DATE	Date	None	1..1	
CDS SENDER IDENTITY	min an3 max an12	None	1..1	
CDS PRIME RECIPIENT IDENTITY	min an3 max an12	None	1..1	
CDS COPY RECIPIENT IDENTITY	min an3 max an12	None	0..7	

DATA GROUP: PATIENT PATHWAY

FUNCTION: To carry the details of the Patient Pathway
Group Status: O
Group Repeats: 0..1

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	SCHEMA DATA ITEM STATUS (M/R/O)	CQUIN DATA ITEM REQUIRED (Y/N)	DATA ITEM REPEATS	FORMAT	SNOMED CT / DM&D /ODS	JUSTIFICATION	ECDS CODE SET	LINK TO CURRENT CDS Type 010 INFORMATION ONLY	VALIDATION RULES		DATA ITEM PROVENANCE	NOTES
											POPULATION VALIDATION F - Format is validated V - Validated against an explicit list of permitted values as defined in the NHS Data Dictionary	POST SCHEMA VALIDATION		
PATIENT PATHWAY - PATIENT PATHWAY IDENTITY **DATA GROUP STATUS: M** **DATA GROUP REPEATS: 1..1** **NOTES: Submit either 'UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)' or 'PATIENT PATHWAY IDENTIFIER'**														
PATIENT PATHWAY - PATIENT PATHWAY IDENTITY	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	The unique booking reference number assigned by the Choose and Book system when a PATIENT accepts an APPOINTMENT DATE OFFERED of an APPOINTMENT OFFER where the offer was made via the Choose and Book system. When a PATIENT accepts an APPOINTMENT DATE OFFERED, the unique booking reference number issued and used during the booking process is considered to be 'converted' i.e. an APPOINTMENT has been created and recorded; and the PATIENT has been placed on an Out-Patient Waiting List even if subsequently the PATIENT does not attend or cancels the APPOINTMENT. UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) should only be recorded where the type of booking system is the Choose and Book system.	M	N	1..1	n12	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/u/un/unique_booking_reference_number_(converted)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	Either submit UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) **OR** PATIENT PATHWAY IDENTIFIER
PATIENT PATHWAY - PATIENT PATHWAY IDENTITY	PATIENT PATHWAY IDENTIFIER	An identifier, which together with the ORGANISATION CODE / ORGANISATION IDENTIFIER of the issuer, uniquely identifies a PATIENT PATHWAY. This is a specific type of the attribute ACTIVITY IDENTIFIER. Where a pathway is initiated by a SERVICE REQUEST using the Choose and Book system, the PATIENT PATHWAY will be uniquely identified by the Unique Booking Reference Number (UBRN) of the first referral and the ORGANISATION CODE of Choose and Book which is X09. Where the pathway is initiated by some other method, the PATIENT PATHWAY IDENTIFIER will be allocated by the Organisation receiving the SERVICE REQUEST which together with that Organisation's ORGANISATION CODE / ORGANISATION IDENTIFIER will uniquely identify the PATIENT PATHWAY.	M	N	1..1	an20	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/p/pat/patient_pathway_identifier_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	Either submit UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) OR PATIENT PATHWAY IDENTIFIER
PATIENT PATHWAY - PATIENT PATHWAY IDENTITY	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER) is the ORGANISATION IDENTIFIER of the Organisation issuing the PATIENT PATHWAY IDENTIFIER.	M	N	1..1	min an3 max an5	ODS	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/attributes/o/org/organisation_code_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT PATHWAY - REFERRAL TO TREATMENT PERIOD CHARACTERISTICS **DATA GROUP STATUS: M** **DATA GROUP REPEATS: 1..1**														
PATIENT PATHWAY - REFERRAL TO TREATMENT PERIOD CHARACTERISTICS	REFERRAL TO TREATMENT PERIOD STATUS	The status of an ACTIVITY (or anticipated ACTIVITY) for the REFERRAL TO TREATMENT PERIOD decided by the lead CARE PROFESSIONAL.	M	N	1..1	an2	DM&D	As per CDS 6.2 Type 010	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/r/ref/referral_to_treatment_period_status_de.asp?shownav=0	V	n/a	Originates from A&E CDS Type 010	
PATIENT PATHWAY - REFERRAL TO TREATMENT PERIOD CHARACTERISTICS	WAITING TIME MEASUREMENT TYPE	The type of waiting time measurement methodology which may be applied during a PATIENT PATHWAY. The methodology applied may be for one part of a PATIENT PATHWAY, such as the measurement of a REFERRAL TO TREATMENT PERIOD, or other parts of the PATIENT PATHWAY according to Department of Health policy.	M	N	1..1	an2	DM&D	As per CDS 6.2 Type 010	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/w/wait/waiting_time_measurement_type_de.asp?shownav=0	V	n/a	Originates from A&E CDS Type 010	
PATIENT PATHWAY - REFERRAL TO TREATMENT PERIOD CHARACTERISTICS	REFERRAL TO TREATMENT PERIOD START DATE	The start date of a REFERRAL TO TREATMENT PERIOD.	O	N	0..1	an10 CCYY-MM-DD	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/r/ref/referral_to_treatment_period_start_date_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT PATHWAY - REFERRAL TO TREATMENT PERIOD CHARACTERISTICS	REFERRAL TO TREATMENT PERIOD END DATE	The end date of a REFERRAL TO TREATMENT PERIOD.	O	N	0..1	an10 CCYY-MM-DD	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/r/ref/referral_to_treatment_period_end_date_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	

ECDS_UniqueID	Sort1	ECDS_Group	ECDS_Description	DM&D_Code (DM&D)	DM&D Description	Notes
n/a	n/a	n/a	First activity - first activity in a referral to treatment period	10	First activity - first activity in a referral to treatment period	
n/a	n/a	n/a	Active Monitoring end - first activity at the start of a new referral to treatment period following active monitoring.	11	Active Monitoring end - first activity at the start of a new referral to treatment period following active monitoring.	
n/a	n/a	n/a	CONSULTANT or NHS Allied Health Professional Service (Referral to Treatment Measurement) referral - the first activity at the start of a new referral to treatment period following a decision to refer directly to the consultant or NHS Allied Health Professional Service (Referral to Treatment Measurement) for a separate condition.	12	CONSULTANT or NHS Allied Health Professional Service (Referral to Treatment Measurement) referral - the first activity at the start of a new referral to treatment period following a decision to refer directly to the consultant or NHS Allied Health Professional Service (Referral to Treatment Measurement) for a separate condition.	
n/a	n/a	n/a	Subsequent activity during a referral to treatment period - further activities anticipated.	20	Subsequent activity during a referral to treatment period - further activities anticipated.	
n/a	n/a	n/a	Transfer to another heath care provider - subsequent activity by another Health Care Provider during a referral to treatment period anticipated.	21	Transfer to another heath care provider - subsequent activity by another Health Care Provider during a referral to treatment period anticipated.	
n/a	n/a	n/a	Start of First Definitive Treatment	30	Start of First Definitive Treatment	
n/a	n/a	n/a	Start of active monitoring initiated by the patient	31	Start of active monitoring initiated by the patient	
n/a	n/a	n/a	Start of active monitoring initiated by the care professional	32	Start of active monitoring initiated by the care professional	
n/a	n/a	n/a	Did not attend - the patient did not attend the first care activity after the referral	33	Did not attend - the patient did not attend the first care activity after the referral	
n/a	n/a	n/a	Decision not to treat - decision not to treat made or no further contact required	34	Decision not to treat - decision not to treat made or no further contact required	
n/a	n/a	n/a	Patient declined offered treatment	35	Patient declined offered treatment	
n/a	n/a	n/a	Patient died before treatment	36	Patient died before treatment	
n/a	n/a	n/a	After treatment - First Definitive Treatment occurred previously (e.g. admitted as an emergency from A&E or the ACTIVITY is after the start of treatment)	90	After treatment - First Definitive Treatment occurred previously (e.g. admitted as an emergency from A&E or the ACTIVITY is after the start of treatment)	
n/a	n/a	n/a	Active Monitoring - CARE ACTIVITY during Active Monitoring	91	Active Monitoring - CARE ACTIVITY during Active Monitoring	
n/a	n/a	n/a	Not yet referred - not yet referred for treatment, undergoing diagnostic tests by GENERAL PRACTITIONER before referral	92	Not yet referred - not yet referred for treatment, undergoing diagnostic tests by GENERAL PRACTITIONER before referral	
n/a	n/a	n/a	Not applicable - ACTIVITY not applicable to referral to treatment periods	98	Not applicable - ACTIVITY not applicable to referral to treatment periods	
n/a	n/a	n/a	Not yet known	99	Not yet known	

ECDS_UniqueID	Sort1	ECDS_Group	ECDS_Description	DM&D_Code	DM&D Description	Notes
n/a	n/a	n/a	Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement	01	Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement	
n/a	n/a	n/a	Allied Health Professional Referral To Treatment Measurement	02	Allied Health Professional Referral To Treatment Measurement	
n/a	n/a	n/a	Other Referral To Treatment Measurement Type	09	Other Referral To Treatment Measurement Type	

DATA GROUP: PATIENT IDENTITY

FUNCTION: To carry the identity of the patient
Group Status: M
Group Repeats: 1..1

NOTES: ONE OF THE FOLLOWING DATA GROUPS MUST BE USED

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	CQUIN DATA ITEM REQUIRED (Y/N)	DATA ITEM REPEATS	FORMAT	SNOMED CT / DM&D /ODS	JUSTIFICATION	ECDS CODE SET	LINK TO CURRENT CDS Type 010 INFORMATION ONLY	VALIDATION RULES		DATA ITEM PROVENANCE	NOTES
											POPULATION VALIDATION F - Format is validated V - Validated against an explicit list of permitted values as defined in the NHS Data Dictionary	POST SCHEMA VALIDATION		
PATIENT PATHWAY - WITHHELD IDENTITY STRUCTURE **DATA GROUP STATUS:** **DATA GROUP REPEATS: 1..1** **NOTES: Must be used where the Commissioning Data Set record has been anonymised**														
PATIENT IDENTITY - WITHHELD IDENTITY STRUCTURE	NHS NUMBER STATUS INDICATOR CODE	The trace status of the NHS number.	M	N	1..1	an2	DM&D	As per CDS 6.2 Type 010	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/n/nhs/nhs_number_status_indicator_code_de.asp?shownav=0	V	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - WITHHELD IDENTITY STRUCTURE	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) is the ORGANISATION IDENTIFIER derived from the PATIENT's POSTCODE OF USUAL ADDRESS, where they reside within the boundary of a: •Clinical Commissioning Group •Care Trust •Local Health Board (Wales) •Scottish Health Board •Northern Ireland Local Commissioning Group •Primary Healthcare Directorate (Isle of Man) •Local Authority.	R	N	0..1	min an3 max an5	ODS	Updated to new Organisation code guidelines	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/o/org/organisation_code_(residence_responsibility)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - WITHHELD IDENTITY STRUCTURE	WITHHELD IDENTITY REASON	WITHHELD IDENTITY REASON allows suppliers of data set records to indicate to recipients of the record (for example, the Commissioner of the activity) that the record has been purposely anonymised for a valid reason.	R	N	0..1	an2	DM&D	As per CDS 6.2 Type 010	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/w/we/withheld_identity_reason_de.asp?shownav=0	V	n/a	Originates from A&E CDS Type 010	
PATIENT PATHWAY - VERIFIED IDENTITY STRUCTURE **DATA GROUP STATUS:** **DATA GROUP REPEATS: 1..1** **NOTES: Must be used where the NHS NUMBER STATUS INDICATOR CODE National Code = 01 (Number present and verified)**														
PATIENT IDENTITY - LOCAL PATIENT IDENTIFIER STRUCTURE	LOCAL PATIENT IDENTIFIER (EXTENDED)	A number used to identify a PATIENT uniquely within a Health Care Provider. It may be different from the PATIENT's case note number and may be assigned automatically by the computer system.	M	N	1..1	max an20	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/l/li/local_patient_identifier_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - LOCAL PATIENT IDENTIFIER STRUCTURE	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) is the ORGANISATION IDENTIFIER of the Organisation that assigned the LOCAL PATIENT IDENTIFIER.	M	N	1..1	min an3 max an5	ODS	Updated to new Organisation code guidelines	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/o/org/organisation_code_(local_patient_identifier)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - VERIFIED IDENTITY STRUCTURE	NHS NUMBER	The NHS NUMBER, the primary identifier of a PERSON, is a unique identifier for a PATIENT within the NHS in England and Wales.	M	N	1..1	n10	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/n/nhs/nhs_number_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - VERIFIED IDENTITY STRUCTURE	NHS NUMBER STATUS INDICATOR CODE	The trace status of the NHS number.	M	N	1..1	an2	DM&D	As per CDS 6.2 Type 010	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/n/nhs/nhs_number_status_indicator_code_de.asp?shownav=0	V	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - VERIFIED IDENTITY STRUCTURE	POSTCODE OF USUAL ADDRESS	The code assigned by Royal Mail to identify postal delivery areas across the United Kingdom.	M	N	1..1	max an8	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/p/po/postcode_of_usual_address_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - VERIFIED IDENTITY STRUCTURE	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	An ORGANISATION CODE is a code which identifies an Organisation uniquely.	R	N	0..1	min an3 max an5	ODS	Updated to new Organisation code guidelines	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/o/org/organisation_code_(residence_responsibility)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - VERIFIED IDENTITY STRUCTURE	PERSON BIRTH DATE	The date on which a PERSON was born or is officially deemed to have been born.	R	N	0..1	an10 CCYY-MM-DD	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/p/per/person_birth_date_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT PATHWAY - UNVERIFIED IDENTITY STRUCTURE **DATA GROUP STATUS:** **DATA GROUP REPEATS: 1..1** **NOTES: Submit either 'UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)' or 'PATIENT PATHWAY IDENTIFIER'**														
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	LOCAL PATIENT IDENTIFIER (EXTENDED)	A number used to identify a PATIENT uniquely within a Health Care Provider. It may be different from the PATIENT's casenote number and may be assigned automatically by the computer system. Where care for NHS patients is sub-commissioned in the independent sector or overseas, the NHS commissioner PAS Number should be used. If no NHS PAS Number has been assigned the independent sector or overseas PAS Number should be used.	M	N	1..1	max an20	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/l/li/local_patient_identifier_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	An ORGANISATION CODE is a code which identifies an Organisation uniquely.	M	N	1..1	min an3 max an5	ODS	Updated to new Organisation code guidelines	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/o/org/organisation_code_(local_patient_identifier)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	NHS NUMBER	The NHS NUMBER, the primary identifier of a PERSON, is a unique identifier for a PATIENT within the NHS in England and Wales.	R	N	0..1	n10	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/n/nhs/nhs_number_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	NHS NUMBER STATUS INDICATOR CODE	The trace status of the NHS number	M	N	1..1	an2	DM&D	As per CDS 6.2 Type 010	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/n/nhs/nhs_number_status_indicator_code_de.asp?shownav=0	V	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	PATIENT NAME - PERSON NAME STRUCTURED OR PATIENT NAME - PERSON NAME UNSTRUCTURED	PATIENT NAME is the PERSON NAME where the PERSON NAME CLASSIFICATION is '*Preferred Name*' of the PATIENT.	O	N	0..1	max an70	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/p/pat/patient_name_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	PATIENT USUAL ADDRESS - ADDRESS STRUCTURED (Label format Postal Address) OR PATIENT USUAL ADDRESS - ADDRESS UNSTRUCTURED (Character string)	PATIENT USUAL ADDRESS is the usual ADDRESS nominated by the PATIENT, where the ADDRESS ASSOCIATION TYPE is '*Main Permanent Residence*' or '*Other Permanent Residence*'.	R	N	0..1	max an175 (5 lines each an35)	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/p/pat/patient_usual_address_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	POSTCODE OF USUAL ADDRESS	The code assigned by Royal Mail to identify postal delivery areas across the United Kingdom.	R	N	0..1	max an8	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/p/po/postcode_of_usual_address_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) is the ORGANISATION IDENTIFIER derived from the PATIENT's POSTCODE OF USUAL ADDRESS, where they reside within the boundary of a: •Clinical Commissioning Group •Care Trust •Local Health Board (Wales) •Scottish Health Board •Northern Ireland Local Commissioning Group •Primary Healthcare Directorate (Isle of Man) •Local Authority.	R	N	0..1	min an3 max an5	ODS	Updated to new Organisation code guidelines	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/o/org/organisation_code_(residence_responsibility)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	PERSON BIRTH DATE	The date on which a PERSON was born or is officially deemed to have been born.	R	N	0..1	an10 CCYY-MM-DD	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/p/per/person_birth_date_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	

ECDS_UniqueID	Sort1	ECDS_Group	ECDS_Description	DM&D_Code	DM&D Description	Notes
n/a	n/a	n/a	Number present and verified	01	Number present and verified	
n/a	n/a	n/a	Number present but not traced	02	Number present but not traced	
n/a	n/a	n/a	Trace required	03	Trace required	
n/a	n/a	n/a	Trace attempted - No match or multiple match found	04	Trace attempted - No match or multiple match found	
n/a	n/a	n/a	Trace needs to be resolved - (NHS Number or PATIENT detail conflict)	05	Trace needs to be resolved - (NHS Number or PATIENT detail conflict)	
n/a	n/a	n/a	Trace in progress	06	Trace in progress	
n/a	n/a	n/a	Number not present and trace not required	07	Number not present and trace not required	
n/a	n/a	n/a	Trace postponed (baby under six weeks old)	08	Trace postponed (baby under six weeks old)	

Note:
In the WITHHELD IDENTITY STRUCTURE, all the above NHS NUMBER STATUS INDICATOR values are accepted
In the VERIFIED IDENTITY STRUCTURE, only value 01 is accepted
In the UNVERIFIED IDENTITY STRUCTURE, all values EXCEPT value 01 are accepted

ECDS_UniqueID	Sort1	ECDS_Group	ECDS_Description	DM&D_Code	DM&D Description	Notes
n/a	n/a	n/a	Record anonymised for legal/ statutory reasons	01	Record anonymised for legal/ statutory reasons	
n/a	n/a	n/a	Record anonymised at request of Caldicott Guardian	02	Record anonymised at request of Caldicott Guardian	
n/a	n/a	n/a	Record anonymised at request of patient	03	Record anonymised at request of patient	
n/a	n/a	n/a	Record anonymised for other reason	97	Record anonymised for other reason	
n/a	n/a	n/a	Identity withheld but reason not known	99	Identity withheld but reason not known	

DATA GROUP: PATIENT CHARACTERISTICS

FUNCTION: To carry the characteristics of the Patient for an Emergency Care Attendance.
Group Status: R
Group Repeats: 0..1

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	CQUIN DATA ITEM REQUIRED (Y/N)	DATA ITEM REPEATS	FORMAT	SNOMED CT / DM&D /ODS	JUSTIFICATION	ECDS CODE SET	LINK TO CURRENT CDS Type 010 INFORMATION ONLY	VALIDATION RULES		DATA ITEM PROVENANCE	NOTES
											POPULATION VALIDATION F - Format is validated V - Validated against an explicit list of permitted values as defined in the NHS Data Dictionary	POST SCHEMA VALIDATION		
PATIENT CHARACTERISTICS (EMERGENCY CARE)	PERSON STATED GENDER CODE	The gender of a PERSON. PERSON STATED GENDER CODE is self declared or inferred by observation for those unable to declare their PERSON STATED GENDER.	R	N	0..1	an1	DM&D	As per CDS 6.2 Type 010. Updated to align to most recent information standard to describe gender, changed from Person Gender Code.	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/p/pers/person_gender_code_current_de.asp?shownav=0	V	n/a	Originates from A&E CDS Type 010	
PATIENT CHARACTERISTICS (EMERGENCY CARE)	ETHNIC CATEGORY	The ethnicity of a PERSON, as specified by the PERSON.	R	N	0..1	max an2	DM&D	As per CDS 6.2 Type 010	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/e/ep/ethnic_category_de.asp?shownav=0	V	n/a	Originates from A&E CDS Type 010	
PATIENT CHARACTERISTICS (EMERGENCY CARE)	ACCOMMODATION STATUS (SNOMED CT)	ACCOMMODATION STATUS (SNOMED CT) is the SNOMED CT concept ID which is used to identify the details of the ACCOMODATION of the PERSON.	R	N	0..1	min n6 max n18	SNOMED CT	This item is necessary to identify rates of ED treatment, admission and discharge of specific populations of patients. This will substantially aid planning and delivery of care for specific population groups at both a local and central level e.g. by identifying patients such as nursing home residents whose care needs may be best met in the community. It will also allow specific incentives to be incorporated into any tariff arrangement.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	
PATIENT CHARACTERISTICS (EMERGENCY CARE)	PREFERRED SPOKEN LANGUAGE (SNOMED CT)	PREFERRED SPOKEN LANGUAGE (SNOMED CT) is the SNOMED CT concept ID which is used to capture the preferred spoken LANGUAGE of the PERSON.	R	N	0..1	min n6 max n18	SNOMED CT	Necessary to understand how best to provide for patient needs, identify language barriers that may prevent optimal healthcare and enable planning for how these may be ameliorated. This data is necessary to ensure that translation resources match patient need.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	
PATIENT CHARACTERISTICS (EMERGENCY CARE)	ACCESSIBLE INFORMATION PROFESSIONAL REQUIRED CODE (SNOMED CT)	ACCESSIBLE INFORMATION PROFESSIONAL REQUIRED CODE (SNOMED CT) is the SNOMED CT concept ID which is used to identify that the PAITENT requires support from a communication professional.	R	N	0..1	min n6 max n18	SNOMED CT	Necessary to understand how best to provide for patient needs, identify language barriers that may prevent optimal healthcare and enable planning for how these may be ameliorated. This data is necessary to ensure that translation resources match patient need.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	
PATIENT CHARACTERISTICS (EMERGENCY CARE)	INTERPRETER LANGUAGE (SNOMED CT)	INTERPRETER LANGUAGE (SNOMED CT) is the SNOMED CT concept ID which is used to capture the preferred spoken LANGUAGE of the communication professional.	R	N	0..1	min n6 max n18	SNOMED CT	Necessary to understand how best to provide for patient needs, identify language barriers that may prevent optimal healthcare and enable planning for how these may be ameliorated. This data is necessary to ensure that translation resources match patient need.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	This data item must be collected if Accessible Information Professional Required Code is 'Interpreter needed'.
PATIENT CHARACTERISTICS (EMERGENCY CARE)	OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE	The charging category relating to an OVERSEAS VISITOR STATUS.	R	N	0..1	an1	DM&D	As per CDS 6.2 Type 010. Code set amended to align to new DH guidance on reclaiming overseas visitors contributions to NHS care.	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/o/ov/overseas_visitor_status_classification_at_cds_activity_date_de.asp?shownav=0	V	n/a	Originates from A&E CDS Type 010	

ECDS_UniqueID	Sort1	ECDS_Group	ECDS_Description	DM&D_Code	DM&D Description	Notes
2018110000	11	n/a	Male	1	Male	
2018220000	22	n/a	Female	2	Female	
2018330000	33	n/a	Indeterminate	9	Indeterminate	
2018440000	44	n/a	Unknown	X	Unknown	

ECDS_UniqueID	Sort1	Sort2	ECDS_Group	ECDS_Description	DM&DS_Code	DM&D Description	Notes
2018111100	11	11	White	White : British, mixed British	A	White : British, mixed British	
2018111400	11	14	White	White : Irish	B	White : Irish	
2018111700	11	17	White	Any other White background	C	Any other White background	
2018511100	51	11	Mixed	White and Back Caribbean	D	White and Back Caribbean	
2018511500	51	15	Mixed	White and Black African	E	White and Black African	
2018511900	51	19	Mixed	White and Asian	F	White and Asian	
2018512300	51	23	Mixed	Any other mixed background	G	Any other mixed background	
2018611100	61	11	Asian or Asian British	Indian	H	Indian	
2018611500	61	15	Asian or Asian British	Pakistani	J	Pakistani	
2018611900	61	19	Asian or Asian British	Bangladeshi	K	Bangladeshi	
2018612300	61	23	Asian or Asian British	Any other Asian background	L	Any other Asian background	
2018711100	71	11	Black or Black British	Caribbean	M	Caribbean	
2018711600	71	16	Black or Black British	African	N	African	
2018712100	71	21	Black or Black British	Any other Black background	P	Any other Black background	
2018811100	81	11	Other ethnic	Chinese	R	Chinese	
2018811600	81	16	Other ethnic	Any other ethnic group	S	Any other ethnic group	
2018912100	91	21	Unknown	Not stated e.g. unwilling to state	Z	Not stated e.g. unwilling to state	
2018991100	99	11	Unknown	Not known e.g. unconscious	99	Not known e.g. unconscious	

ECDS_UniqueID	Sort1	ECDS_Group	ECDS_Description	SNOMED_Code	SNOMED_Description	ECDS_Notes
2018110000	11	n/a	Patient has own stable accommodation e.g. home / flat	242711000000100	Lives in house (finding)	Includes : house, farm house, non-institutional place of residence, apartment/ flat, boarding house, hotel, caravan park, refuge, long-term squat with utilities Excludes : Institutional long-term place of residence, Abandoned or derelict house
2018210000	21	n/a	Warden controlled accommodation	224221006	Lives in warden controlled accommodation (finding)	Includes : home with intermittent welfare checksExcludes : residential / nursing home with continuous dedicated staffing
2018310000	31	n/a	Residential institution WITHOUT routine nursing care	394923006	Lives in a residential home (finding)	Includes : Children’s home, residential home, old people’s home, military camp, prison, monasteryExcludes : Hospital, nursing home, hospice, psychiatric hospital
2018410000	41	n/a	Residential institution WITH routine nursing care	160734000	Lives in a nursing home (finding)	Includes : nursing home, hospiceExcludes : hospital, residential home, psychiatric hospital
2018510000	51	n/a	Medical area	224225002	Lives in hospital (finding)	Includes : hospital, clinic, psychiatric hospital (long term)Excludes : hospice, nursing home
2018610000	61	n/a	Homeless in night shelter	224231004	Sleeping in night shelter (finding)	Includes : night shelter, homeless shelter, emergency housingExcludes : sleeping rough
2018710000	71	n/a	Homeless without accommodation	32911000	Homeless (finding)	Includes : homeless, sleeping rough, abandoned or derelict housing, squatting without utilitiesExcludes : night shelter, homeless shelter
2018910000	91	n/a	Usual accommodation not given : patient refused	1064831000000106	Declines to provide accommodation details (finding)	Includes : any situation where the patient can physically answer questions but refuses to answer this question.
2018920000	92	n/a	Usual accommodation not given : patient physically unable	1064841000000102	Unable to provide accommodation details (finding)	Includes : only situation when patient physically unable to respond e.g. unconscious and not able to establish by other means
2018930000	93	n/a	Usual accommodation not known	1066881000000100	Residence and accommodation circumstances unknown (finding)	Do not use unless all no other code applicable

ECDS_UniqueID	Sort1	Sort2	ECDS_Group	ECDS_Description	SNOMED_Code	SNOMED_TERM
1111110000	11	111	Most common	English	315570003	Main spoken language English (finding)
1112110000	11	211	Most common	French	315571004	Main spoken language French (finding)
1112260000	11	226	Most common	German	407643006	Main spoken language German (finding)
1113310000	11	331	Most common	Polish	315579002	Main spoken language Polish (finding)
1115990000	11	599	Most common	Spanish	315584008	Main spoken language Spanish (finding)
1116110000	11	611	Most common	Chinese	970501000000106	Main spoken language Chinese (finding)
1117010000	11	701	Most common	Welsh	408532009	Main spoken language Welsh (finding)
1117110000	11	711	Most common	Irish	698667006	Main spoken language Irish (finding)
1117220000	11	722	Most common	Gaelic	408522002	Main spoken language Gaelic (finding)
1117870000	11	787	Most common	Cornish	970531000000100	Main spoken language Cornish (finding)
1117990000	11	799	Most common	Romany	1036381000000101	Main spoken language Romany (finding)
1311110000	31	111	Common A-E	Albanian	407648002	Main spoken language Albanian (finding)
1311160000	31	116	Common A-E	Arabic	315566006	Main spoken language Arabic (finding)
1311210000	31	121	Common A-E	Belarusian	698655009	Main spoken language Belarusian (finding)
1311260000	31	126	Common A-E	Bengali	315567002	Main spoken language Bengali (finding)
1311310000	31	131	Common A-E	Bosnian	970471000000104	Main spoken language Bosnian (finding)
1311360000	31	136	Common A-E	Bulgarian	699945003	Main spoken language Bulgarian (finding)
1311410000	31	141	Common A-E	Burmese	698891000	Main spoken language Burmese (finding)
1311460000	31	146	Common A-E	Cantonese	315568007	Main spoken language Cantonese (finding)
1311510000	31	151	Common A-E	Catalan	698892007	Main spoken language Catalan (finding)
1311560000	31	156	Common A-E	Chechen	970491000000100	Main spoken language Chechen (finding)
1311660000	31	166	Common A-E	Croatian	407650005	Main spoken language Croatian (finding)
1311710000	31	171	Common A-E	Czech	315569004	Main spoken language Czech (finding)
1311760000	31	176	Common A-E	Danish	698894008	Main spoken language Danish (finding)
1311810000	31	181	Common A-E	Dutch	408528003	Main spoken language Dutch (finding)
1311860000	31	186	Common A-E	Estonian	698659003	Main spoken language Estonian (finding)
1311910000	31	191	Common A-E	Ethiopian	408515005	Main spoken language Ethiopian (finding)
1331960000	33	196	Common F-J	Filipino	503511000000100	Main spoken language Filipino (finding)
1332010000	33	201	Common F-J	Finnish	414640006	Main spoken language Finnish (finding)
1332060000	33	206	Common F-J	Flemish	408520005	Main spoken language Flemish (finding)
1332210000	33	221	Common F-J	Georgian	698898006	Main spoken language Georgian (finding)
1332310000	33	231	Common F-J	Greek	407652002	Main spoken language Greek (finding)
1332360000	33	236	Common F-J	Gujerati	315572006	Main spoken language Gujerati (finding)
1332410000	33	241	Common F-J	Hebrew	408524001	Main spoken language Hebrew (finding)
1332460000	33	246	Common F-J	Hindi	315575008	Main spoken language Hindi (finding)
1332510000	33	251	Common F-J	Hungarian	698900008	Main spoken language Hungarian (finding)
1332560000	33	256	Common F-J	Icelandic	698663005	Main spoken language Icelandic (finding)
1332610000	33	261	Common F-J	Indonesian	698901007	Main spoken language Indonesian (finding)
1332710000	33	271	Common F-J	Italian	407642001	Main spoken language Italian (finding)
1332760000	33	276	Common F-J	Japanese	407654001	Main spoken language Japanese (finding)
1372810000	37	281	Common K-R	Kashmiri	698906002	Main spoken language Kashmiri (finding)
1372910000	37	291	Common K-R	Kurdish	395109004	Main spoken language Kurdish (finding)
1372960000	37	296	Common K-R	Latvian	698909009	Main spoken language Latvian (finding)
1373010000	37	301	Common K-R	Lithuanian	407656004	Main spoken language Lithuanian (finding)
1373060000	37	306	Common K-R	Macedonian	698670005	Main spoken language Macedonian (finding)
1373110000	37	311	Common K-R	Malay	698672002	Main spoken language Malay (finding)
1373160000	37	316	Common K-R	Mandarin	315578005	Main spoken language Mandarin (finding)
1373210000	37	321	Common K-R	Nepali	698676004	Main spoken language Nepali (finding)
1373260000	37	326	Common K-R	Norwegian	408530001	Main spoken language Norwegian (finding)

1373360000	37	336 Common K-R	Portuguese	315580004	Main spoken language Portuguese (finding)
1373410000	37	341 Common K-R	Punjabi	315581000	Main spoken language Punjabi (finding)
1373460000	37	346 Common K-R	Romanian	698678003	Main spoken language Romanian (finding)
1373510000	37	351 Common K-R	Russian	315582007	Main spoken language Russian (finding)
1392860000	39	286 Common K-R	Kazakh	698668001	Main spoken language Kazakh (finding)
1393560000	39	356 Common S-Z	Serbian	408535006	Main spoken language Serbian (finding)
1393610000	39	361 Common S-Z	Slovak	698920009	Main spoken language Slovak (finding)
1393660000	39	366 Common S-Z	Slovenian	698921008	Main spoken language Slovenian (finding)
1393710000	39	371 Common S-Z	Somali	315583002	Main spoken language Somali (finding)
1393810000	39	381 Common S-Z	Sundanese	698681008	Main spoken language Sundanese (finding)
1393860000	39	386 Common S-Z	Swahili	315585009	Main spoken language Swahili (finding)
1393910000	39	391 Common S-Z	Swedish	408516006	Main spoken language Swedish (finding)
1393960000	39	396 Common S-Z	Tamil	315587001	Main spoken language Tamil (finding)
1394010000	39	401 Common S-Z	Thai	408519004	Main spoken language Thai (finding)
1394060000	39	406 Common S-Z	Turkish	407657008	Main spoken language Turkish (finding)
1394110000	39	411 Common S-Z	Turkmen	698928002	Main spoken language Turkmen (finding)
1394160000	39	416 Common S-Z	Ukrainian	407659006	Main spoken language Ukrainian (finding)
1394210000	39	421 Common S-Z	Urdu	315588006	Main spoken language Urdu (finding)
1394260000	39	426 Common S-Z	Uzbek	698930000	Main spoken language Uzbek (finding)
1394310000	39	431 Common S-Z	Vietnamese	407661002	Main spoken language Vietnamese (finding)
1511110000	51	111 Uncommon A-E	Abkhazian	698651000	Main spoken language Abkhazian (finding)
1511160000	51	116 Uncommon A-E	Afar	698652007	Main spoken language Afar (finding)
1511210000	51	121 Uncommon A-E	Afrikaans	698653002	Main spoken language Afrikaans (finding)
1511260000	51	126 Uncommon A-E	Akan	408525000	Main spoken language Akan (finding)
1511310000	51	131 Uncommon A-E	Amharic	408507007	Main spoken language Amharic (finding)
1511360000	51	136 Uncommon A-E	Aragonese	809341000000106	Main spoken language Aragonese (finding)
1511410000	51	141 Uncommon A-E	Armenian	698885002	Main spoken language Armenian (finding)
1511460000	51	146 Uncommon A-E	Assamese	698886001	Main spoken language Assamese (finding)
1511510000	51	151 Uncommon A-E	Avaric	970441000000105	Main spoken language Avaric (finding)
1511560000	51	156 Uncommon A-E	Avestan	970451000000108	Main spoken language Avestan (finding)
1511610000	51	161 Uncommon A-E	Aymara	698887005	Main spoken language Aymara (finding)
1511660000	51	166 Uncommon A-E	Azerbaijani	698888000	Main spoken language Azerbaijani (finding)
1511710000	51	171 Uncommon A-E	Bambara	970461000000106	Main spoken language Bambara (finding)
1511760000	51	176 Uncommon A-E	Bamun	609092003	Main spoken language Bamun (finding)
1511810000	51	181 Uncommon A-E	Bashkir	698889008	Main spoken language Bashkir (finding)
1511860000	51	186 Uncommon A-E	Basque	698654008	Main spoken language Basque (finding)
1511910000	51	191 Uncommon A-E	Bihari	698656005	Main spoken language Bihari (finding)
1511960000	51	196 Uncommon A-E	Bislama	698890004	Main spoken language Bislama (finding)
1512010000	51	201 Uncommon A-E	Brawa	408513003	Main spoken language Brawa (finding)
1512060000	51	206 Uncommon A-E	Breton	698657001	Main spoken language Breton (finding)
1512110000	51	211 Uncommon A-E	Central Khmer	698893002	Main spoken language Central Khmer (finding)
1512160000	51	216 Uncommon A-E	Chamorro	970481000000102	Main spoken language Chamorro (finding)
1512210000	51	221 Uncommon A-E	Chuang	698935005	Main spoken language Chuang (finding)
1512260000	51	226 Uncommon A-E	Church Slavic	970511000000108	Main spoken language Church Slavic (finding)
1512310000	51	231 Uncommon A-E	Chuvash	970521000000102	Main spoken language Chuvash (finding)
1512410000	51	241 Uncommon A-E	Corsican	698658006	Main spoken language Corsican (finding)
1512460000	51	246 Uncommon A-E	Cree	970541000000109	Main spoken language Cree (finding)
1512510000	51	251 Uncommon A-E	Dari	609093008	Main spoken language Dari (finding)
1512560000	51	256 Uncommon A-E	Dhivehi	970551000000107	Main spoken language Dhivehi (finding)
1512610000	51	261 Uncommon A-E	Esperanto	698896005	Main spoken language Esperanto (finding)

1512660000	51	266 Uncommon A-E	Ewe	970561000000105	Main spoken language Ewe (finding)
1552760000	55	276 Uncommon F-J	Faroese	698660008	Main spoken language Faroese (finding)
1552810000	55	281 Uncommon F-J	Farsi	395108007	Main spoken language Farsi (finding)
1552860000	55	286 Uncommon F-J	Fijian	698897001	Main spoken language Fijian (finding)
1552910000	55	291 Uncommon F-J	French Creole	408521009	Main spoken language French Créole (finding)
1552960000	55	296 Uncommon F-J	Frisian	698661007	Main spoken language Frisian (finding)
1553010000	55	301 Uncommon F-J	Fulani	729051000000103	Main spoken language Fulani (finding)
1553060000	55	306 Uncommon F-J	Galician	698662000	Main spoken language Galician (finding)
1553110000	55	311 Uncommon F-J	Guarani	698899003	Main spoken language Guarani (finding)
1553160000	55	316 Uncommon F-J	Haitian	970601000000105	Main spoken language Haitian (finding)
1553210000	55	321 Uncommon F-J	Hakka	408523007	Main spoken language Hakka (finding)
1553260000	55	326 Uncommon F-J	Hausa	315574007	Main spoken language Hausa (finding)
1553310000	55	331 Uncommon F-J	Herero	970611000000107	Main spoken language Herero (finding)
1553360000	55	336 Uncommon F-J	Hindko	511841000000102	Main spoken language Hindko (finding)
1553410000	55	341 Uncommon F-J	Hiri Motu	970621000000101	Main spoken language Hiri Motu (finding)
1553460000	55	346 Uncommon F-J	Iba	315576009	Main spoken language Iba (finding)
1553510000	55	351 Uncommon F-J	Ido	970631000000104	Main spoken language Ido (finding)
1553560000	55	356 Uncommon F-J	Igbo	408514009	Main spoken language Igbo (finding)
1553610000	55	361 Uncommon F-J	Interlingua	698664004	Main spoken language Interlingua (finding)
1553660000	55	366 Uncommon F-J	Inuktitut	698665003	Main spoken language Inuktitut (finding)
1553710000	55	371 Uncommon F-J	Inupiaq	698666002	Main spoken language Inupiaq (finding)
1553760000	55	376 Uncommon F-J	Javanese	698903005	Main spoken language Javanese (finding)
1553810000	55	381 Uncommon F-J	Jonkha	698895009	Main spoken language Jonkha (finding)
1573860000	57	386 Uncommon K-R	Kalaallisut	698904004	Main spoken language Kalaallisut (finding)
1573910000	57	391 Uncommon K-R	Kanarese	698905003	Main spoken language Kanarese (finding)
1573960000	57	396 Uncommon K-R	Kanuri	970641000000108	Main spoken language Kanuri (finding)
1574010000	57	401 Uncommon K-R	Kikuyu	729061000000100	Main spoken language Kikuyu (finding)
1574060000	57	406 Uncommon K-R	Kirgiz	698908001	Main spoken language Kirgiz (finding)
1574110000	57	411 Uncommon K-R	Komi	970651000000106	Main spoken language Komi (finding)
1574160000	57	416 Uncommon K-R	Kongo	970661000000109	Main spoken language Kongo (finding)
1574210000	57	421 Uncommon K-R	Konkani	609094002	Main spoken language Konkani (finding)
1574260000	57	426 Uncommon K-R	Korean	407655000	Main spoken language Korean (finding)
1574310000	57	431 Uncommon K-R	Kuanyama	970681000000100	Main spoken language Kuanyama (finding)
1574360000	57	436 Uncommon K-R	Kutchi	315577000	Main spoken language Kutchi (finding)
1574410000	57	441 Uncommon K-R	Lao	698669009	Main spoken language Lao (finding)
1574460000	57	446 Uncommon K-R	Latin	970691000000103	Main spoken language Latin (finding)
1574510000	57	451 Uncommon K-R	Limburgan	970701000000103	Main spoken language Limburgan (finding)
1574560000	57	456 Uncommon K-R	Lingala	408526004	Main spoken language Lingala (finding)
1574610000	57	461 Uncommon K-R	Luba-Katanga	970711000000101	Main spoken language Luba-Katanga (finding)
1574660000	57	466 Uncommon K-R	Luganda	408527008	Main spoken language Luganda (finding)
1574710000	57	471 Uncommon K-R	Luxembourgish	970721000000107	Main spoken language Luxembourgish (finding)
1574760000	57	476 Uncommon K-R	Malagasy	698671009	Main spoken language Malagasy (finding)
1574810000	57	481 Uncommon K-R	Malayalam	408529006	Main spoken language Malayalam (finding)
1574860000	57	486 Uncommon K-R	Maltese	698910004	Main spoken language Maltese (finding)
1574910000	57	491 Uncommon K-R	Manx	970741000000100	Main spoken language Manx (finding)
1574960000	57	496 Uncommon K-R	Maori	698673007	Main spoken language Maori (finding)
1575010000	57	501 Uncommon K-R	Marathi	698674001	Main spoken language Marathi (finding)
1575060000	57	506 Uncommon K-R	Marshallese	970751000000102	Main spoken language Marshallese (finding)
1575110000	57	511 Uncommon K-R	Moldavian	698911000	Main spoken language Moldavian (finding)
1575160000	57	516 Uncommon K-R	Mongolian	698675000	Main spoken language Mongolian (finding)

1575210000	57	521 Uncommon K-R	Nauruan	698912007	Main spoken language Nauruan (finding)
1575260000	57	526 Uncommon K-R	Navajo	970771000000106	Main spoken language Navajo (finding)
1575310000	57	531 Uncommon K-R	Ndebele	698913002	Main spoken language Ndebele (finding)
1575360000	57	536 Uncommon K-R	Ndonga	970781000000108	Main spoken language Ndonga (finding)
1575410000	57	541 Uncommon K-R	Northern Ndebele	970801000000109	Main spoken language Northern Ndebele (finding)
1575460000	57	546 Uncommon K-R	Northern Sami	970811000000106	Main spoken language Northern Sami (finding)
1575510000	57	551 Uncommon K-R	Norwegian Bokmal	970821000000100	Main spoken language Norwegian Bokmål (finding)
1575560000	57	556 Uncommon K-R	Norwegian Nynorsk	970831000000103	Main spoken language Norwegian Nynorsk (finding)
1575610000	57	561 Uncommon K-R	Nuosu	970961000000102	Main spoken language Nuosu (finding)
1575660000	57	566 Uncommon K-R	Nyanja	729041000000101	Main spoken language Nyanja (finding)
1575710000	57	571 Uncommon K-R	Occidental	698902000	Main spoken language Occidental (finding)
1575760000	57	576 Uncommon K-R	Occitan	698914008	Main spoken language Occitan (finding)
1575810000	57	581 Uncommon K-R	Ojibwa	970851000000105	Main spoken language Ojibwa (finding)
1575860000	57	586 Uncommon K-R	Oriya	698915009	Main spoken language Oriya (finding)
1575910000	57	591 Uncommon K-R	Oromo	698916005	Main spoken language Oromo (finding)
1575960000	57	596 Uncommon K-R	Ossetian	970871000000101	Main spoken language Ossetian (finding)
1576010000	57	601 Uncommon K-R	Pali	970881000000104	Main spoken language Pali (finding)
1576060000	57	606 Uncommon K-R	Pashto	408531002	Main spoken language Pashto (finding)
1576110000	57	611 Uncommon K-R	Patois	408534005	Main spoken language Patois (finding)
1576160000	57	616 Uncommon K-R	Pushto	970911000000104	Main spoken language Pushto (finding)
1576210000	57	621 Uncommon K-R	Quechua	698677008	Main spoken language Quechua (finding)
1576260000	57	626 Uncommon K-R	Romansh	698917001	Main spoken language Romansh (finding)
1576310000	57	631 Uncommon K-R	Ruanda	698907006	Main spoken language Ruanda (finding)
1576360000	57	636 Uncommon K-R	Rundi	698679006	Main spoken language Rundi (finding)
1596410000	59	641 Uncommon S-Z	Samoan	698680009	Main spoken language Samoan (finding)
1596460000	59	646 Uncommon S-Z	Sango	698918006	Main spoken language Sango (finding)
1596510000	59	651 Uncommon S-Z	Sanskrit	970921000000105	Main spoken language Sanskrit (finding)
1596560000	59	656 Uncommon S-Z	Sardinian	970931000000107	Main spoken language Sardinian (finding)
1596610000	59	661 Uncommon S-Z	Scottish Gaelic	970941000000103	Main spoken language Scottish Gaelic (finding)
1596660000	59	666 Uncommon S-Z	Shona	395110009	Main spoken language Shona (finding)
1596710000	59	671 Uncommon S-Z	Sindhi	698919003	Main spoken language Sindhi (finding)
1596760000	59	676 Uncommon S-Z	Sinhala	408518007	Main spoken language Sinhala (finding)
1596810000	59	681 Uncommon S-Z	South Ndebele	970971000000109	Main spoken language South Ndebele (finding)
1596860000	59	686 Uncommon S-Z	Southern Sotho	698922001	Main spoken language Southern Sotho (finding)
1596910000	59	691 Uncommon S-Z	Swazi	698923006	Main spoken language Swazi (finding)
1596960000	59	696 Uncommon S-Z	Sylheti	315586005	Main spoken language Sylheti (finding)
1597010000	59	701 Uncommon S-Z	Tagalog	408517002	Main spoken language Tagalog (finding)
1597060000	59	706 Uncommon S-Z	Tahitian	970991000000108	Main spoken language Tahitian (finding)
1597110000	59	711 Uncommon S-Z	Tajik	698682001	Main spoken language Tajik (finding)
1597160000	59	716 Uncommon S-Z	Tatar	698924000	Main spoken language Tatar (finding)
1597210000	59	721 Uncommon S-Z	Telugu	698925004	Main spoken language Telugu (finding)
1597260000	59	726 Uncommon S-Z	Tetum	609095001	Main spoken language Tetum (finding)
1597310000	59	731 Uncommon S-Z	Tibetan	698926003	Main spoken language Tibetan (finding)
1597360000	59	736 Uncommon S-Z	Tigrinya	408533004	Main spoken language Tigrinya (finding)
1597410000	59	741 Uncommon S-Z	Tongan	698927007	Main spoken language Tongan (finding)
1597460000	59	746 Uncommon S-Z	Tsonga	698683006	Main spoken language Tsonga (finding)
1597510000	59	751 Uncommon S-Z	Tswana	698684000	Main spoken language Tswana (finding)
1597560000	59	756 Uncommon S-Z	Twi	698685004	Main spoken language Twi (finding)
1597610000	59	761 Uncommon S-Z	Uigur	698929005	Main spoken language Uigur (finding)
1597660000	59	766 Uncommon S-Z	Venda	971011000000109	Main spoken language Venda (finding)

1597710000	59	771 Uncommon S-Z	Volapuk	971021000000103	Main spoken language Volapük (finding)
1597760000	59	776 Uncommon S-Z	Walloon	971031000000101	Main spoken language Walloon (finding)
1597810000	59	781 Uncommon S-Z	Western Frisian	971041000000105	Main spoken language Western Frisian (finding)
1597860000	59	786 Uncommon S-Z	Wolof	698932008	Main spoken language Wolof (finding)
1597910000	59	791 Uncommon S-Z	Xhosa	698933003	Main spoken language Xhosa (finding)
1597960000	59	796 Uncommon S-Z	Yiddish	698934009	Main spoken language Yiddish (finding)
1598010000	59	801 Uncommon S-Z	Yoruba	315589003	Main spoken language Yoruba (finding)
1598060000	59	806 Uncommon S-Z	Zulu	698936006	Main spoken language Zulu (finding)
1599990000	59	999 Uncommon S-Z	Unknown	312954003	Language not recorded (finding)

ECDS_UniqueID	Sort1	ECDS_Group	ECDS_Description	SNOMED_Code	SNOMED_Description	Notes
2018111100	11	n/a	Interpreter not needed	315595002	Interpreter not needed (finding)	
2018221100	22	n/a	Interpreter needed	315594003	Interpreter needed (finding)	

ECDS_UniqueID	Sort1	Sort2	ECDS_Group	ECDS_Description	SNOMED_Code	SNOMED_TERM
2018111110	11	111	Most common	French	203441000000106	French language interpreter needed (finding)
2018112160	11	216	Most common	German	203581000000102	German language interpreter needed (finding)
2018112260	11	226	Most common	Polish	203901000000102	Polish language interpreter needed (finding)
2018112560	11	256	Most common	Italian	203371000000106	Italian language interpreter needed (finding)
2018113710	11	371	Most common	Spanish	204031000000105	Spanish language interpreter needed (finding)
2018116460	11	646	Most common	Chinese	972591000000100	Chinese interpreter needed (finding)
2018116600	11	660	Most common	Hindi	203651000000107	Hindi language interpreter needed (finding)
2018116650	11	665	Most common	Urdu	204211000000109	Urdu language interpreter needed (finding)
2018117770	11	777	Most common	Irish	972731000000105	Irish interpreter needed (finding)
2018117880	11	788	Most common	Gaelic	343721000000107	Gaelic language interpreter needed (finding)
2018117990	11	799	Most common	Welsh	204231000000101	Welsh language interpreter needed (finding)
2018211110	21	111	Signing	British sign language	204331000000107	British Sign Language interpreter needed (finding)
2018212220	21	222	Signing	Hands-on signing	945731000000104	Hands-on signing interpreter needed (finding)
2018213330	21	333	Signing	Makaton sign language	204341000000103	Makaton Sign Language interpreter needed (finding)
2018214440	21	444	Signing	Sign supported english	936761000000104	Sign Supported English interpreter needed (finding)
2018215550	21	555	Signing	Visual frame sign language	945711000000107	Visual frame sign language interpreter needed (finding)
2018511110	51	111	Common A-E	Albanian	203291000000102	Albanian language interpreter needed (finding)
2018511160	51	116	Common A-E	Arabic	203311000000101	Arabic language interpreter needed (finding)
2018511210	51	121	Common A-E	Armenian	362261000000106	Armenian language interpreter needed (finding)
2018511260	51	126	Common A-E	Bengali	203321000000107	Bengali language interpreter needed (finding)
2018511310	51	131	Common A-E	Bosnian	972561000000106	Bosnian interpreter needed (finding)
2018511360	51	136	Common A-E	Bulgarian	353921000000107	Bulgarian language interpreter needed (finding)
2018511410	51	141	Common A-E	Burmese	362371000000109	Burmese language interpreter needed (finding)
2018511460	51	146	Common A-E	Cantonese	203381000000108	Cantonese language interpreter needed (finding)
2018511510	51	151	Common A-E	Chechen	972581000000102	Chechen interpreter needed (finding)
2018511610	51	161	Common A-E	Croatian	203391000000105	Croatian language interpreter needed (finding)
2018511660	51	166	Common A-E	Czech	203401000000108	Czech language interpreter needed (finding)
2018511710	51	171	Common A-E	Danish	361971000000101	Danish language interpreter needed (finding)
2018511760	51	176	Common A-E	Dutch	203411000000105	Dutch language interpreter needed (finding)
2018511810	51	181	Common A-E	Estonian	361911000000106	Estonian language interpreter needed (finding)
2018511860	51	186	Common A-E	Ethiopian	359791000000109	Ethiopian language interpreter needed (finding)
2018551910	55	191	Common F-J	Finnish	343701000000103	Finnish language interpreter needed (finding)
2018551960	55	196	Common F-J	Flemish	343711000000101	Flemish language interpreter needed (finding)
2018552110	55	211	Common F-J	Georgian	361471000000106	Georgian language interpreter needed (finding)
2018552210	55	221	Common F-J	Greek	203591000000100	Greek language interpreter needed (finding)
2018552260	55	226	Common F-J	Gujarati	203601000000106	Gujarati language interpreter needed (finding)
2018552310	55	231	Common F-J	Hebrew	203641000000109	Hebrew language interpreter needed (finding)
2018552410	55	241	Common F-J	Hungarian	360431000000104	Hungarian language interpreter needed (finding)
2018552460	55	246	Common F-J	Icelandic	360401000000105	Icelandic language interpreter needed (finding)
2018552510	55	251	Common F-J	Indonesian	362111000000101	Indonesian language interpreter needed (finding)
2018552610	55	261	Common F-J	Japanese	203681000000101	Japanese language interpreter needed (finding)
2018552660	55	266	Common F-J	Javanese	360281000000101	Javanese language interpreter needed (finding)
2018572710	57	271	Common K-R	Kashmiri	360191000000109	Kashmiri language interpreter needed (finding)
2018572760	57	276	Common K-R	Kazakh	360221000000102	Kazakh language interpreter needed (finding)
2018572810	57	281	Common K-R	Korean	203691000000104	Korean language interpreter needed (finding)
2018572860	57	286	Common K-R	Kurdish	203701000000104	Kurdish language interpreter needed (finding)
2018572910	57	291	Common K-R	Latvian	360071000000106	Latvian language interpreter needed (finding)
2018572960	57	296	Common K-R	Lithuanian	203721000000108	Lithuanian language interpreter needed (finding)
2018573010	57	301	Common K-R	Macedonian	359971000000108	Macedonian language interpreter needed (finding)

2018573060	57	306 Common K-R	Malay	360161000000103	Malay language interpreter needed (finding)
2018573110	57	311 Common K-R	Mandarin	203821000000101	Mandarin language interpreter needed (finding)
2018573160	57	316 Common K-R	Nepali	364251000000104	Nepali language interpreter needed (finding)
2018573210	57	321 Common K-R	Norwegian	203831000000104	Norwegian language interpreter needed (finding)
2018573310	57	331 Common K-R	Portuguese	203911000000100	Portuguese language interpreter needed (finding)
2018573330	57	333 Common K-R	Panjabi	203961000000103	Panjabi language interpreter needed (finding)
2018573360	57	336 Common K-R	Romanian	353881000000101	Romanian language interpreter needed (finding)
2018573410	57	341 Common K-R	Russian	203971000000105	Russian language interpreter needed (finding)
2018593460	59	346 Common S-Z	Serbian	203981000000107	Serbian language interpreter needed (finding)
2018593510	59	351 Common S-Z	Serbo-Croatian	973061000000107	Serbo-Croatian interpreter needed (finding)
2018593560	59	356 Common S-Z	Slovak	352901000000108	Slovak language interpreter needed (finding)
2018593610	59	361 Common S-Z	Slovenian	363591000000107	Slovenian language interpreter needed (finding)
2018593660	59	366 Common S-Z	Somali	204021000000108	Somali language interpreter needed (finding)
2018593760	59	376 Common S-Z	Sundanese	363781000000103	Sundanese language interpreter needed (finding)
2018593810	59	381 Common S-Z	Swahili	204041000000101	Swahili language interpreter needed (finding)
2018593860	59	386 Common S-Z	Swedish	204051000000103	Swedish language interpreter needed (finding)
2018593910	59	391 Common S-Z	Tamil	204131000000109	Tamil language interpreter needed (finding)
2018593960	59	396 Common S-Z	Thai	204151000000102	Thai language interpreter needed (finding)
2018594010	59	401 Common S-Z	Tibetan	363141000000105	Tibetan language interpreter needed (finding)
2018594060	59	406 Common S-Z	Turkish	204191000000105	Turkish language interpreter needed (finding)
2018594110	59	411 Common S-Z	Ukrainian	204201000000107	Ukrainian language interpreter needed (finding)
2018594210	59	421 Common S-Z	Vietnamese	204221000000103	Vietnamese language interpreter needed (finding)
2018711110	71	111 Uncommon A-E	Abkhazian	362721000000106	Abkhazian language interpreter needed (finding)
2018711160	71	116 Uncommon A-E	Afar	362691000000102	Afar language interpreter needed (finding)
2018711210	71	121 Uncommon A-E	Afrikaans	362571000000102	Afrikaans language interpreter needed (finding)
2018711260	71	126 Uncommon A-E	Akan	203281000000104	Akan language interpreter needed (finding)
2018711310	71	131 Uncommon A-E	Amharic	203301000000103	Amharic language interpreter needed (finding)
2018711360	71	136 Uncommon A-E	Aragonese	972511000000109	Aragonese interpreter needed (finding)
2018711410	71	141 Uncommon A-E	Assamese	362231000000101	Assamese language interpreter needed (finding)
2018711460	71	146 Uncommon A-E	Avaric	972521000000103	Avaric interpreter needed (finding)
2018711510	71	151 Uncommon A-E	Avestan	972531000000101	Avestan interpreter needed (finding)
2018711560	71	156 Uncommon A-E	Aymara	362541000000108	Aymara language interpreter needed (finding)
2018711610	71	161 Uncommon A-E	Azerbaijani	362611000000106	Azerbaijani language interpreter needed (finding)
2018711660	71	166 Uncommon A-E	Bambara	972541000000105	Bambara interpreter needed (finding)
2018711710	71	171 Uncommon A-E	Bashkir	972551000000108	Bashkir interpreter needed (finding)
2018711760	71	176 Uncommon A-E	Basque	362641000000107	Basque language interpreter needed (finding)
2018711810	71	181 Uncommon A-E	Belarusian	362071000000107	Belarusian language interpreter needed (finding)
2018711860	71	186 Uncommon A-E	Bihari	362201000000107	Bihari language interpreter needed (finding)
2018711910	71	191 Uncommon A-E	Bislama	362171000000106	Bislama language interpreter needed (finding)
2018711960	71	196 Uncommon A-E	Brawa	359821000000104	Brawa language interpreter needed (finding)
2018712010	71	201 Uncommon A-E	Breton	362141000000100	Breton language interpreter needed (finding)
2018712060	71	206 Uncommon A-E	Catalan	362041000000101	Catalan language interpreter needed (finding)
2018712110	71	211 Uncommon A-E	Central Khmer	362331000000107	Central Khmer language interpreter needed (finding)
2018712160	71	216 Uncommon A-E	Chamorro	972571000000104	Chamorro interpreter needed (finding)
2018712210	71	221 Uncommon A-E	Church Slavic	972601000000106	Church Slavic interpreter needed (finding)
2018712260	71	226 Uncommon A-E	Chuvash	972611000000108	Chuvash interpreter needed (finding)
2018712310	71	231 Uncommon A-E	Cornish	972621000000102	Cornish interpreter needed (finding)
2018712360	71	236 Uncommon A-E	Corsican	361941000000107	Corsican language interpreter needed (finding)
2018712410	71	241 Uncommon A-E	Cree	972631000000100	Cree interpreter needed (finding)
2018712460	71	246 Uncommon A-E	Dhivehi	972641000000109	Dhivehi interpreter needed (finding)

2018712510	71	251 Uncommon A-E	Dzongkha	362781000000107	Dzongkha language interpreter needed (finding)
2018712520	71	252 Uncommon A-E	English	343671000000102	English language interpreter needed (finding)
2018712560	71	256 Uncommon A-E	Esperanto	361881000000106	Esperanto language interpreter needed (finding)
2018712610	71	261 Uncommon A-E	Ewe	972651000000107	Ewe interpreter needed (finding)
2018752660	75	266 Uncommon F-J	Faeroese	361791000000100	Faroese language interpreter needed (finding)
2018752710	75	271 Uncommon F-J	Fijian	361821000000105	Fijian language interpreter needed (finding)
2018752760	75	276 Uncommon F-J	French Creole	203521000000103	French Creole language interpreter needed (finding)
2018752810	75	281 Uncommon F-J	Frisian	361501000000104	Frisian language interpreter needed (finding)
2018752860	75	286 Uncommon F-J	Fulah	972671000000103	Fulah interpreter needed (finding)
2018752910	75	291 Uncommon F-J	Galician	361851000000100	Galician language interpreter needed (finding)
2018752960	75	296 Uncommon F-J	Ganda	203801000000105	Ganda language interpreter needed (finding)
2018753010	75	301 Uncommon F-J	Guarani	361441000000100	Guarani language interpreter needed (finding)
2018753060	75	306 Uncommon F-J	Haitian	972681000000101	Haitian interpreter needed (finding)
2018753110	75	311 Uncommon F-J	Hakka	203611000000108	Hakka language interpreter needed (finding)
2018753160	75	316 Uncommon F-J	Hausa	203631000000100	Hausa language interpreter needed (finding)
2018753210	75	321 Uncommon F-J	Herero	972691000000104	Herero interpreter needed (finding)
2018753260	75	326 Uncommon F-J	Hiri Motu	972701000000104	Hiri Motu interpreter needed (finding)
2018753310	75	331 Uncommon F-J	Iban	359881000000103	Iban language interpreter needed (finding)
2018753360	75	336 Uncommon F-J	Ido	972711000000102	Ido interpreter needed (finding)
2018753410	75	341 Uncommon F-J	Igbo	203531000000101	Igbo language interpreter needed (finding)
2018753460	75	346 Uncommon F-J	Interlingua	972721000000108	Interlingua interpreter needed (finding)
2018753510	75	351 Uncommon F-J	Interlingue	360341000000102	Interlingue language interpreter needed (finding)
2018753560	75	356 Uncommon F-J	Inuktitut	360311000000103	Inuktitut language interpreter needed (finding)
2018753610	75	361 Uncommon F-J	Inupiaq	360251000000107	Inupiaq language interpreter needed (finding)
2018773660	77	366 Uncommon K-R	Kalaallisut	362011000000102	Kalaallisut language interpreter needed (finding)
2018773710	77	371 Uncommon K-R	Kannada	360101000000102	Kannada language interpreter needed (finding)
2018773760	77	376 Uncommon K-R	Kanuri	972741000000101	Kanuri interpreter needed (finding)
2018773810	77	381 Uncommon K-R	Kikuyu	972751000000103	Kikuyu interpreter needed (finding)
2018773860	77	386 Uncommon K-R	Kinyarwanda	360131000000108	Kinyarwanda language interpreter needed (finding)
2018773910	77	391 Uncommon K-R	Kirghiz	359851000000109	Kirghiz language interpreter needed (finding)
2018773960	77	396 Uncommon K-R	Komi	972771000000107	Komi interpreter needed (finding)
2018774010	77	401 Uncommon K-R	Kongo	972781000000109	Kongo interpreter needed (finding)
2018774060	77	406 Uncommon K-R	Kuanyama	972791000000106	Kuanyama interpreter needed (finding)
2018774110	77	411 Uncommon K-R	Kutchi	343771000000106	Kutchi language interpreter needed (finding)
2018774160	77	416 Uncommon K-R	Lao	360371000000108	Lao language interpreter needed (finding)
2018774210	77	421 Uncommon K-R	Latin	972801000000105	Latin interpreter needed (finding)
2018774260	77	426 Uncommon K-R	Limburgan	972811000000107	Limburgan interpreter needed (finding)
2018774310	77	431 Uncommon K-R	Lingala	203711000000102	Lingala language interpreter needed (finding)
2018774360	77	436 Uncommon K-R	Luba-Katanga	972821000000101	Luba-Katanga interpreter needed (finding)
2018774410	77	441 Uncommon K-R	Luganda	359761000000103	Luganda language interpreter needed (finding)
2018774460	77	446 Uncommon K-R	Luxembourgish	972831000000104	Luxembourgish interpreter needed (finding)
2018774510	77	451 Uncommon K-R	Malagasy	360011000000101	Malagasy language interpreter needed (finding)
2018774560	77	456 Uncommon K-R	Malayalam	203811000000107	Malayalam language interpreter needed (finding)
2018774610	77	461 Uncommon K-R	Maltese	359731000000108	Maltese language interpreter needed (finding)
2018774660	77	466 Uncommon K-R	Manx	972851000000106	Manx interpreter needed (finding)
2018774710	77	471 Uncommon K-R	Maori	359911000000103	Maori language interpreter needed (finding)
2018774760	77	476 Uncommon K-R	Marathi	359701000000102	Marathi language interpreter needed (finding)
2018774810	77	481 Uncommon K-R	Marshallese	972861000000109	Marshallese interpreter needed (finding)
2018774860	77	486 Uncommon K-R	Moldavian	359671000000101	Moldavian language interpreter needed (finding)
2018774910	77	491 Uncommon K-R	Mongolian	359641000000107	Mongolian language interpreter needed (finding)

2018774960	77	496	Uncommon K-R	Nauru	364351000000107	Nauru language interpreter needed (finding)
2018775010	77	501	Uncommon K-R	Navajo	972881000000100	Navajo interpreter needed (finding)
2018775060	77	506	Uncommon K-R	Ndebele	352931000000102	Ndebele language interpreter needed (finding)
2018775110	77	511	Uncommon K-R	Ndonga	972891000000103	Ndonga interpreter needed (finding)
2018775160	77	516	Uncommon K-R	North Ndebele	972911000000100	North Ndebele interpreter needed (finding)
2018775210	77	521	Uncommon K-R	Northern Sami	972921000000106	Northern Sami interpreter needed (finding)
2018775260	77	526	Uncommon K-R	Norwegian Bokmal	972931000000108	Norwegian Bokmål interpreter needed (finding)
2018775310	77	531	Uncommon K-R	Norwegian Nynorsk	972941000000104	Norwegian Nynorsk interpreter needed (finding)
2018775360	77	536	Uncommon K-R	Nuosu	973071000000100	Nuosu interpreter needed (finding)
2018775410	77	541	Uncommon K-R	Nyanja	972951000000101	Nyanja interpreter needed (finding)
2018775460	77	546	Uncommon K-R	Occitan	364311000000108	Occitan language interpreter needed (finding)
2018775510	77	551	Uncommon K-R	Ojibwa	972981000000107	Ojibwa interpreter needed (finding)
2018775560	77	556	Uncommon K-R	Oriya	364211000000103	Oriya language interpreter needed (finding)
2018775610	77	561	Uncommon K-R	Oromo	362991000000107	Oromo language interpreter needed (finding)
2018775660	77	566	Uncommon K-R	Ossetian	973001000000108	Ossetian interpreter needed (finding)
2018775710	77	571	Uncommon K-R	Pali	973011000000105	Pali interpreter needed (finding)
2018775810	77	581	Uncommon K-R	Pashto	203841000000108	Pashto language interpreter needed (finding)
2018775860	77	586	Uncommon K-R	Persian	203421000000104	Persian language interpreter needed (finding)
2018775910	77	591	Uncommon K-R	Quechua	364011000000105	Quechua language interpreter needed (finding)
2018775960	77	596	Uncommon K-R	Romansh	364481000000106	Romansh language interpreter needed (finding)
2018775990	77	599	Uncommon K-R	Romany	1047321000000104	Romany language interpreter needed (finding)
2018776010	77	601	Uncommon K-R	Rundi	363061000000105	Rundi language interpreter needed (finding)
2018796060	79	606	Uncommon S-Z	Samoan	363841000000104	Samoan language interpreter needed (finding)
2018796110	79	611	Uncommon S-Z	Sango	364051000000109	Sango language interpreter needed (finding)
2018796160	79	616	Uncommon S-Z	Sanskrit	973031000000102	Sanskrit interpreter needed (finding)
2018796210	79	621	Uncommon S-Z	Sardinian	973041000000106	Sardinian interpreter needed (finding)
2018796260	79	626	Uncommon S-Z	Scottish Gaelic	973051000000109	Scottish Gaelic interpreter needed (finding)
2018796310	79	631	Uncommon S-Z	Shona	203991000000109	Shona language interpreter needed (finding)
2018796360	79	636	Uncommon S-Z	Sindhi	363711000000105	Sindhi language interpreter needed (finding)
2018796410	79	641	Uncommon S-Z	Sinhala	204011000000102	Sinhala language interpreter needed (finding)
2018796460	79	646	Uncommon S-Z	South Ndebele	973081000000103	South Ndebele interpreter needed (finding)
2018796510	79	651	Uncommon S-Z	Southern Sotho	363651000000100	Southern Sotho language interpreter needed (finding)
2018796560	79	656	Uncommon S-Z	Swati	363621000000105	Swati language interpreter needed (finding)
2018796610	79	661	Uncommon S-Z	Sylheti	204081000000109	Sylheti language interpreter needed (finding)
2018796660	79	666	Uncommon S-Z	Tagalog	204111000000101	Tagalog language interpreter needed (finding)
2018796710	79	671	Uncommon S-Z	Tahitian	973101000000109	Tahitian interpreter needed (finding)
2018796760	79	676	Uncommon S-Z	Tajik	363681000000106	Tajik language interpreter needed (finding)
2018796810	79	681	Uncommon S-Z	Tatar	363221000000107	Tatar language interpreter needed (finding)
2018796860	79	686	Uncommon S-Z	Telugu	363341000000107	Telugu language interpreter needed (finding)
2018796910	79	691	Uncommon S-Z	Tigrinya	204171000000106	Tigrinya language interpreter needed (finding)
2018796960	79	696	Uncommon S-Z	Tongan	363461000000100	Tongan language interpreter needed (finding)
2018797010	79	701	Uncommon S-Z	Tsonga	363181000000102	Tsonga language interpreter needed (finding)
2018797060	79	706	Uncommon S-Z	Tswana	363941000000108	Tswana language interpreter needed (finding)
2018797110	79	711	Uncommon S-Z	Turkmen	363551000000104	Turkmen language interpreter needed (finding)
2018797160	79	716	Uncommon S-Z	Twi	363301000000109	Twi language interpreter needed (finding)
2018797210	79	721	Uncommon S-Z	Uighur	364141000000107	Uighur language interpreter needed (finding)
2018797260	79	726	Uncommon S-Z	Uzbek	362961000000101	Uzbek language interpreter needed (finding)
2018797310	79	731	Uncommon S-Z	Venda	973121000000100	Venda interpreter needed (finding)
2018797360	79	736	Uncommon S-Z	Volapuk	973131000000103	Volapük interpreter needed (finding)
2018797410	79	741	Uncommon S-Z	Walloon	973141000000107	Walloon interpreter needed (finding)

2018797460	79	746 Uncommon S-Z	Western Frisian	973151000000105	Western Frisian interpreter needed (finding)
2018797510	79	751 Uncommon S-Z	Wolof	973161000000108	Wolof interpreter needed (finding)
2018797560	79	756 Uncommon S-Z	Xhosa	364511000000100	Xhosa language interpreter needed (finding)
2018797610	79	761 Uncommon S-Z	Yiddish	363021000000102	Yiddish language interpreter needed (finding)
2018797660	79	766 Uncommon S-Z	Yoruba	204241000000105	Yoruba language interpreter needed (finding)
2018797710	79	771 Uncommon S-Z	Zhuang	362911000000103	Zhuang language interpreter needed (finding)
2018797760	79	776 Uncommon S-Z	Zulu	362821000000104	Zulu language interpreter needed (finding)

ECDS_UniqueID	Sort1	ECDS_Group	ECDS_Description	DM&D_Code	DM&D Description	Notes
n/a	n/a	n/a	Charging category A: Standard NHS -funded PATIENT	A	Charging category A: Standard NHS -funded PATIENT	
n/a	n/a	n/a	Charging category B: Immigration Health Surcharge payee	B	Charging category B: Immigration Health Surcharge payee	
n/a	n/a	n/a	Charging category C: Charge-exempt Overseas Visitor (European Economic Area)	C	Charging category C: Charge-exempt Overseas Visitor (European Economic Area)	
n/a	n/a	n/a	Charging category D: Chargeable European Economic Area PATIENT	D	Charging category D: Chargeable European Economic Area PATIENT	
n/a	n/a	n/a	Charging category E: Charge-exempt Overseas Visitor (non-European Economic Area)	E	Charging category E: Charge-exempt Overseas Visitor (non-European Economic Area)	
n/a	n/a	n/a	Charging category F: Chargeable non-European Economic Area PATIENT	F	Charging category F: Chargeable non-European Economic Area PATIENT	
n/a	n/a	n/a	Not known	X	Not known	

DATA GROUP: MENTAL HEALTH ACT LEGAL STATUS

FUNCTION: To carry the patients Mental Health Act Legal Status.
Group Status: R
Group Repeats: 0..*

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	CQUIN DATA ITEM REQUIRED (Y/N)	DATA ITEM REPEATS	FORMAT	SNOMED CT / DM&D /ODS	JUSTIFICATION	ECDS CODE SET	LINK TO CURRENT CDS Type 010 - INFORMATION ONLY	VALIDATION RULES		DATA ITEM PROVENANCE	NOTES
											POPULATION VALIDATION F - Format is validated V - Validated against an explicit list of permitted values as defined in the NHS Data Dictionary	POST SCHEMA VALIDATION		
MENTAL HEALTH ACT LEGAL STATUS	START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	The MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START DATE records the start date of the Mental Health Act Legal Status Classification Assignment Period.	M	N	1..1	an10 CCYY-MM-DD	DM&D	To support a better understanding of the use of the Mental Health Act in acute trusts, specifically Emergency Departments.	n/a	n/a	F	n/a	NEW' A&E data item	
MENTAL HEALTH ACT LEGAL STATUS	START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	The MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START TIME records the start time of the Mental Health Act Legal Status Classification Assignment Period.	M	N	1..1	an8 HH:MM:SS	DM&D	To support a better understanding of the use of the Mental Health Act in acute trusts, specifically Emergency Departments.	n/a	n/a	F	n/a	NEW' A&E data item	
MENTAL HEALTH ACT LEGAL STATUS	EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	The DATE when a MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION for a PATIENT expires.	R	N	0..1	an10 CCYY-MM-DD	DM&D	To support a better understanding of the use of the Mental Health Act in acute trusts, specifically Emergency Departments.	n/a	n/a	F	n/a	NEW' A&E data item	
MENTAL HEALTH ACT LEGAL STATUS	EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	The TIME when a MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION for a PATIENT expires.	R	N	0..1	an8 HH:MM:SS	DM&D	To support a better understanding of the use of the Mental Health Act in acute trusts, specifically Emergency Departments.	n/a	n/a	F	n/a	NEW' A&E data item	
MENTAL HEALTH ACT LEGAL STATUS	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE	A code which identifies the MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION. Note that the National Code 'Informal' is used for those PATIENTS who are neither formally detained nor receiving supervised aftercare.	M	N	1..1	an2	DM&D	To support a better understanding of the use of the Mental Health Act in acute trusts, specifically Emergency Departments.	Link to code set	n/a	V	n/a	NEW' A&E data item	

ECDS_UniqueID	Sort1	ECDS_Group	ECDS_Description	DM&D_Code	DM&D Description	Notes
n/a	n/a	n/a	Informal	01	Informal	
n/a	n/a	n/a	Formally detained under Mental Health Act Section 2	02	Formally detained under Mental Health Act Section 2	
n/a	n/a	n/a	Formally detained under Mental Health Act Section 3	03	Formally detained under Mental Health Act Section 3	
n/a	n/a	n/a	Formally detained under Mental Health Act Section 4	04	Formally detained under Mental Health Act Section 4	
n/a	n/a	n/a	Formally detained under Mental Health Act Section 5(2)	05	Formally detained under Mental Health Act Section 5(2)	
n/a	n/a	n/a	Formally detained under Mental Health Act Section 5(4)	06	Formally detained under Mental Health Act Section 5(4)	
n/a	n/a	n/a	Formally detained under Mental Health Act Section 35	07	Formally detained under Mental Health Act Section 35	
n/a	n/a	n/a	Formally detained under Mental Health Act Section 36	08	Formally detained under Mental Health Act Section 36	
n/a	n/a	n/a	Formally detained under Mental Health Act Section 37 with section 41 restrictions	09	Formally detained under Mental Health Act Section 37 with section 41 restrictions	
n/a	n/a	n/a	Formally detained under Mental Health Act Section 37	10	Formally detained under Mental Health Act Section 37	
n/a	n/a	n/a	Formally detained under Mental Health Act Section 38	12	Formally detained under Mental Health Act Section 38	
n/a	n/a	n/a	Formally detained under Mental Health Act Section 44	13	Formally detained under Mental Health Act Section 44	
n/a	n/a	n/a	Formally detained under Mental Health Act Section 46	14	Formally detained under Mental Health Act Section 46	
n/a	n/a	n/a	Formally detained under Mental Health Act Section 47 with section 49 restrictions	15	Formally detained under Mental Health Act Section 47 with section 49 restrictions	
n/a	n/a	n/a	Formally detained under Mental Health Act Section 47	16	Formally detained under Mental Health Act Section 47	
n/a	n/a	n/a	Formally detained under Mental Health Act Section 48 with section 49 restrictions	17	Formally detained under Mental Health Act Section 48 with section 49 restrictions	
n/a	n/a	n/a	Formally detained under Mental Health Act Section 48	18	Formally detained under Mental Health Act Section 48	
n/a	n/a	n/a	Formally detained under Mental Health Act Section 135	19	Formally detained under Mental Health Act Section 135	
n/a	n/a	n/a	Formally detained under Mental Health Act Section 136	20	Formally detained under Mental Health Act Section 136	
n/a	n/a	n/a	Formally detained under Criminal Procedure(Insanity) Act 1964 as amended by the Criminal Procedures (Insanity and Unfitness to Plead) Act 1991	31	Formally detained under Criminal Procedure(Insanity) Act 1964 as amended by the Criminal Procedures (Insanity and Unfitness to Plead) Act 1991	
n/a	n/a	n/a	Formally detained under other acts	32	Formally detained under other acts	
n/a	n/a	n/a	Subject to guardianship under Mental Health Act Section 7	35	Subject to guardianship under Mental Health Act Section 7	
n/a	n/a	n/a	Subject to guardianship under Mental Health Act Section 37	36	Subject to guardianship under Mental Health Act Section 37	
n/a	n/a	n/a	Formally detained under Mental Health Act Section 45A (Limited direction in force)	37	Formally detained under Mental Health Act Section 45A (Limited direction in force)	
n/a	n/a	n/a	Formally detained under Mental Health Act Section 45A (Limitation direction ended)	38	Formally detained under Mental Health Act Section 45A (Limitation direction ended)	
n/a	n/a	n/a	Not Applicable	98	Not Applicable	
n/a	n/a	n/a	Not Known	99	Not Known	

DATA GROUP: GP REGISTRATION

FUNCTION: To carry the Patient's General Medical Practitioner and the General Practice details.
Group Status: R
Group Repeats: 0..1

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	CQUIN DATA ITEM REQUIRED (Y/N)	DATA ITEM REPEATS	FORMAT	SNOMED CT / DM&D /ODS	JUSTIFICATION	ECDS CODE SET	LINK TO CURRENT CDS Type 010 INFORMATION ONLY	VALIDATION RULES		DATA ITEM PROVENANCE	NOTES
											POPULATION VALIDATION F - Format is validated V - Validated against an explicit list of permitted values as defined in the NHS Data Dictionary	POST SCHEMA VALIDATION		
GP REGISTRATION	GENERAL MEDICAL PRACTITIONER (SPECIFIED)	GENERAL MEDICAL PRACTITIONER (SPECIFIED) is the GENERAL MEDICAL PRACTITIONER PPD CODE of the GENERAL MEDICAL PRACTITIONER specified by the PATIENT.	O	N	0..1	an8	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/g/general_medical_practitioner_(specified)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
GP REGISTRATION	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	An ORGANISATION SITE CODE is a code which identifies an Organisation Site uniquely.	R	N	0..1	an6	ODS	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/g/general_medical_practice_code_(patient_registration)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	

DATA GROUP: EMERGENCY CARE ATTENDANCE LOCATION

FUNCTION: To carry the details of the Emergency Care Attendance location.
Group Status: M
Group Repeats: 1..1

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	CQUIN DATA ITEM REQUIRED (Y/N)	DATA ITEM REPEATS	FORMAT	SNOMED CT / DM&D /ODS	JUSTIFICATION	ECDS CODE SET	LINK TO CURRENT CDS Type 010 INFORMATION ONLY	VALIDATION RULES		DATA ITEM PROVENANCE	NOTES
											POPULATION VALIDATION F - Format is validated V - Validated against an explicit list of permitted values as defined in the NHS Data Dictionary	POST SCHEMA VALIDATION		
EMERGENCY CARE ATTENDANCE LOCATION	ORGANISATION SITE IDENTIFIER (OF TREATMENT)	An ORGANISATION SITE CODE is a code which identifies an Organisation Site uniquely.	M	N	1..1	min an5 max an9	Updated to new Organisation code guidelines	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/s/site/site_code_(of_treatment)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
EMERGENCY CARE ATTENDANCE LOCATION	EMERGENCY CARE DEPARTMENT TYPE	The type of Emergency Care Department	M	N	1..1	an2	As per CDS 6.2 Type 010. Updated to include new code for Ambulatory Emergency Care Unit in anticipation of this data set being used to support the collection of AEC data in the future.	As per CDS 6.2 Type 010	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/a_and_e_department_type_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	Urgent Care Centres should be recorded as a Type 3 Department.

ECDS_UniqueID	Sort1	ECDS_Group	ECDS_Description	DM&D_Code	DM&D Description	Notes
n/a	n/a	n/a	Type 1 : General Emergency Department (24 hour)	01	Type 1 : General Emergency Department (24 hour)	
n/a	n/a	n/a	Type 2 : Specialist Emergency Department (e.g. paediatric, ophthalmology)	02	Type 2 : Specialist Emergency Department (e.g. paediatric, ophthalmology)	
n/a	n/a	n/a	Type 3 : Minor Injury Unit	03	Type 3 : Minor Injury Unit	
n/a	n/a	n/a	Type 4 : Walk in Centre	04	Type 4 : Walk in Centre	
n/a	n/a	n/a	Ambulatory Emergency Care Service*	05	Ambulatory Emergency Care Service*	

*Note that National Code 05 is only valid for piloting purposes in the CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set and must not be submitted in the CDS V6-2 Type 010 - Accident and Emergency Commissioning Data Set.

DATA GROUP:AMBULANCE DETAILS

FUNCTION: To carry ambulance details relating to the patients arrival at Emergency Care.
Group Status: R
Group Repeats: 0..1

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	CQUIN DATA ITEM REQUIRED (Y/N)	DATA ITEM REPEATS	FORMAT	SNOMED CT / DM&D /ODS	JUSTIFICATION	ECDS CODE SET	LINK TO CURRENT CDS Type 010 INFORMATION ONLY	VALIDATION RULES		DATA ITEM PROVENANCE	NOTES
											POPULATION VALIDATION F - Format is validated V - Validated against an explicit list of permitted values as defined in the NHS Data Dictionary	POST SCHEMA VALIDATION		
AMBULANCE DETAILS	AMBULANCE INCIDENT NUMBER	An identifier for each PATIENT TRANSPORT JOURNEY.	R	N	0..1	max an20	DM&D	As per CDS 6.2 Type 010 Amended from 'Optional' to 'Required' at request of DH. Making these data items required will allow linking of ambulance and emergency department data, thus providing information about a patient from the moment an ambulance is called until they leave hospital. This will provide learning opportunities that can benefit ambulance services, emergency departments and patients.	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/ag/ambulance_incident_number_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	This information should be recorded when EMERGENCY CARE ARRIVAL MODE is recorded as patient arrives by Emergency road ambulance, Emergency road ambulance with medical escort, Non-emergency road ambulance, Helicopter, or Fixed wing / medical repatriation by air.
AMBULANCE DETAILS	ORGANISATION CODE (CONVEYING AMBULANCE TRUST)	An ORGANISATION CODE is a code which identifies an Organisation uniquely.	R	N	0..1	min an3 max an5	ODS	Updated to new Organisation code guidelines. Amended from 'Optional' to 'Required' at request of DH. Making these data items required will allow linking of ambulance and emergency department data, thus providing information about a patient from the moment an ambulance is called until they leave hospital. This will provide learning opportunities that can benefit ambulance services, emergency departments and patients.	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/o/org/organisation_code_(conveying_ambulance_trust)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	This information should be recorded when EMERGENCY CARE ARRIVAL MODE is recorded as patient arrives by Emergency road ambulance, Emergency road ambulance with medical escort, Non-emergency road ambulance, Helicopter, or Fixed wing / medical repatriation by air.

DATA GROUP: EMERGENCY CARE ATTENDANCE ACTIVITY CHARACTERISTICS

FUNCTION: To carry the characteristics of the Patient for an Emergency Care Attendance.
Group Status: M
Group Repeats: 1..1

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	CQUIN DATA ITEM REQUIRED (Y/N)	DATA ITEM REPEATS	FORMAT	SNOMED CT / DM&D /ODS	JUSTIFICATION	ECDS CODE SET	LINK TO CURRENT CDS Type 010 INFORMATION ONLY	VALIDATION RULES		DATA ITEM PROVENANCE	NOTES
											POPULATION VALIDATION F - Format is validated V - Validated against an explicit list of permitted values as defined in the NHS Data Dictionary	POST SCHEMA VALIDATION		
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ATTENDANCE IDENTIFIER	A unique number or set of characters that is applicable to only one ACTIVITY for a PATIENT within an Organisation.	M	N	1..1	max an12	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/a_and_e_attendance_number_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ARRIVAL MODE (SNOMED CT)	EMERGENCY CARE ARRIVAL MODE (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the transport mode by which the PATIENT arrived at the Emergency Care Department.	R	N	0..1	min n6 max n18	SNOMED CT	As per CDS 6.2 Type 010. Code set updated to include greater granularity in descriptors than used currently (brought in by emergency ambulance and other). Arrival mode helps commissioners to match the records of ambulance patients to Emergency Care and inpatient activity and is part of the information set that allows the patient journey to be across different providers in the healthcare system. Arrival mode is often used as a proxy for patient acuity in analysis and planning as patients brought to the Emergency Care facility by ambulance are more likely to be admitted than those who have arrived by private or public transport. Amended to be collected in SNOMED CT.	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/accident_and_emergency_arrival_mode_code_de.asp?shownav=0	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	Originates from A&E CDS Type 010	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ATTENDANCE CATEGORY	The category of Emergency Care Attendance.	R	N	0..1	an1	DM&D	As per CDS 6.2 Type 010. Necessary to understand the reason and nature for the visit to the healthcare provider. This data item provides an indication of whether a PATIENT is making first or follow-up attendance at a particular Accident and Emergency Department. The increased clarity that the revised code set will bring will be important in commissioning services at local and national level. One of the most contentious areas in acute healthcare is whether patients who attend Emergency healthcare because other potentially more cost-effective alternatives have not been used or have failed. If patients attend Emergency healthcare despite having been seen recently in other healthcare settings, it may well be that the services currently commissioned are not effective. The recent evidence suggest that the optimal horizon is approximately seven days, which is why this is chosen rather than 72 hours or 28 days.	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/accident_and_emergency_attendance_category_code_de.asp?shownav=0	V	n/a	Originates from A&E CDS Type 010	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT)	The source of referral of each Accident and Emergency Episode. Source from which patient was referred/ advised to attend the ED. Not mode of transport	R	Y	0..1	min n6 max n18	SNOMED CT	Code set updated to include greater granularity in descriptors than currently used. This data item is necessary to understand why patients attend Emergency Care. This informs commissioning both locally and centrally and for long-term workforce planning so that the NHS can ensure that the correct blend of staff are recruited and trained.	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/s/so/source_of_referral_for_a_and_e_de.asp?shownav=0	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	Originates from A&E CDS Type 010	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE)	ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE) is the ORGANISATION IDENTIFIER of the Organisation Site from which a PATIENT arrived at an Emergency Care Department.	R	N	0..1	min an5 max an9	ODS	This data necessary to link records for the (rare, but high acuity) patients who are transferred between institutions. As acute care networks and retrieval/ transfer arrangements become more common, recording this information will be increasingly important for commissioners of services to understand patient pathways, and where in the pathways value is added. This information is also important in payment mechanisms as incentives will need to be in place to ensure that the correct patients are transferred e.g. referring providers are not penalised because they transfer 'high value' patients. The regional organisation of healthcare into networks has increased the need for patients to be transferred to Emergency Centres with Specialist Services for optimum care of conditions that require highly specialised acute care delivered in regional centres e.g. Stroke, Cardiac, and Trauma.	n/a	n/a	F		NEW' A&E data item	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ARRIVAL DATE	An Emergency Care Arrival Date may be either: • the Arrival Date At Accident and Emergency Department or • the Ambulatory Emergency Care Arrival Date. An Arrival Date At Accident and Emergency Department is the date the PATIENT self presented at the Accident and Emergency Department or arrived in an Ambulance at the Accident and Emergency Department.	M	N	1..1	an10 CCYY-MM-DD	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/ap/arrival_date_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ARRIVAL TIME	The Emergency Care Arrival Time may be either: • the Arrival Time At Accident and Emergency Department or • the Ambulatory Emergency Care Arrival Time. An Arrival Time At Accident and Emergency Department is the date the PATIENT self presented at the Accident and Emergency Department or arrived in an Ambulance at the Accident and Emergency Department.	M	N	1..1	an8 HH:MM:SS	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/ap/arrival_time_at_accident_and_emergency_department_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	AGE AT CDS ACTIVITY DATE	AGE AT CDS ACTIVITY DATE is derived as the number of completed years between the PERSON BIRTH DATE of the PATIENT and the CDS ACTIVITY DATE.	M	N	1..1	max n3	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/ag/age_at_cds_activity_date_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE INITIAL ASSESSMENT DATE	The Emergency Care Initial Assessment Date may be either: • the Accident and Emergency Initial Assessment Date or • the Ambulatory Emergency Care Initial Assessment Date. An Accident and Emergency Initial Assessment Date is the date that the PATIENT is first assessed in the Accident and Emergency Department.	R	N	0..1	an10 CCYY-MM-DD	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/accident_and_emergency_initial_assessment_date_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE INITIAL ASSESSMENT TIME	The Emergency Care Initial Assessment Time may be either: • the Accident and Emergency Initial Assessment Time or • the Ambulatory Emergency Care Initial Assessment Time. An Accident and Emergency Initial Assessment Time is the time, recorded using the 24 hour clock, that the PATIENT is first assessed in the Accident and Emergency Department for first attendances and unplanned follow-up attendances.	R	N	0..1	an8 HH:MM:SS	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/a_and_e_initial_assessment_time_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ACUITY (SNOMED CT)	EMERGENCY CARE ACUITY (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE. EMERGENCY CARE ACUITY (SNOMED CT) is the SNOMED CT® concept ID which is used to indicate the acuity of the PATIENT's condition on the Emergency Care Initial Assessment Date and Emergency Care Initial Assessment Time. The EMERGENCY CARE ACUITY (SNOMED CT) may be determined by a formal triage process, or by the physical allocation of the PATIENT to a specific clinical area such as Resuscitation.	R	N	0..1	min n6 max n18	SNOMED CT	Emergency Care Acuity is a measure of the urgency and severity of the condition with which the patient has presented to the emergency care facility as defined by the first clinician who assesses the patient. 'Clinician' in this context could be any member of staff registered by the General Medical Council, Nursing and Midwifery Council or Health and Care Professions Council who has appropriate training and support for this role and who is authorised to treat patients independently - in practice this is usually a nurse. 'Clinician' does not include trainees or Health Care Assistants. Emergency Care Acuity is represented by an integer (number) between '1' and '5', '1' being the most serious / time sensitive and '5' the least. The measure of acuity submitted must be the initial assessment of acuity. If this subsequently changes e.g. the patient deteriorates, this may be recorded locally but only the first value should be submitted as Emergency Care Acuity. Emergency care facilities must use one consistent measure of acuity across all modes of care within their organisation.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	This data item will required providers to map current triage scores or allocation of a patients intended treatment area to a five point acuity score. Please refer to ECDS User Guidance
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT)	EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE. EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT) is the SNOMED CT® concept ID which is used to indicate the nature of the PATIENT's chief complaint as assessed by the CARE PROFESSIONAL first assessing the PATIENT.	R	N	0..1	min n6 max n18	SNOMED CT	There is a need for Emergency Care to standardise input measurement to record accurately the type of patients attending across a range of Emergency Care services, which will help inform commissioners – both central and local - as to the likely nature and complexity of patient loads. As the NHS moves to value-based commissioning, it is fundamentally important to be able to measure inputs and outputs. In the UK there has been no single measure of presenting symptoms, and many EDs have historically used their own set of measures or modified existing systems. A system-wide adoption of the Chief Complaint measure will allow patient pathways to be standardised with decision support, and there is ample evidence that this improves quality of care and efficiency.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	Chief complaint code sets should be implemented with flags as highlighted. When a chief complaint has an injury flag this will require the injury data items to be completed.
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE DATE SEEN FOR TREATMENT	The Emergency Care Date Seen For Treatment may be: • the Accident and Emergency Date Seen For Treatment or • the Ambulatory Emergency Care Date Seen For Treatment. Accident and Emergency Date Seen For Treatment is the date, that the PATIENT is seen by a clinical decision maker (someone who can define the management plan and discharge the PATIENT) to diagnose the problem and arrange or start definite treatment as necessary.	R	N	0..1	an10 CCYY-MM-DD	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/accident_and_emergency_date_seen_for_treatment_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE TIME SEEN FOR TREATMENT	The Emergency Care Time Seen For Treatment may be either: • the Accident and Emergency Time Seen For Treatment or • the Ambulatory Emergency Care Time Seen For Treatment An Accident and Emergency Time Seen For Treatment is the time, recorded using the 24 hour clock, that the PATIENT is seen by a clinical decision maker (someone who can define the management plan and discharge the PATIENT) to diagnose the problem and arrange or start definite treatment as necessary.	R	N	0..1	an8 HH:MM:SS	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/a_and_e_time_seen_for_treatment_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	

ECDS_UniqueID	Sort1	ECDS_Group	ECDS_Description	SNOMED_Code	SNOMED_Description	Notes
2018110000	11	n/a	Patient arranged own transport / walk-in	1048071000000103	Arrival by patient’s own transport (finding)	
2018210000	21	n/a	Public transport / taxi	1048061000000105	Arrival by public transport (finding)	
2018310000	31	n/a	Emergency road ambulance	1048031000000100	Arrival by emergency road ambulance (finding)	
2018350000	35	n/a	Emergency road ambulance with medical escort	1048041000000109	Arrival by emergency road ambulance with medical escort (finding)	
2018370000	37	n/a	Non-emergency road ambulance	1048021000000102	Arrival by non-emergency road ambulance (finding)	
2018510000	51	n/a	Helicopter	1048051000000107	Arrival by helicopter Air Ambulance (finding)	
2018550000	55	n/a	Fixed wing / medical repatriation by air	1048081000000101	Arrival by medical repatriation air ambulance (finding)	
2018810000	81	n/a	Custodial services : prison / detention centre transport	1047991000000102	Arrival by prison transport (finding)	
2018910000	91	n/a	Police transport	1048001000000106	Arrival by police transport (finding)	

ECDS_UniqueID	Sort1	ECDS_Group	ECDS_Description	DM&D_Code	DM&D Description	Notes
2018111100	11	n/a	Unplanned First Emergency Care Attendance for a new clinical condition (or deterioration of a chronic condition).	1	Unplanned First Emergency Care Attendance for a new clinical condition (or deterioration of a chronic condition).	
2018211100	21	n/a	Unplanned Follow-up Emergency Care Attendance for the same or a related clinical condition and within 7 days of the First Emergency Care Attendance at THIS Emergency Care Department	2	Unplanned Follow-up Emergency Care Attendance for the same or a related clinical condition and within 7 days of the First Emergency Care Attendance at THIS Emergency Care Department	
2018311100	31	n/a	Unplanned Follow-up Emergency Care Attendance for the same or a related clinical condition and within 7 days of the First Emergency Care Attendance at ANOTHER Emergency Care Department	3	Unplanned Follow-up Emergency Care Attendance for the same or a related clinical condition and within 7 days of the First Emergency Care Attendance at ANOTHER Emergency Care Department	
2018511100	51	n/a	Planned Follow-up Emergency Care Attendance within 7 days of the First Emergency Care Attendance at THIS Emergency Care Department	4	Planned Follow-up Emergency Care Attendance within 7 days of the First Emergency Care Attendance at THIS Emergency Care Department	
2018911100	91	n/a	Not Applicable/Dead on arrival : no intent / attempt to resuscitate in Emergency Care facility	X	Not Applicable (Patient dead on arrival at Emergency Care Department)	

ECDS_UniqueID	Sort1	Sort2	ECDS_Group	ECDS_Description	SNOMED_Code	SNOMED_Description	Notes
2018111100	11	11	Personal	Self / family / friends / education / work colleague	507291000000100	Self-referral to accident and emergency department (procedure)	
2018113100	11	31	Personal	Carer (external, not family / friend)	1065391000000104	Referred by carer (finding)	
2018117100	11	71	Personal	Non-NHS telephone / internet advice	315261000000101	Advised to attend accident and emergency department (situation)	
2018311100	31	11	Primary care	GP / practice nurse	276491000	Referred by member of Primary Health Care Team (finding)	
2018312100	31	21	Primary care	Out of hours GP service	166941000000106	Referral by out of hours service (procedure)	
2018315100	31	51	Primary care	NHS telephone / internet advice e.g. NHS 111	879591000000102	Referred by National Health Service 111 service (finding)	
2018513100	51	31	Hospital	Emergency department	1066431000000102	Referred by hospital emergency department (finding)	
2018514100	51	41	Hospital	Urgent care service	1066441000000106	Referred by urgent care service (finding)	
2018515100	51	51	Hospital	Outpatient service inc. ambulatory care	835091000000109	Referred by hospital outpatient department (finding)	
2018516100	51	61	Hospital	Inpatient	835101000000101	Referred by hospital ward (finding)	
2018519100	51	91	Hospital	Private specialist	183877003	Private referral (procedure)	
2018611100	61	11	Community	Community nurse (not practice nurse)	1077191000000103	Referred by community nurse (finding)	
2018611500	61	15	Community	Health visitor	1052681000000105	Referred by health visitor (finding)	
2018612100	61	21	Community	Midwife	185363009	Referred by midwife (finding)	
2018612500	61	25	Community	School nurse	1065401000000101	Referred by school nurse (finding)	
2018613100	61	31	Community	Community mental health nurse	1077201000000101	Referred by community mental health nurse (finding)	
2018613700	61	37	Community	Mental health assessment team	1065991000000100	Referred by mental health assessment team (finding)	
2018614100	61	41	Community	Social services	877171000000103	Referred by social services (finding)	
2018614500	61	45	Community	Older persons day care centre	1077761000000105	Referred by adult day care centre (finding)	
2018614700	61	47	Community	Homeless persons drop in centre	1077211000000104	Referred by homeless drop-in centre (finding)	
2018615100	61	51	Community	Custodial services : prison	1066011000000104	Referred by Her Majesty's Prison Service (finding)	
2018615500	61	55	Community	Custodial services : detention centre	1066001000000101	Referred by detention centre (finding)	
2018616100	61	61	Community	Pharmacist (including community pharmacist)	185369008	Referred by pharmacist (finding)	
2018617100	61	71	Community	Dentist (including community dentist)	185366001	Referred by dentist (finding)	
2018618100	61	81	Community	Optician / optometrist	185368000	Referred by optician (finding)	
2018812100	81	21	Emergency Services	Advanced care practitioner	1066021000000105	Referred by advanced care practitioner (finding)	
2018813100	81	31	Emergency Services	Ambulance service - patient in transit	198261000000104	Referred by ambulance service (finding)	
2018815100	81	51	Emergency Services	Police service / forensic medical officer	889801000000100	Referred by police (finding)	
2018817100	81	71	Emergency Services	Fire service	1066031000000107	Referred by Fire and Rescue Service (finding)	
2018818100	81	81	Emergency Services	Search and rescue	1066061000000102	Referred by search and rescue service (finding)	
2018818300	81	83	Emergency Services	Coastguard	1066041000000103	Referred by Coastguard Rescue Service (finding)	
2018818500	81	85	Emergency Services	Mountain rescue	1066051000000100	Referred by mountain rescue service (finding)	

ECDS_UniqueID	Sort1	ECDS_Group	ECDS_Description	SNOMED_Code	SNOMED_Description	Notes
2018111100	11	n/a	1 - Immediate care level emergency care	1064891000000107	Immediate resuscitation level emergency care (regime/therapy)	Maps to 'Resus'
2018211100	21	n/a	2 - Very urgent level emergency care	1064911000000105	Very urgent level emergency care (regime/therapy)	
2018311100	31	n/a	3 - Urgent level emergency care	1064901000000108	Urgent level emergency care (regime/therapy)	Maps to 'Majors'
2018411100	41	n/a	4 - Standard level emergency care	1077241000000103	Standard level emergency care (regime/therapy)	Maps to 'Minors'
2018511100	51	n/a	5 - Low acuity level emergency care	1077251000000100	Non-urgent level emergency care (regime/therapy)	

ECDS_UniqueID	Sort1	Sort2	ECDS_Group	ECDS_Description	SNOMED_Code	SNOMED_Description	Flag_Injury	Flag_Male	Flag_Female	Notes
1111110000	11	11	Airway / breathing	Short of breath	267036007	Dyspnea (finding)	0	1	1	
1111120000	11	12	Airway / breathing	Difficulty breathing	230145002	Difficulty breathing (finding)	0	1	1	
1111130000	11	13	Airway / breathing	Noisy breathing	70407001	Stridor (finding)	0	1	1	
1111310000	11	31	Airway / breathing	Coughing up blood (haemoptysis)	66857006	Hemoptysis (disorder)	0	1	1	
1111510000	11	51	Airway / breathing	Foreign body in respiratory tract	262599003	Foreign body in respiratory tract (disorder)	1	1	1	
1111610000	11	61	Airway / breathing	Infant with episodes not breathing (apnoea)	13094009	Apnoea of newborn (disorder)	0	1	1	
1111710000	11	71	Airway / breathing	Respiratory arrest	87317003	Respiratory arrest (disorder)	0	1	1	
1121110000	21	11	Circulation / chest	Chest pain	29857009	Chest pain (finding)	0	1	1	
1121120000	21	12	Circulation / chest	Palpitations	80313002	Palpitations (finding)	0	1	1	
1121230000	21	23	Circulation / chest	Collapse / fainting episode	427461000	Near syncope (disorder)	0	1	1	
1121240000	21	24	Circulation / chest	Collapse / fainting episode with loss of consciousness	271594007	Syncope (disorder)	0	1	1	
1121350000	21	35	Circulation / chest	Swollen legs (both)	275319005	Swollen legs (finding)	0	1	1	
1121360000	21	36	Circulation / chest	Swollen leg (single)	162784002	Unilateral leg edema (situation)	0	1	1	
1121440000	21	44	Circulation / chest	Cold painful limb	21631000119105	Limb ischaemia (disorder)	0	1	1	
1121510000	21	51	Circulation / chest	Cardiac arrest	410429000	Cardiac arrest (disorder)	0	1	1	
1121520000	21	52	Circulation / chest	Cardiac arrest due to trauma	422970001	Cardiac arrest due to trauma (disorder)	1	1	1	
1131110000	31	11	Gastrointestinal	Abdominal pain	21522001	Abdominal pain (finding)	0	1	1	
1131120000	31	12	Gastrointestinal	Constipation	14760008	Constipation (disorder)	0	1	1	
1131130000	31	13	Gastrointestinal	Diarrhoea	62315008	Diarrhea (finding)	0	1	1	
1131140000	31	14	Gastrointestinal	Vomiting + / - nausea	422400008	Vomiting (disorder)	0	1	1	
1131150000	31	15	Gastrointestinal	Nausea without vomiting	422587007	Nausea (finding)	0	1	1	
1131160000	31	16	Gastrointestinal	Abdominal distension	41931001	Abdominal distension (finding)	0	1	1	
1131170000	31	17	Gastrointestinal	Hiccoughs	65958008	Hiccoughs (finding)	0	1	1	
1131180000	31	18	Gastrointestinal	Jaundice	18165001	Jaundice (finding)	0	1	1	
1131210000	31	21	Gastrointestinal	Loss of appetite	79890006	Loss of appetite (finding)	0	1	1	
1131310000	31	31	Gastrointestinal	Vomiting blood	8765009	Hematemesis (disorder)	0	1	1	
1131320000	31	32	Gastrointestinal	Rectal pain	77880009	Rectal pain (finding)	0	1	1	
1131330000	31	33	Gastrointestinal	Blood in stools	249624003	Blood in feces symptom (finding)	0	1	1	
1131410000	31	41	Gastrointestinal	Injury of anus	276464002	Injury of anus (disorder)	1	1	1	
1131520000	31	52	Gastrointestinal	Food / foreign body in oesophagus	47609003	Foreign body in esophagus (disorder)	1	1	1	
1131550000	31	55	Gastrointestinal	Foreign body in digestive tract	33334006	Foreign body in digestive tract (disorder)	1	1	1	
1131590000	31	59	Gastrointestinal	Foreign body in rectum	70176004	Foreign body in rectum (disorder)	1	1	1	
1135110000	35	11	Neurological	Headache	25064002	Headache (finding)	0	1	1	
1135250000	35	25	Neurological	Confusion	40917007	Clouded consciousness (finding)	0	1	1	
1135270000	35	27	Neurological	Drowsy (altered level of consciousness)	3006004	Disturbance of consciousness (finding)	0	1	1	
1135310000	35	31	Neurological	Limb weakness	713514005	Muscle weakness of limb (finding)	0	1	1	
1135350000	35	35	Neurological	Facial weakness	95666008	weakness of face muscles (finding)	0	1	1	
1135410000	35	41	Neurological	Speech disturbance	23168003	Speech dysfunction (disorder)	0	1	1	
1135510000	35	51	Neurological	Seizure (fit)	91175000	Seizure (finding)	0	1	1	
1135610000	35	61	Neurological	Dizziness	404640003	Dizziness (finding)	0	1	1	
1135650000	35	65	Neurological	Numbness / tingling (parasthesia)	44077006	Numbness (finding)	0	1	1	
1135710000	35	71	Neurological	Tremor	26079004	Tremor (finding)	0	1	1	
1135750000	35	75	Neurological	Falls / unsteady on feet	394616008	Unsteady gait (finding)	0	1	1	
1135910000	35	91	Neurological	Insomnia	193462001	Insomnia (disorder)	0	1	1	
1141110000	41	11	Skin	Wound : abrasion	399963005	Abrasion (disorder)	1	1	1	
1141120000	41	12	Skin	Wound : laceration	312608009	Laceration - injury (disorder)	1	1	1	
1141130000	41	13	Skin	Wound : puncture	312609001	Puncture wound - injury (disorder)	1	1	1	
1141140000	41	14	Skin	Wound : sting	299972003	Sting of skin (disorder)	1	1	1	
1141150000	41	15	Skin	Wound : bite	283682007	Bite - wound (disorder)	1	1	1	
1141210000	41	21	Skin	Burn	125666000	Burn (disorder)	1	1	1	
1141310000	41	31	Skin	Rash	271807003	Eruption of skin (disorder)	0	1	1	
1141320000	41	32	Skin	Localised swelling / redness / lumps / bumps	95320005	Disorder of skin (disorder)	0	1	1	
1141420000	41	42	Skin	Itching	418363000	Itching of skin (finding)	0	1	1	
1141610000	41	61	Skin	Spontaneous bruising	161887000	Spontaneous bruising (disorder)	0	1	1	
1141710000	41	71	Skin	Foreign body in skin / subcutaneous tissue	93459000	Foreign body in subcutaneous tissue (disorder)	1	1	1	
1151130000	51	13	Head and neck	Facial pain (inc. toothache)	95668009	Pain in face (finding)	0	1	1	
1151180000	51	18	Head and neck	Neck pain	81680005	Neck pain (finding)	0	1	1	
1151210000	51	21	Head and neck	Ear : pain	162356005	Earache symptom (finding)	0	1	1	
1151220000	51	22	Head and neck	Ear : injury	2999009	Injury of ear (disorder)	1	1	1	
1151230000	51	23	Head and neck	Ear : discharge	300132001	Ear discharge (finding)	0	1	1	
1151240000	51	24	Head and neck	Ear : hearing loss	15188001	Hearing loss (disorder)	0	1	1	
1151250000	51	25	Head and neck	Ear : ringing in ears (tinnitus)	60862001	Tinnitus (finding)	0	1	1	
1151290000	51	29	Head and neck	Ear : foreign body	75441006	Foreign body in ear (disorder)	1	1	1	
1151310000	51	31	Head and neck	Nose : bleeding from nose	12441001	Epistaxis (disorder)	0	1	1	
1151320000	51	32	Head and neck	Nose : injury	19491003	Injury of nose (disorder)	1	1	1	
1151340000	51	34	Head and neck	Nose : congestion	68235000	Nasal congestion (finding)	0	1	1	
1151390000	51	39	Head and neck	Nose : foreign body	74699008	Foreign body in nose (disorder)	0	1	1	
1151410000	51	41	Head and neck	Throat : sore	267102003	Sore throat symptom (finding)	0	1	1	

1151420000	51	42	Head and neck	Throat : cough	49727002	Cough (finding)	0	1	1
1151490000	51	49	Head and neck	Throat : foreign body in throat / mouth	14380007	Foreign body in mouth (disorder)	1	1	1
1155110000	55	11	Eye	Red eye	75705005	Red eye (disorder)	0	1	1
1155120000	55	12	Eye	Foreign body on eye	55899000	Foreign body on external eye (disorder)	1	1	1
1155210000	55	21	Eye	Pain in / around eye	41652007	Pain in eye (finding)	0	1	1
1155220000	55	22	Eye	Discharge from eye	246679005	Discharge from eye (finding)	0	1	1
1155320000	55	32	Eye	Visual disturbance	63102001	Visual disturbance (disorder)	0	1	1
1155330000	55	33	Eye	Photophobia	409668002	Photophobia (finding)	0	1	1
1155410000	55	41	Eye	Eye injury	282752000	Injury of eye region (disorder)	1	1	1
1155510000	55	51	Eye	Eye review	170720001	Follow-up ophthalmological assessment (regime / therapy)	0	1	1
1161110000	61	11	Trauma / musculoskeletal	Head injury	82271004	Injury of head (disorder)	1	1	1
1161130000	61	13	Trauma / musculoskeletal	Facial injury	125593007	Injury of face (disorder)	1	1	1
1161180000	61	18	Trauma / musculoskeletal	Injury of neck	90460009	Injury of neck (disorder)	1	1	1
1161210000	61	21	Trauma / musculoskeletal	Injury of shoulder / arm / elbow / wrist / hand	127278005	Injury of upper extremity (disorder)	1	1	1
1161310000	61	31	Trauma / musculoskeletal	Injury of hip / leg / knee / ankle / foot	127279002	Injury of lower extremity (disorder)	1	1	1
1161410000	61	41	Trauma / musculoskeletal	Injury of thorax	262525000	Chest injury (disorder)	1	1	1
1161450000	61	45	Trauma / musculoskeletal	Injury of abdomen	128069005	Injury of abdomen (disorder)	1	1	1
1161460000	61	46	Trauma / musculoskeletal	Injury of cervical region of back (disorder)	450724008	Injury of cervical region of back (disorder)	1	1	1
1161470000	61	47	Trauma / musculoskeletal	Injury of upper back	282765009	Upper back injury (disorder)	1	1	1
1161480000	61	48	Trauma / musculoskeletal	Injury of lower back	282766005	Lower back injury (disorder)	1	1	1
1161510000	61	51	Trauma / musculoskeletal	Backache (no recent injury)	161891005	Backache (finding)	0	1	1
1161530000	61	53	Trauma / musculoskeletal	Pain in shoulder / arm / elbow / wrist / hand	102556003	Pain in upper limb (finding)	0	1	1
1161610000	61	61	Trauma / musculoskeletal	Pain in hip / leg / knee / ankle / foot	10601006	Pain in lower limb (finding)	0	1	1
1161710000	61	71	Trauma / musculoskeletal	Joint swelling	271771009	Joint swelling (finding)	0	1	1
1161810000	61	81	Trauma / musculoskeletal	Major trauma (serious injury >1 body area)	417746004	Traumatic injury (disorder)	1	1	1
1161910000	61	91	Trauma / musculoskeletal	Traumatic amputation	262595009	Traumatic amputation (disorder)	1	1	1
1171110000	71	11	Genitourinary	Pain on passing urine	49650001	Dysuria (finding)	0	1	1
1171130000	71	13	Genitourinary	Frequent urination	28442001	Polyuria (finding)	0	1	1
1171140000	71	14	Genitourinary	Unable to pass urine	267064002	Retention of urine (disorder)	0	1	1
1171150000	71	15	Genitourinary	Low urine output	83128009	Oliguria (finding)	0	1	1
1171160000	71	16	Genitourinary	Blood in urine	34436003	Blood in urine (finding)	0	1	1
1171210000	71	21	Genitourinary	Flank pain	247355005	Flank pain (finding)	0	1	1
1171220000	71	22	Genitourinary	Pain in scrotum / testes	20502007	Pain in scrotum (finding)	0	1	0
1171410000	71	41	Genitourinary	Abnormal swelling groin area	281398003	Groin mass (finding)	0	1	1
1171610000	71	61	Genitourinary	Pain in genital area (generalised)	225565007	Perineal pain (finding)	0	1	1
1171620000	71	62	Genitourinary	Injury to genital area	6923002	Injury to perineum (disorder)	1	1	1
1171810000	71	81	Genitourinary	Problem related to penis	33958003	Disorder of penis (disorder)	0	1	0
1171910000	71	91	Genitourinary	States victim of sexual assault	56890008	Victim of sexual aggression (finding)	1	1	1
1175110000	75	11	ObGyn	Pregnancy related : less than 20 weeks	428566005	Gestation less than 20 weeks (finding)	0	0	1
1175210000	75	21	ObGyn	Pregnancy related : greater than 20 weeks	429715006	Gestation greater than 20 weeks (finding)	0	0	1
1175310000	75	31	ObGyn	Vaginal bleeding (abnormal)	289530006	Bleeding from vagina (finding)	0	0	1
1175510000	75	51	ObGyn	Foreign body in vagina	34124000	Foreign body in vagina (disorder)	1	0	1
1175610000	75	61	ObGyn	Problem related to vagina	25658005	Disorder of vagina (finding)	0	0	1
1175710000	75	71	ObGyn	Problem related to breast	79604008	Disorder of breast (finding)	0	0	1
1181110000	81	11	Environmental	Poisoning from any source	75478009	Poisoning (disorder)	1	1	1
1181310000	81	31	Environmental	Electrical exposure (inc. lightning)	371708003	Injury due to electrical exposure (disorder)	1	1	1
1181410000	81	41	Environmental	Hypothermia	386689009	Hypothermia (finding)	1	1	1
1181450000	81	45	Environmental	Frostbite	370977006	Frostbite (disorder)	1	1	1
1181610000	81	61	Environmental	Near drowning	87970004	Nonfatal submersion (disorder)	1	1	1
1181710000	81	71	Environmental	Exposure to communicable disease (inc. needlestick / body fluids)	417981005	Exposure to blood and / or body fluid (event)	1	1	1
1181810000	81	81	Environmental	Chemical exposure	371704001	Injury due to chemical exposure (disorder)	1	1	1
1181850000	81	85	Environmental	Noxious inhalation - gas / fumes / vapour / smoke	57335002	Toxic effect of gas, fumes AND/OR vapors (disorder)	1	1	1
1191110000	91	11	Psychosocial / Behaviour change	Drug / alcohol intoxication or withdrawal	66214007	Substance abuse (disorder)	0	1	1
1191310000	91	31	Psychosocial / Behaviour change	Self-harm	248062006	Self-injurious behavior (finding)	1	1	1
1191410000	91	41	Psychosocial / Behaviour change	Suicidal thoughts	267073005	Suicidal (finding)	0	1	1
1191510000	91	51	Psychosocial / Behaviour change	Depressive disorder	35489007	Depressive disorder (disorder)	0	1	1
1191610000	91	61	Psychosocial / Behaviour change	Anxiety disorder	48694002	Anxiety (finding)	0	1	1
1191810000	91	81	Psychosocial / Behaviour change	Behaviour : unusual	248020004	Bizarre behavior (finding)	0	1	1
1191820000	91	82	Psychosocial / Behaviour change	Behaviour : agitated / violent	248004009	Physical aggression (finding)	0	1	1
1191910000	91	91	Psychosocial / Behaviour change	Hallucinations / delusions	7011001	Hallucinations (finding)	0	1	1
1197110000	97	11	General / minor / admin	Fever	386661006	Fever (finding)	0	1	1
1197210000	97	21	General / minor / admin	Hyperglycaemia	80394007	Hyperglycemia (disorder)	0	1	1
1197250000	97	25	General / minor / admin	Hypoglycaemia	302866003	Hypoglycemia (disorder)	0	1	1
1197310000	97	31	General / minor / admin	Postoperative / wound care (no complication)	225358003	Wound care (regime/therapy)	0	1	1
1197350000	97	35	General / minor / admin	Postoperative / medical device with complication	385486001	Postoperative complication (disorder)	1	1	1
1197510000	97	51	General / minor / admin	Crying infant	162214009	Crying infant (finding)	0	1	1
1197610000	97	61	General / minor / admin	Generalised weakness	13791008	Asthenia (finding)	0	1	1
1197640000	97	64	General / minor / admin	Pale colour	398979000	Pale complexion (finding)	0	1	1
1197690000	97	69	General / minor / admin	Blue colour (cyanosis)	3415004	Cyanosis (finding)	0	1	1

1197810000	97	81	General / minor / admin	Social problem (medically well)	161152002	Social problem (finding)	0	1	1
1197850000	97	85	General / minor / admin	Direct referral to inpatient unit	78680009	Hospital admission, emergency, direct (procedure)	0	1	1
1197890000	97	89	General / minor / admin	Requesting prescription	182888003	Medication requested (situation)	0	1	1

DATA GROUP:INJURY CHARACTERISTICS

FUNCTION: To carry the details of injuries
Group Status: R
Group Repeats: 0..1

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	CQUIN DATA ITEM REQUIRED (Y/N)	DATA ITEM REPEATS	FORMAT	SNOMED CT / DM&D /ODS	JUSTIFICATION	ECDS CODE SET	LINK TO CURRENT CDS Type 010 INFORMATION ONLY	VALIDATION RULES		DATA ITEM PROVENANCE	NOTES
											POPULATION VALIDATION F - Format is validated V - Validated against an explicit list of permitted values as defined in the NHS Data Dictionary	POST SCHEMA VALIDATION		
INJURY CHARACTERISTICS	INJURY DATE	The date that the injury occurred.	M	N	1..1	an10 CCYY-MM-DD	DM&D	This data item is necessary to identify delay between injury occurrence and presentation. Delay from injury is important to know in two situations: • 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.	n/a	n/a	F	n/a	NEW' A&E data item	Injury data items should be captured when a Chief Complaint is recorded which has an injury flag.
INJURY CHARACTERISTICS	INJURY TIME	The time that the injury occurred.	M	N	1..1	an8 HH:MM:SS	DM&D	This data item is necessary to identify delay between injury occurrence and presentation. Delay from injury is important to know in two situations: • 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.	n/a	n/a	F	n/a	NEW' A&E data item	Injury data items should be captured when a Chief Complaint is recorded which has an injury flag.
INJURY CHARACTERISTICS	EMERGENCY CARE PLACE OF INJURY (SNOMED CT)	The type of location at which the person was present when the injury occurred.	R	N	0..1	min n6 max n18	SNOMED CT	To be able to understand the patterns of injury, and more importantly how to prevent them, it is necessary to be able to collect basic information regarding the type of place where the injury occurred. This information allows the data to be aggregated in a meaningful way so that analysis can pick up patterns of injury that occur in certain contexts e.g. assaults outside a particular pub on a particular day of the week.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as “Value for records X, field Y is not in the acceptable range”	NEW' A&E data item	Injury data items should be captured when a Chief Complaint is recorded which has an injury flag.
INJURY CHARACTERISTICS	EMERGENCY CARE PLACE OF INJURY (LATITUDE)	EMERGENCY CARE PLACE OF INJURY (LATITUDE) is the latitude of the EMERGENCY CARE PLACE OF INJURY (SNOMED CT), expressed in decimal degrees.	O	N	0..1	max n2.n6	DM&D	Exact longitude and latitude is the preferred method of coding injury place if extracted from an electronic system e.g. ambulance electronic patient record system or a kiosk system with an inbuilt map.	n/a	n/a	F	n/a	NEW' A&E data item	
INJURY CHARACTERISTICS	EMERGENCY CARE PLACE OF INJURY (LONGITUDE)	EMERGENCY CARE PLACE OF INJURY (LONGITUDE) is the longitude of the EMERGENCY CARE PLACE OF INJURY (SNOMED CT), expressed in decimal degrees.	O	N	0..1	max n3.n6	DM&D	Exact longitude and latitude is the preferred method of coding injury place if extracted from an electronic system e.g. ambulance electronic patient record system or a kiosk system with an inbuilt map.	n/a	n/a	F	n/a	NEW' A&E data item	
INJURY CHARACTERISTICS	EMERGENCY CARE INJURY INTENT (SNOMED CT)	The most likely **human** intent in the occurrence of the injury or poisoning as assessed by clinician.	R	N	0..1	min n6 max n18	SNOMED CT	Preventing preventable injury is of great benefit to individuals and society, and identifying the number and severity of assaults has been very difficult. Understanding injury intent underpins all injury prevention work, whether at a local or national level. An example of a targeted prevention strategy specifically focusing on one area of intent is the Information Sharing to Tackle Violence Information Standard (ISB 1594) which relies on assault related data (intent - apparent assault).	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as “Value for records X, field Y is not in the acceptable range”	NEW' A&E data item	Injury data items should be captured when a Chief Complaint is recorded which has an injury flag.
INJURY CHARACTERISTICS	EMERGENCY CARE INJURY ACTIVITY STATUS (SNOMED CT)	The status of activity being undertaken by the person at the moment the injury occurred.	R	N	0..1	min n6 max n18	SNOMED CT	Injury surveillance has resulted in major reductions in injury from road traffic collisions and workplace incidents. However the biggest rise in injury in the last ten years are injuries occurring in the home and during leisure and sport. The ageing population has meant that the pattern and severity of injuries occurring at home has become a significant health burden to the NHS. Better data will inform prevention of these injuries, and more granular activity data is essential for this process to understand the cause.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as “Value for records X, field Y is not in the acceptable range”	NEW' A&E data item	Injury data items should be captured when a Chief Complaint is recorded which has an injury flag.
INJURY CHARACTERISTICS	EMERGENCY CARE INJURY ACTIVITY TYPE (SNOMED CT)	The type of activity being undertaken by the person at the moment the injury occurred.	R	N	0..1	min n6 max n18	SNOMED CT	Injury surveillance has resulted in major reductions in injury from road traffic collisions and workplace incidents. However the biggest rise in injury in the last ten years are injuries occurring in the home and during leisure and sport. The ageing population has meant that the pattern and severity of injuries occurring at home has become a significant health burden to the NHS. Better data will inform prevention of these injuries, and more granular activity data is essential for this process to understand the cause. 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.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as “Value for records X, field Y is not in the acceptable range”	NEW' A&E data item	Injury data items should be captured when a Chief Complaint is recorded which has an injury flag.
INJURY CHARACTERISTICS	EMERGENCY CARE INJURY MECHANISM (SNOMED CT)	How the injury was caused.	R	N	0..1	min n6 max n18	SNOMED CT	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.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as “Value for records X, field Y is not in the acceptable range”	NEW' A&E data item	Injury data items should be captured when a Chief Complaint is recorded which has an injury flag.
INJURY CHARACTERISTICS	EMERGENCY CARE INJURY ALCOHOL OR DRUG INVOLVEMENT (SNOMED CT)	A record of any drugs or alcohol used by the patient, which are thought likely to have contributed to the need to attend the ED.	R	N	0..*	min n6 max n18	SNOMED CT	Drugs and alcohol are frequently implicated in the cause of injury and the ECDS proposes a structured way to capture this data.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as “Value for records X, field Y is not in the acceptable range”	NEW' A&E data item	Injury data items should be captured when a Chief Complaint is recorded which has an injury flag.

ECDS_UniqueID	Sort1	Sort2	ECDS_Group	ECDS_Description	SNOMED_Code	SNOMED_Description	Notes
2018111100	11	11	Home	Living room	1064991000000101	Place of occurrence of injury is living room in home environment (finding)	
2018111500	11	15	Home	Kitchen	1065001000000108	Place of occurrence of injury is kitchen in home environment (finding)	
2018112100	11	21	Home	Garage	1065011000000105	Place of occurrence of injury is garage in home environment (finding)	
2018112500	11	25	Home	Hallway	1065021000000104	Place of occurrence of injury is hallway in home environment (finding)	
2018113100	11	31	Home	Stairway	1065031000000102	Place of occurrence of injury is stairway in home environment (finding)	
2018113500	11	35	Home	Bathroom	1065041000000106	Place of occurrence of injury is bathroom in home environment (finding)	
2018114100	11	41	Home	Bedroom	1065051000000109	Place of occurrence of injury is bedroom in home environment (finding)	
2018114500	11	45	Home	Utility room	1065061000000107	Place of occurrence of injury is utility room in home environment (finding)	
2018115100	11	51	Home	Study	1065071000000100	Place of occurrence of injury is study in home environment (finding)	
2018115500	11	55	Home	Dining room	1065081000000103	Place of occurrence of injury is dining room in home environment (finding)	
2018116100	11	61	Home	Home gym	1065091000000101	Place of occurrence of injury is gym in home environment (finding)	
2018116500	11	65	Home	Conservatory	1065101000000109	Place of occurrence of injury is conservatory in home environment (finding)	
2018117500	11	75	Home	Garden	1065411000000104	Place of occurrence of injury is garden in home environment (finding)	
2018118500	11	85	Home	Outbuilding / shed	1065121000000100	Place of occurrence of injury is outbuilding in home environment (finding)	
2018119100	11	91	Home	Swimming pool	1065111000000106	Place of occurrence of injury is swimming pool in home environment (finding)	
2018119200	11	92	Home	Pond	1065131000000103	Place of occurrence of injury is garden pond in home environment (finding)	
2018211100	21	11	Indoor	Educational establishment	244211000000103	Place of occurrence of injury is educational establishment (finding)	
2018212100	21	21	Indoor	Retail service area e.g. shop	981021000000108	Place of occurrence of injury is trade or service environment (finding)	
2018212500	21	25	Indoor	Licensed premises e.g. bar cafe club	980911000000107	Place of occurrence of injury is licensed premises (finding)	
2018216100	21	61	Indoor	Public building	244281000000105	Place of occurrence of injury is public building environment (finding)	
2018217100	21	71	Indoor	Sports facility	244301000000106	Place of occurrence of injury is sports facility (finding)	
2018218100	21	81	Indoor	Workplace	244321000000102	Place of occurrence of injury is workplace environment (finding)	
2018218900	21	89	Indoor	Medical / clinical area	244251000000104	Place of occurrence of injury is hospital environment (finding)	
2018411100	41	11	Outdoor	Road / pavement	244231000000106	Place of occurrence of injury is highway environment (finding)	
2018412100	41	21	Outdoor	Recreational area	979981000000100	Place of occurrence of injury is recreational area (finding)	
2018413100	41	31	Outdoor	Countryside	979971000000102	Place of occurrence of injury is countryside environment (finding)	
2018414100	41	41	Outdoor	Farm	979961000000109	Place of occurrence of injury is farm environment (finding)	
2018414500	41	45	Outdoor	Construction area	244201000000100	Place of occurrence of injury is construction area (finding)	
2018419100	41	91	Outdoor	Water / waterside	980891000000109	Place of occurrence of injury is water or waterside environment (finding)	

ECDS_UniqueID	Sort1	ECDS_Group	ECDS_Description	SNOMED_Code	SNOMED_Description	Notes
2018110000	11	n/a	Non-intentional injury	242056005	Accidental injury (disorder)	
2018210000	21	n/a	Self inflicted injury	276853009	Self inflicted injury (disorder)	
2018310000	31	n/a	Apparent assault	298231000000106	Alleged victim of physical assault (situation)	
2018410000	41	n/a	Complication of medical care	35688006	Complication of medical care (disorder)	
2018510000	51	n/a	Injury caused by animal	242651001	Injury caused by animal (disorder)	
2018610000	61	n/a	Injury due to legal intervention	219256006	Injury due to legal intervention (disorder)	
2018710000	71	n/a	Undetermined / no information available	269735005	Injury undetermined whether accidentally or purposely inflicted (disorder)	

ECDS_UniqueID	Sort1	ECDS_Group	ECDS_Description	SNOMED_Code	SNOMED_Description	Notes
2018211100	21	n/a	Activity of daily living	129025006	Activity of daily living (observable entity)	
2018411100	41	n/a	Unpaid work	276061003	Unpaid work (finding)	
2018511100	51	n/a	Being educated	301466009	Education and training activity (observable entity)	
2018311100	31	n/a	Paid work	406156006	In paid employment (finding)	
2018111100	11	n/a	Leisure	4751000	Leisure physical activity (observable entity)	

ECDS_UniqueID	Sort1	Sort2	ECDS_Group	ECDS_Description	SNOMED_Code	SNOMED_Description	Notes
1111210000	11	21	Leisure at home	Indoor recreation	1068401000000109	Injury whilst engaged in indoor recreational activity (disorder)	
1111250000	11	25	Leisure at home	Using electronic device - TV / game / computer	1068291000000103	Injury whilst using electronic audiovisual device (disorder)	
1111410000	11	41	Leisure at home	Ascending stairs	1068301000000104	Injury whilst ascending stairs (disorder)	
1111420000	11	42	Leisure at home	Descending stairs	1068311000000102	Injury whilst descending stairs (disorder)	
1111450000	11	45	Leisure at home	Walking indoors	1068321000000108	Injury whilst walking indoors (disorder)	
1112110000	12	11	Essential activities	Food preparation (inc. as work)	1068341000000101	Injury whilst preparing food (disorder)	
1112210000	12	21	Essential activities	Food consumption	1068351000000103	Injury whilst consuming food (disorder)	
1112410000	12	41	Essential activities	In bedroom / sleeping	1068421000000100	Injury whilst sleeping (disorder)	
1112610000	12	61	Essential activities	Bathing	1068371000000107	Injury whilst bathing (disorder)	
1112620000	12	62	Essential activities	Showering	1068381000000109	Injury whilst showering (disorder)	
1112650000	12	65	Essential activities	Using toilet facility	1068791000000107	Injury whilst using toilet facility (disorder)	
1112710000	12	71	Essential activities	Being nursed / cared for	1068361000000100	Injury whilst receiving healthcare (disorder)	
1113610000	13	61	Leisure	DIY / maintenance	1068411000000106	Injury whilst undertaking home maintenance (disorder)	
1113710000	13	71	Leisure	Gardening	1068391000000106	Injury whilst gardening (disorder)	
1113810000	13	81	Leisure	Crafts	1068001000000102	injury whilst engaged in crafting (disorder)	
1113850000	13	85	Leisure	Hobbies	1068061000000103	Injury whilst engaged in hobby (disorder)	
1115110000	15	11	Leisure outside home	Social : restaurant / cafe / pub / club	1068281000000100	Injury whilst engaged in social activity outside the home (disorder)	
1115210000	15	21	Leisure outside home	Social : play / recreation	1068271000000102	Injury whilst engaged in outdoor recreational activity (disorder)	
1115310000	15	31	Leisure outside home	Entertainment : cinema	1068031000000108	Injury whilst attending cinema (disorder)	
1115320000	15	32	Leisure outside home	Entertainment : theatre	1068051000000101	Injury whilst attending theatre (disorder)	
1115350000	15	35	Leisure outside home	Entertainment : music	1068041000000104	Injury whilst attending music venue (disorder)	
1115810000	15	81	Leisure outside home	Fishing	1068811000000108	Injury whilst fishing (disorder)	
1115850000	15	85	Leisure outside home	Hunting	1068801000000106	Injury whilst hunting (disorder)	
1121110000	21	11	Transport	Walking outdoors	1068331000000105	Injury whilst walking outdoors (disorder)	
1121150000	21	15	Transport	Pedestrian crossing road	1068651000000108	Injury whilst walking across road (disorder)	
1121210000	21	21	Transport	Cyclist on road / public highway	1068431000000103	Injury whilst cycling on public highway (disorder)	
1121310000	21	31	Transport	Motorcycle rider	1068681000000102	Injury due to activity involving motorcycle riding (disorder)	
1121320000	21	32	Transport	Motorcycle passenger	1068731000000106	Injury whilst motorcycle passenger (disorder)	
1121410000	21	41	Transport	Motor vehicle driver	1068741000000102	Injury whilst driving motor vehicle on public highway (disorder)	
1121420000	21	42	Transport	Motor vehicle passenger (not public transport)	1068751000000104	Injury whilst motor vehicle passenger (disorder)	
1121610000	21	61	Transport	Passenger (public transport)	1068781000000105	Injury whilst passenger on public transport (disorder)	
1121710000	21	71	Transport	Electric personal mobility device	1076901000000105	Injury whilst using electronic personal transport (disorder)	
1141110000	41	11	Work	Manual / unskilled / labour	1068591000000101	Injury whilst undertaking manual work (disorder)	
1141150000	41	15	Work	Trade / retail	1068621000000103	Injury whilst engaged in retail work (disorder)	
1141210000	41	21	Work	Administration / clerical / professional	1068581000000103	Injury whilst engaged in administrative work (disorder)	
1141310000	41	31	Work	Healthcare / caring	1068531000000102	Injury whilst delivering healthcare (disorder)	
1141350000	41	35	Work	Teaching	1068641000000105	Injury whilst teaching (disorder)	
1141410000	41	41	Work	Entertainment / creative	1068661000000106	Injury whilst engaged in entertainment work (disorder)	
1141450000	41	45	Work	Security work	1068631000000101	Injury whilst engaged in security work (disorder)	
1141550000	41	55	Work	Factory work	1068551000000109	Injury whilst working in factory (disorder)	
1141610000	41	61	Work	Environmental	1068611000000109	Injury whilst engaged in environmental work (disorder)	
1141650000	41	65	Work	Engineering / technology	1068601000000107	Injury whilst engaged in engineering work (disorder)	
1141670000	41	67	Work	Science / research	1068671000000104	Injury whilst engaged in scientific work (disorder)	
1141710000	41	71	Work	Construction / maintenance	1068571000000100	Injury whilst engaged in construction work (disorder)	
1141750000	41	75	Work	Farming	1068541000000106	Injury whilst working on farm (disorder)	
1141770000	41	77	Work	Mining	1068561000000107	Injury whilst working in mine (disorder)	
1161110000	61	11	Sports : team : ball	Football (soccer)	1067311000000103	Injury whilst playing football (disorder)	
1161210000	61	21	Sports : team : ball	Rugby union	1067331000000106	Injury whilst playing rugby union (disorder)	
1161220000	61	22	Sports : team : ball	Rugby league	1067321000000109	Injury whilst playing rugby league (disorder)	
1161310000	61	31	Sports : team : ball	Australian rules football	1067591000000102	Injury whilst playing Australian rules football (disorder)	
1161320000	61	32	Sports : team : ball	Gaelic football	1067581000000104	Injury whilst playing Gaelic football (disorder)	
1161350000	61	35	Sports : team : ball	American football	1067391000000107	Injury whilst playing American football (disorder)	

1161410000	61	41	Sports : team : ball	Basketball	1067341000000102	Injury whilst playing basketball (disorder)
1161430000	61	43	Sports : team : ball	Netball	1067351000000104	Injury whilst playing netball (disorder)
1161450000	61	45	Sports : team : ball	Volleyball	1067371000000108	Injury whilst playing volleyball (disorder)
1161470000	61	47	Sports : team : ball	Korfball	1067381000000105	Injury whilst playing korfball (disorder)
1161910000	61	91	Sports : team : ball	Handball	1067361000000101	Injury whilst playing handball (disorder)
1163110000	63	11	Sports : team : bat / stick	Hockey	1067401000000105	Injury whilst playing hockey (disorder)
1163210000	63	21	Sports : team : bat / stick	Cricket	1067421000000101	Injury whilst playing cricket (disorder)
1163310000	63	31	Sports : team : bat / stick	Baseball	1067431000000104	Injury whilst playing baseball (disorder)
1163350000	63	35	Sports : team : bat / stick	Softball	1067441000000108	Injury whilst playing softball (disorder)
1163410000	63	41	Sports : team : bat / stick	Lacrosse	1067411000000107	Injury whilst playing lacrosse (disorder)
1163450000	63	45	Sports : team : bat / stick	Hurling	1068011000000100	Injury whilst playing hurling (disorder)
1169110000	69	11	Sports : racquet	Tennis	1067451000000106	Injury whilst playing tennis (disorder)
1169210000	69	21	Sports : racquet	Squash	1067461000000109	Injury whilst playing squash (disorder)
1169310000	69	31	Sports : racquet	Badminton	1067471000000102	Injury whilst playing badminton (disorder)
1169410000	69	41	Sports : racquet	Table tennis	1067481000000100	Injury whilst playing table tennis (disorder)
1169510000	69	51	Sports : racquet	Real tennis	1068021000000106	Injury whilst playing real tennis (disorder)
1170110000	70	11	Sports : target / precision	Golf	1067491000000103	Injury whilst playing golf (disorder)
1170210000	70	21	Sports : target / precision	Pool	1067501000000109	Injury whilst playing pool (disorder)
1170220000	70	22	Sports : target / precision	Snooker	1067511000000106	Injury whilst playing snooker (disorder)
1170310000	70	31	Sports : target / precision	Darts	1067521000000100	Injury whilst playing darts (disorder)
1170410000	70	41	Sports : target / precision	Croquet / roque	1067531000000103	Injury whilst playing croquet (disorder)
1170450000	70	45	Sports : target / precision	Bowls	1067541000000107	Injury whilst playing bowls (disorder)
1170470000	70	47	Sports : target / precision	Ten pin bowling	1067551000000105	Injury whilst playing ten-pin bowling (disorder)
1170710000	70	71	Sports : target / precision	Archery	1068071000000105	Injury whilst engaged in archery (disorder)
1170730000	70	73	Sports : target / precision	Boules	1068261000000109	Injury whilst playing boules (disorder)
1170750000	70	75	Sports : target / precision	Clay pigeon shooting	1067561000000108	Injury whilst clay-pigeon shooting (disorder)
1170770000	70	77	Sports : target / precision	Target shooting	1067571000000101	Injury whilst target shooting (disorder)
1173110000	73	11	Sports : athletics	Jogging	1068091000000109	Injury whilst jogging (disorder)
1173210000	73	21	Sports : athletics	Running	1068081000000107	Injury whilst running (disorder)
1173310000	73	31	Sports : athletics	Fell / mountain running	1067611000000105	Injury whilst fell running (disorder)
1173410000	73	41	Sports : athletics	Power-walking / race-walking	1068101000000101	Injury whilst power-walking (disorder)
1173510000	73	51	Sports : athletics	Jumping sports	1068111000000104	Injury whilst engaged in jumping sports activity (disorder)
1173610000	73	61	Sports : athletics	Throwing sports	1068121000000105	Injury whilst engaged in throwing sports activity (disorder)
1175110000	75	11	Sports : gym / acrobatic / aesthetic	Trampoline	1068131000000107	Injury whilst trampolining (disorder)
1175210000	75	21	Sports : gym / acrobatic / aesthetic	Gymnastics	1067621000000104	Injury whilst engaged in gymnastics (disorder)
1175230000	75	23	Sports : gym / acrobatic / aesthetic	Gym : aerobics	1067631000000102	Injury during aerobic exercise (disorder)
1175250000	75	25	Sports : gym / acrobatic / aesthetic	Gym : circuit training	1067641000000106	Injury whilst circuit training (disorder)
1175270000	75	27	Sports : gym / acrobatic / aesthetic	Yoga	1068491000000102	Injury whilst engaged in yoga (disorder)
1175280000	75	28	Sports : gym / acrobatic / aesthetic	Tai chi	1068511000000105	Injury whilst engaged in tai chi (disorder)
1175290000	75	29	Sports : gym / acrobatic / aesthetic	Pilates	1068501000000108	Injury whilst engaged in pilates (disorder)
1175410000	75	41	Sports : gym / acrobatic / aesthetic	Cheerleading	1068821000000102	Injury whilst cheerleading (disorder)
1175450000	75	45	Sports : gym / acrobatic / aesthetic	Dancing	1068471000000101	Injury whilst dancing (disorder)
1175610000	75	61	Sports : gym / acrobatic / aesthetic	Indoor gym equipment	1067651000000109	Injury whilst using gym equipment (disorder)
1175650000	75	65	Sports : gym / acrobatic / aesthetic	Weightlifting / body building	1067661000000107	Injury whilst weightlifting (disorder)
1177110000	77	11	Sports : combat	Judo	1068151000000100	Injury whilst engaged in judo (disorder)
1177150000	77	15	Sports : combat	Taekwondo	1068161000000102	Injury whilst engaged in Taekwondo (disorder)
1177210000	77	21	Sports : combat	Martial arts	1068171000000109	Injury whilst engaged in martial arts activity (disorder)
1177410000	77	41	Sports : combat	Boxing	1067671000000100	Injury whilst boxing (disorder)
1177450000	77	45	Sports : combat	Kick-boxing	1067681000000103	Injury whilst kickboxing (disorder)
1177510000	77	51	Sports : combat	Wrestling	1067691000000101	Injury whilst wrestling (disorder)
1177610000	77	61	Sports : combat	Fencing	1068141000000103	Injury whilst sport fencing (disorder)
1179110000	79	11	Sports : wheeled	Cycling : track	1068451000000105	Injury whilst cycling on track (disorder)
1179210000	79	21	Sports : wheeled	Cycling : mountain biking	1068461000000108	Injury whilst mountain biking (disorder)

1179310000	79	31	Sports : wheeled	Cycling : BMX	1068481000000104	Injury whilst bicycle motocross biking (disorder)
1179410000	79	41	Sports : wheeled	Skateboarding	1067721000000105	Injury whilst skateboarding (disorder)
1179510000	79	51	Sports : wheeled	Rollerskates	1067711000000104	Injury whilst roller skating (disorder)
1179520000	79	52	Sports : wheeled	Rollerblades	1067701000000101	Injury whilst rollerblading (disorder)
1181210000	81	21	Sports : wheeled : powered	Off road motorcycle	1068711000000103	Injury whilst riding motorcycle off-road (disorder)
1181250000	81	25	Sports : wheeled : powered	Off road quad bike	1068251000000106	Injury whilst off-road quad biking (disorder)
1181710000	81	71	Sports : wheeled : powered	Off-road car / buggy	1068761000000101	Injury whilst driving motor vehicle off-road (disorder)
1181810000	81	81	Sports : wheeled : powered	car / motor vehicle on track	1068771000000108	Injury whilst driving motor vehicle on track (disorder)
1181850000	81	85	Sports : wheeled : powered	Motorcycle on track	1068701000000100	Injury whilst riding motorcycle on track (disorder)
1186110000	86	11	Sports : swimming	Swimming	1067731000000107	Injury whilst swimming (disorder)
1186210000	86	21	Sports : swimming	Water polo	1067741000000103	Injury whilst playing water polo (disorder)
1186310000	86	31	Sports : swimming	Synchronised swimming	1068181000000106	Injury whilst synchronised swimming (disorder)
1186410000	86	41	Sports : swimming	Diving	1067751000000100	Injury whilst diving (disorder)
1186510000	86	51	Sports : swimming	SCUBA diving	1067761000000102	Injury whilst scuba diving (disorder)
1187110000	87	11	Sports : water-based	Rowing	1067771000000109	Injury whilst rowing boat (disorder)
1187210000	87	21	Sports : water-based	Canoeing	1067781000000106	Injury whilst canoeing (disorder)
1187310000	87	31	Sports : water-based	Sailing	1067791000000108	Injury whilst sailing (disorder)
1187410000	87	41	Sports : water-based	Windsurfing	1067811000000109	Injury whilst windsurfing (disorder)
1187450000	87	45	Sports : water-based	Surfing	1067801000000107	Injury whilst surfing (disorder)
1187510000	87	51	Sports : water-based	Kite surfing	1068191000000108	Injury whilst kite surfing (disorder)
1187710000	87	71	Sports : water-based	Powered boat	1068231000000104	Injury whilst power-boating (disorder)
1187730000	87	73	Sports : water-based	Water-skiing	1067821000000103	Injury whilst waterskiing (disorder)
1187770000	87	77	Sports : water-based	Towed behind power boat	1068241000000108	Injury whilst being towed by powerboat (disorder)
1187910000	87	91	Sports : water-based	Personal motorised watercraft	1068221000000101	Injury whilst using personal motorised watercraft (disorder)
1191110000	91	11	Sports : winter	Ice-skating	1067831000000101	Injury whilst ice skating (disorder)
1191210000	91	21	Sports : winter	Ice hockey	1067841000000105	Injury whilst playing ice hockey (disorder)
1191310000	91	31	Sports : winter	Skiing : downhill	1067851000000108	Injury whilst downhill skiing (disorder)
1191350000	91	35	Sports : winter	Skiing : cross country	1067861000000106	Injury whilst cross-country skiing (disorder)
1191410000	91	41	Sports : winter	Snowboarding	1067871000000104	Injury whilst snowboarding (disorder)
1191510000	91	51	Sports : winter	Snow walking	1067881000000102	Injury whilst snow walking (disorder)
1191610000	91	61	Sports : winter	Motorised snow vehicle	1068201000000105	Injury whilst using motorised snow vehicle (disorder)
1191710000	91	71	Sports : winter	Curling	1068211000000107	injury whilst sport curling (disorder)
1193110000	93	11	Sports : equestrian / adventure	Horse riding	1067991000000106	Injury whilst horse riding (disorder)
1193510000	93	51	Sports : equestrian / adventure	Hiking / hill-walking	1067981000000109	Injury whilst hill walking (disorder)
1193610000	93	61	Sports : equestrian / adventure	Climbing / mountaineering	1067961000000100	Injury whilst rock climbing (disorder)
1193710000	93	71	Sports : equestrian / adventure	Caving / pot-holing	1067891000000100	Injury whilst caving (disorder)
1195110000	95	11	Sports : aero	Gliding	1067921000000108	Injury whilst glider flying (disorder)
1195210000	95	21	Sports : aero	Hang-gliding	1067911000000102	Injury whilst hang gliding (disorder)
1195310000	95	31	Sports : aero	Parachuting	1067931000000105	Injury whilst parachute jumping (disorder)
1195350000	95	35	Sports : aero	BASE jumping	1067941000000101	Injury whilst base-jumping (disorder)
1195410000	95	41	Sports : aero	Paragliding	1067951000000103	Injury whilst paragliding (disorder)

ECDS_UniqueID	Sort1	Sort2	ECDS_Group	ECDS_Description	SNOMED_Code	SNOMED Description
1111110000	11	11	Fall	Slipping	54670004	Slipping (event)
1111120000	11	12	Fall	Tripping	75941004	Tripping (event)
1111410000	11	41	Fall	Fall from height of less than one metre	240871000000104	Fall through height of less than one meter (event)
1111510000	11	51	Fall	Fall from height of more than one metre	429482004	Fall from high place (event)
1121110000	21	11	Blunt injury	Blunt force / pushed	425359009	Blunt injury (disorder)
1121210000	21	21	Blunt injury	Punch with fist	242890000	Punch with fist (event)
1121220000	21	22	Blunt injury	Kick with foot	242892008	Kick with foot (event)
1121230000	21	23	Blunt injury	Hit with head (head butt)	242895005	Head butt (event)
1121410000	21	41	Blunt injury	Blow from blunt object [specify]	219236005	Assault by striking with blunt object (event)
1121710000	21	71	Blunt injury	Crushing injury	125665001	Crushing injury (disorder)
1131110000	31	11	Sharp injury	Stabbed / cut with knife	425322008	Stab wound (disorder)
1131210000	31	21	Sharp injury	Stabbed / cut with glass / bottle	426058000	Penetrating injury by glass (disorder)
1131310000	31	31	Sharp injury	Stabbed / cut with other sharp object [specify]	425999002	Penetrating injury by sharp object (disorder)
1141110000	41	11	Firearm / explosion	Gunshot wound	283545005	Gunshot wound (disorder)
1141210000	41	21	Firearm / explosion	Injury due to projectile	242999003	Injury due to projectile (disorder)
1141510000	41	51	Firearm / explosion	Injury due to firework	241924003	Firework causing toxic effect (disorder)
1141610000	41	61	Firearm / explosion	Injury due to explosion	397996002	Injury due to explosion (disorder)
1151110000	51	11	Threat to breathing	Respiratory obstruction due to inhaled foreign body	242669005	Respiratory obstruction due to inhaled foreign body (event)
1151210000	51	21	Threat to breathing	Patient found hanging	241121000000102	Patient found hanging (finding)
1151310000	51	31	Threat to breathing	Asphyxia by obstruction of mouth and nose	242020007	Asphyxia by obstruction of mouth and nose (event)
1151410000	51	41	Threat to breathing	Asphyxiation : other	66466001	Asphyxiation (event)
1161110000	61	11	Environment	Poisoning / overdose	75478009	Poisoning (disorder)
1161510000	61	51	Environment	Burn : thermal	314534006	Thermal burn (disorder)
1161530000	61	53	Environment	Burn : chemical	371704001	Injury due to chemical exposure (disorder)
1161550000	61	55	Environment	Burn : electrical	371708003	Injury caused by electrical exposure (disorder)
1161570000	61	57	Environment	Burn : radiation	24803000	Injury caused by exposure to ionizing radiation (disorder)
1161590000	61	59	Environment	Burn : ultraviolet / sunlight	402165001	Acute effect of ultraviolet radiation on normal skin (disorder)
1161710000	61	71	Environment	Hyperthermia	409702008	Hyperpyrexia (finding)
1161750000	61	75	Environment	Hypothermia	386689009	Hypothermia (finding)
1161810000	61	81	Environment	Physical exertion	64113006	Exhaustion due to excessive exertion (finding)
1161910000	61	91	Environment	Near drowning	87970004	Nonfatal submersion (disorder)
1161920000	61	92	Environment	Diving barotrauma	241977008	Diving barotrauma (disorder)
1171110000	71	11	Animal related	Injury from dog	283734005	Dog bite - wound (disorder)
1171210000	71	21	Animal related	Injury from cat	283782004	Cat bite - wound (disorder)
1171310000	71	31	Animal related	Injury from horse	283784003	Horse bite wound (disorder)
1171490000	71	49	Animal related	Injury from mammal - other [specify]	283683002	Mammal bite wound (disorder)
1171510000	71	51	Animal related	Injury from reptile (e.g. snake)	283838000	Reptile bite wound (disorder)
1171550000	71	55	Animal related	Injury from bird	217716004	Peck by bird (event)
1171610000	71	61	Animal related	Injury from spider	403149008	Injury from arachnid (spider)
1171710000	71	71	Animal related	Injury from insect	276433004	Insect bite - wound (disorder)
1171810000	71	81	Animal related	Injury from aquatic animal	283837005	Fish bite wound (disorder)
1191110000	91	11	Not applicable	Patient refuses to disclose	1077171000000102	Declines to provide information on cause of injury (finding)
1191510000	91	51	Not applicable	Patient cannot disclose e.g. coma, intubated	1077161000000109	Unable to provide information on cause of injury (finding)

ECDS_UniqueID	Sort1	Sort2	ECDS_Group	ECDS_Description	SNOMED_Code	SNOMED_Description	Notes
2018111100	11	11	Alcohol	Alcohol : retail beer / wine / spirits	984801000000105	Injury following alcohol use (disorder)	
2018117100	11	71	Alcohol	Alcohol : not sold for consumption e.g. meths, antifreeze	1066421000000104	Injury following industrial alcohol use (disorder)	
2018211100	21	11	Cannabis	Cannabis	984851000000106	Injury following cannabis use (disorder)	
2018311100	31	11	Opiate	Heroin	984831000000104	Injury following heroin use (disorder)	
2018312100	31	21	Opiate	Morphine	1065191000000102	Injury following morphine use (disorder)	
2018313100	31	31	Opiate	Codeine	1065201000000100	Injury following codeine use (disorder)	
2018313300	31	33	Opiate	Dihydrocodeine	1065211000000103	Injury following dihydrocodeine use (disorder)	
2018313500	31	35	Opiate	Oxycodone	1065221000000109	Injury following oxycodone use (disorder)	
2018314100	31	41	Opiate	Methadone	1066091000000108	Injury following methadone use (disorder)	
2018319100	31	91	Opiate	Other opiate drug	984951000000101	Injury following opiate use (disorder)	
2018411100	41	11	Club drug	Ecstasy (MDMA)	984871000000102	Injury following ecstasy use (disorder)	
2018412100	41	21	Club drug	Mephedrone (MKAT)	1035751000000103	Injury following mephedrone use (disorder)	
2018413100	41	31	Club drug	GHB (gamma hydroxybutyrate)	984881000000100	Injury following gamma hydroxybutyrate use (disorder)	
2018413200	41	32	Club drug	GBL (gamma butyrolactone)	984891000000103	Injury following gamma butyrolactone use (disorder)	
2018414100	41	41	Club drug	Synthetic cannabinoid e.g. Spice	1065241000000102	Injury following synthetic cannabinoid use (disorder)	
2018417100	41	71	Club drug	Ketamine	1065231000000106	Injury following ketamine use (disorder)	
2018511100	51	11	CNS Stimulant	Cocaine	984841000000108	Injury following cocaine use (disorder)	
2018513100	51	31	CNS Stimulant	Crack cocaine	984901000000102	Injury following crack cocaine use (disorder)	
2018515100	51	51	CNS Stimulant	Amphetamine	984861000000109	Injury following amphetamine use (disorder)	
2018515500	51	55	CNS Stimulant	Crystal meth	984911000000100	Injury following crystal methamphetamine use (disorder)	
2018519100	51	91	CNS Stimulant	Other CNS stimulant	1066071000000109	Injury following central nervous system stimulant use (disorder)	
2018611100	61	11	CNS Depressant	Benzodiazepine	984941000000104	Injury following benzodiazepine use (disorder)	
2018615100	61	51	CNS Depressant	Barbiturate	1065251000000104	Injury following barbiturate use (disorder)	
2018619100	61	91	CNS Depressant	Other CNS depressant / sleep-inducing drugs	1066081000000106	Injury following central nervous system depressant use (disorder)	
2018711100	71	11	Hallucinogen	LSD	1065271000000108	Injury following lysergic acid diethylamide use (disorder)	
2018713100	71	31	Hallucinogen	Organic e.g. magic mushrooms	1065321000000102	Injury following organic hallucinogen use (disorder)	
2018715100	71	51	Hallucinogen	PCP angel dust	1065311000000108	Injury following phencyclidine use (disorder)	
2018811100	81	11	Inhalant	Solvent	1065291000000107	Injury following solvent inhalation (disorder)	
2018811500	81	15	Inhalant	Aerosol	1065301000000106	Injury following aerosol inhalation (disorder)	
2018815100	81	51	Inhalant	Nitrous oxide	1065281000000105	Injury following nitrous oxide inhalation (disorder)	
2018911100	91	11	Unknown drug	Unknown drug	984921000000106	Injury following unknown drug use (disorder)	

DATA GROUP: PATIENT CLINICAL HISTORY

FUNCTION: To carry the patient clinical history details
Group Status: R
Group Repeats: 0..1

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	CQUIN DATA ITEM REQUIRED (Y/N)	DATA ITEM REPEATS	FORMAT	SNOMED CT / DM&D /ODS	JUSTIFICATION	ECDS CODE SET	LINK TO CURRENT CDS Type 010 INFORMATION ONLY	VALIDATION RULES		DATA ITEM PROVENANCE	NOTES
											POPULATION VALIDATION F - Format is validated V - Validated against an explicit list of permitted values as defined in the NHS Data Dictionary	POST SCHEMA VALIDATION		
PATIENT CLINICAL HSITORY	COMORBIDITY (SNOMED CT)	A record of whether a person has any of the NHS list of medical co-morbidities.	R	N	0..*	min n6 max n18	SNOMED CT	Co-morbidities are a key determinant in patient care e.g. whether it is safe to treat a patient in the community or whether a patient should be admitted to hospital e.g. for pneumonia, cellulitis. An accurate list of co-morbidities and current medications are therefore essential pieces of knowledge in the effort to minimise inpatient admissions and risk to patients – ensuring the right treatment in the right place. Flowing this data nationally allows a better understanding of the factors that predict complexity of emergency care which in turn allows accurate commissioning of services to meet the needs of patients in the best and most effective way e.g. if there are many attendances for patients with diabetes-related complaints, would a community nurse be an effective intervention to 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.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	It is anticipated that data item will be populated automatically from the patient's local electronic health record or in from a local or national care record system such as SCR. Data entry will **not** be performed by ED staff.

ECDS_UniqueID	Sort1	Sort2	ECDS_Group	ECDS_Description	SNOMED_Code	SNOMED_Description	Notes
2018111100	11	11	Circulation / blood	Hypertension	38341003	Hypertensive disorder, systemic arterial (disorder)	
2018111500	11	15	Circulation / blood	History of anticoagulant therapy	161647008	History of anticoagulant therapy (situation)	
2018112100	11	21	Circulation / blood	Ischaemic heart disease	414545008	Ischemic heart disease (disorder)	
2018113100	11	31	Circulation / blood	Cardiac pacemaker in situ	441509002	Cardiac pacemaker in situ (finding)	
2018114300	11	43	Circulation / blood	Congestive heart failure	42343007	Congestive heart failure (disorder)	
2018114500	11	45	Circulation / blood	Left heart failure	85232009	Left heart failure (disorder)	
2018114900	11	49	Circulation / blood	Heart failure	84114007	Heart failure (disorder)	
2018115100	11	51	Circulation / blood	Mitral valve disorder	11851006	Mitral valve disorder (disorder)	
2018118100	11	81	Circulation / blood	Congenital cardiac failure	206586007	Congenital cardiac failure (disorder)	
2018211100	21	11	Respiratory	Asthma	195967001	Asthma (disorder)	
2018212100	21	21	Respiratory	Chronic obstructive lung disease	13645005	Chronic obstructive lung disease (disorder)	
2018212300	21	23	Respiratory	Chronic bronchitis	63480004	Chronic bronchitis (disorder)	
2018214100	21	41	Respiratory	Pulmonary emphysema	87433001	Pulmonary emphysema (disorder)	
2018215100	21	51	Respiratory	Respiratory failure	409622000	Respiratory failure (disorder)	
2018311100	31	11	Gastrointestinal	Dysphagia	40739000	Dysphagia (disorder)	
2018312100	31	21	Gastrointestinal	Jaundice	18165001	Jaundice (finding)	
2018312500	31	25	Gastrointestinal	Liver function tests abnormal	166603001	Liver function tests abnormal (finding)	
2018511100	51	11	Endocrine / Rheumatology	Diabetes mellitus	73211009	Diabetes mellitus (disorder)	
2018515100	51	51	Endocrine / Rheumatology	Rheumatoid arthritis	69896004	Rheumatoid arthritis (disorder)	
2018551100	55	11	Renal / urology	Retention of urine	267064002	Retention of urine (disorder)	
2018552100	55	21	Renal / urology	Renal impairment	236423003	Renal impairment (disorder)	
2018553100	55	31	Renal / urology	Chronic kidney disease	709044004	Chronic kidney disease (disorder)	
2018555100	55	51	Renal / urology	Chronic interstitial nephritis	60926001	Chronic interstitial nephritis (disorder)	
2018555500	55	55	Renal / urology	Small kidney	236448000	Small kidney (disorder)	
2018556100	55	61	Renal / urology	Multiple renal cysts	253883006	Multiple renal cysts (disorder)	
2018556300	55	63	Renal / urology	Congenital cystic kidney disease	82525005	Congenital cystic kidney disease (disorder)	
2018556500	55	65	Renal / urology	Polycystic kidney disease, adult type	28728008	Polycystic kidney disease, adult type (disorder)	
2018611100	61	11	Neurology	Epilepsy	84757009	Epilepsy (disorder)	
2018612100	61	21	Neurology	Multiple sclerosis	24700007	Multiple sclerosis (disorder)	
2018613100	61	31	Neurology	Cerebral infarction	432504007	Cerebral infarction (disorder)	
2018613300	61	33	Neurology	Cerebrovascular accident	230690007	Cerebrovascular accident (disorder)	
2018613700	61	37	Neurology	Cerebrovascular disease	62914000	Cerebrovascular disease (disorder)	
2018615100	61	51	Neurology	Subarachnoid haemorrhage	21454007	Subarachnoid intracranial hemorrhage (disorder)	
2018615500	61	55	Neurology	Cerebral haemorrhage	274100004	Cerebral hemorrhage (disorder)	
2018618100	61	81	Neurology	Aphasia	87486003	Aphasia (finding)	
2018618100	61	81	Neurology	Hemiplegia	50582007	Hemiplegia (disorder)	
2018711100	71	11	Psychiatry / psychology	Anxiety disorder	197480006	Anxiety disorder (disorder)	
2018712100	71	21	Psychiatry / psychology	Depressive disorder	35489007	Depressive disorder (disorder)	
2018712500	71	25	Psychiatry / psychology	History of deliberate self harm	314550003	History of deliberate self harm (situation)	
2018712900	71	29	Psychiatry / psychology	Bipolar disorder	13746004	Bipolar disorder (disorder)	
2018716500	71	65	Psychiatry / psychology	Eating disorder	72366004	Eating disorder (disorder)	
2018716700	71	67	Psychiatry / psychology	Schizotypal personality disorder	31027006	Schizotypal personality disorder (disorder)	
2018717100	71	71	Psychiatry / psychology	Schizophrenia	58214004	Schizophrenia (disorder)	
2018717500	71	75	Psychiatry / psychology	Psychotic disorder	69322001	Psychotic disorder (disorder)	
2018717700	71	77	Psychiatry / psychology	Delusional disorder	48500005	Delusional disorder (disorder)	
2018751100	75	11	Developmental	Developmental delay	248290002	Developmental delay (disorder)	
2018752100	75	21	Developmental	Autistic disorder	408856003	Autistic disorder (disorder)	
2018753100	75	31	Developmental	Learning difficulties	161129001	Learning difficulties (finding)	
2018754100	75	41	Developmental	Developmental academic disorder	1855002	Developmental academic disorder (disorder)	

2018811100	81	11	Sensory / age related	Dementia	52448006	Dementia (disorder)
2018811500	81	15	Sensory / age related	Alzheimer's disease	26929004	Alzheimer's disease (disorder)
2018812100	81	21	Sensory / age related	Elderly fall	298344006	Elderly fall (finding)
2018814100	81	41	Sensory / age related	Blindness - both eyes	193699007	Blindness - both eyes (disorder)
2018814500	81	45	Sensory / age related	Blindness of one eye	22950006	Blindness of one eye (disorder)
2018814900	81	49	Sensory / age related	Registered blind	170727003	Registered blind (finding)
2018815100	81	51	Sensory / age related	Complete deafness	8531006	Complete deafness (disorder)
2018815200	81	52	Sensory / age related	Bilateral deafness	162344009	Bilateral deafness (disorder)
2018815300	81	53	Sensory / age related	Profound acquired hearing loss	525791000000105	Profound acquired hearing loss (disorder)
2018815400	81	54	Sensory / age related	Profound sensorineural hearing loss	700454004	Profound sensorineural hearing loss (disorder)
2018815500	81	55	Sensory / age related	Severe hearing loss	3561000119106	Severe hearing loss (disorder)
2018911100	91	11	Social / drug / alcohol	Smoker	77176002	Smoker (finding)
2018912100	91	21	Social / drug / alcohol	Lives alone	105529008	Lives alone (finding)
2018915100	91	51	Social / drug / alcohol	Alcohol abuse	15167005	Alcohol abuse (disorder)
2018916100	91	61	Social / drug / alcohol	Recreational drug use	26416006	Drug abuse (disorder)
2018916200	91	62	Social / drug / alcohol	Misuses drugs	361055000	Misuses drugs (finding)

DATA GROUP: SERVICE AGREEMENT DETAILS

FUNCTION: To carry the details of the Service Agreement.
Group Status: M
Group Repeats: 1..1

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	CQUIN DATA ITEM REQUIRED (Y/N)	DATA ITEM REPEATS	FORMAT	SNOMED CT / DM&D /ODS	JUSTIFICATION	ECDS CODE SET	LINK TO CURRENT CDS Type 010 INFORMATION ONLY	VALIDATION RULES		DATA ITEM PROVENANCE	NOTES
											POPULATION VALIDATION F - Format is validated V - Validated against an explicit list of permitted values as defined in the NHS Data Dictionary	POST SCHEMA VALIDATION		
SERVICE AGREEMENT DETAILS	COMMISSIONING SERIAL NUMBER	A number used to uniquely identify a NHS SERVICE AGREEMENT by an Organisation acting as commissioner of patient care services.	R	N	0..1	max an6	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/c/co/commissioning_serial_number_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
SERVICE AGREEMENT DETAILS	NHS SERVICE AGREEMENT LINE NUMBER	A number (alphanumeric) to provide a unique identifier for a line within a NHS SERVICE AGREEMENT.	O	N	0..1	max an10	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/n/nhs/nhs_service_agreement_line_number_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
SERVICE AGREEMENT DETAILS	PROVIDER REFERENCE NUMBER	PROVIDER REFERENCE NUMBER is a number convention agreed locally between a provider and Commissioner for use within a Commissioning Data Set message.	O	N	0..1	max an17	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/p/prod/provider_reference_number_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
SERVICE AGREEMENT DETAILS	COMMISSIONER REFERENCE NUMBER	A number (alphanumeric) allocated by the commissioner to a REFERRAL REQUEST.	O	N	0..1	max an17	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/c/co/commissioner_reference_number_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
SERVICE AGREEMENT DETAILS	ORGANISATION IDENTIFIER (CODE OF PROVIDER)	ORGANISATION IDENTIFIER (CODE OF PROVIDER) is the ORGANISATION IDENTIFIER of the Organisation acting as a Health Care Provider.	M	N	1..1	min an3 max an5	ODS	Updated to new Organisation code guidelines	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/o/org/organisation_code_(code_of_provider)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
SERVICE AGREEMENT DETAILS	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) is the ORGANISATION IDENTIFIER of the Organisation commissioning health care.	M	N	1..1	min an3 max an5	ODS	Updated to new Organisation code guidelines	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/o/org/organisation_code_(code_of_commissioner)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	

DATA GROUP: CARE PROFESSIONALS (EMERGENCY CARE)

FUNCTION: To carry the details of the Care Professionals active during the Emergency Care Attendance.
Group Status: R
Group Repeats: 0..*

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	CQUIN DATA ITEM REQUIRED (Y/N)	DATA ITEM REPEATS	FORMAT	SNOMED CT / DM&D /ODS	JUSTIFICATION	ECDS CODE SET	LINK TO CURRENT CDS Type 010 INFORMATION ONLY	VALIDATION RULES		DATA ITEM PROVENANCE	NOTES
											POPULATION VALIDATION F - Format is validated V - Validated against an explicit list of permitted values as defined in the NHS Data Dictionary	POST SCHEMA VALIDATION		
CARE PROFESSIONALS (EMERGENCY CARE)	PROFESSIONAL REGISTRATION ISSUER CODE	A code which identifies the PROFESSIONAL REGISTRATION BODY.	M	N	1..1	an2	DM&D	As per CDS 6.2 Type 010	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/p/prod/professional_registration_issuer_code_de.asp?shownav=0	V	n/a	Originates from A&E CDS Type 010	
CARE PROFESSIONALS (EMERGENCY CARE)	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER	The registration identifier allocated by an Organisation.	M	Y	1..1	max an32	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/p/prod/professional_registration_entry_identifier_(main_operating_care_professional)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
CARE PROFESSIONALS (EMERGENCY CARE)	CARE PROFESSIONAL TIER (EMERGENCY CARE)	The tier of CARE PROFESSIONAL treating the PATIENT during an Emergency Care Attendance. The CARE PROFESSIONAL TIERS FOR EMERGENCY CARE are defined in the Royal College of Emergency Medicine Guidelines for Medical and Practitioner Staffing in Emergency Departments. See the Royal College of Emergency Medicine website at Medical and Practitioner Workforce Guidance.	M	Y	1..1	an2	DM&D	Recording the clinician(s) responsible for patient care is necessary for • Operational planning and clinical governance- ensuring that the right grade of clinician is responsible for the right acuity and complexity of patient load • Workforce planning – ensuring that the right number of clinical staff are trained to satisfy the service need • Training metrics – ensuring that trainees are exposed to a suitable case mix of patients to achieve an appropriate level of expertise in their field. • Performance data. Time to see clinician is used as a performance/ quality metric in many healthcare systems. This 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.	Link to code set	n/a	V	n/a	NEW' A&E data item	
CARE PROFESSIONALS (EMERGENCY CARE)	CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR (EMERGENCY CARE)	An indication of whether a CARE PROFESSIONAL is responsible for discharge of the PATIENT from an Emergency Care Attendance.	M	Y	1..1	an1	DM&D	Recording the clinician(s) responsible for patient care is necessary for • Operational planning and clinical governance- ensuring that the right grade of clinician is responsible for the right acuity and complexity of patient load • Workforce planning – ensuring that the right number of clinical staff are trained to satisfy the service need • Training metrics – ensuring that trainees are exposed to a suitable case mix of patients to achieve an appropriate level of expertise in their field. • Performance data. Time to see clinician is used as a performance/ quality metric in many healthcare systems. This 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.	Link to code set	n/a	V	n/a	NEW' A&E data item	

ECDS_UniqueID	Sort1	ECDS_Group	ECDS_Description	DM&D_Code	DM&D Description	Notes
2018110000	11	n/a	General Medical Council	03	General Medical Council	
2018210000	21	n/a	Nursing and Midwifery Council	09	Nursing and Midwifery Council	
2018310000	31	n/a	Health and Care Professions Council	08	Health and Care Professions Council	
2018510000	51	n/a	General Dental Council	02	General Dental Council	

ECDS_UniqueID	Sort1	ECDS_Group	ECDS_Description	DM&D_Code	DM&D Description	Notes
2018111100	11	n/a	Require complete supervision. All PATIENTS must be signed off by a senior CARE PROFESSIONAL before admission or discharge.	01	Require complete supervision. All PATIENTS must be signed off by a senior CARE PROFESSIONAL before admission or discharge.	F1 doctors, trainee practitioners
2018211100	21	n/a	Require access to advice or direct supervision, or practice independently but with limited scope.	02	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
2018311100	31	n/a	More senior/experienced CARE PROFESSIONALS, requiring less direct supervision. Fewer limitations in scope of practice.	03	More senior/experienced CARE PROFESSIONALS, requiring less direct supervision. Fewer limitations in scope of practice.	CT3 in EM, junior Speciality Doctors, some ANPs / ACPs and PAs, some primary care clinicians
2018411100	41	n/a	Senior CARE PROFESSIONALS able to supervise an Emergency Care Department alone with remote support. Possess some extended skills. Full scope of practice.	04	Senior CARE PROFESSIONALS able to supervise an Emergency Care Department alone with remote support. Possess some extended skills. Full scope of practice.	CT4 and above, senior Speciality Doctors
2018511100	51	n/a	Senior CARE PROFESSIONALS (CONSULTANTS) with accredited advanced qualifications in Emergency Medicine. Full set of extended skills. Full scope of practice.	05	Senior CARE PROFESSIONALS (CONSULTANTS) with accredited advanced qualifications in Emergency Medicine. Full set of extended skills. Full scope of practice.	Consultants in EM

ECDS_UniqueID	Sort 1	ECDS_Group	ECDS_Description	DM&D_Code	DM&D Description	Notes
n/a	n/a	n/a	Yes - the CARE PROFESSIONAL is responsible for discharge of the PATIENT	Y	Yes - the CARE PROFESSIONAL is responsible for discharge of the PATIENT	
n/a	n/a	n/a	No - the CARE PROFESSIONAL is not responsible for discharge of the PATIENT	N	No - the CARE PROFESSIONAL is not responsible for discharge of the PATIENT	

DATA GROUP: EMERGENCY CARE DIAGNOSIS (SNOMED CT)

FUNCTION: To carry the details of SNOMED CT coded Clinical Diagnoses.
Group Status: R
Group Repeats: 0..*

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	CQUIN DATA ITEM REQUIRED (Y/N)	DATA ITEM REPEATS	FORMAT	SNOMED CT / DM&D /ODS	JUSTIFICATION	ECDS CODE SET	LINK TO CURRENT CDS Type 010 INFORMATION ONLY	VALIDATION RULES		DATA ITEM PROVENANCE	NOTES
											POPULATION VALIDATION F - Format is validated V - Validated against an explicit list of permitted values as defined in the NHS Data Dictionary	POST SCHEMA VALIDATION		
EMERGENCY CARE DIAGNOSIS (SNOMED CT)	EMERGENCY CARE DIAGNOSIS (SNOMED CT)	Diagnoses of the patient, in order of their relevance to the emergency presentation.	M	Y	1..1	min n6 max n18	SNOMED CT	As per CDS 6.2 Type 010. A key element of the ECDS is a system to record diagnosis by pairing a diagnosis code from a SNOMED-CT subset (the ECDS Diagnostic Data Set) with a two way qualifier. The quality of diagnosis data currently collected in emergency care (CDS type 010 v6.2) is very poor. In developing the ECDS Diagnostic Data Set (DDS) a few key design principles were used: - Exhaustive : the DDS items should cover all conditions commonly seen, but not very rare conditions – i.e. if a candidate condition had not been seen during the >50 physician years of experience of the senior EM physicians constructing the original list. - Exclusive: for any given clinical picture, there should be one and only one best answer. - There should be no vague terms ('unwell ?cause' 'unspecified') - There should be no symptoms (e.g. back pain) presented as a diagnosis. - The diagnosis terms should maximise usability by being presented to IT suppliers in a form, and with instructions that facilitate ease of use and coding validity and reliability.	Link to code set	n/a	F	a. For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for record X, field Y is not in the acceptable range". In addition, any normal business logic for IG reasons shall be followed. b. If one of the items corresponds to the "extremely sensitive" list of items then the record MUST be anonymised. c. The "extremely sensitive" list of SNOMED values must be added to SUS so that it can cross-check, and then follow existing IG rules appropriately (flagging / warning to the user for feedback). • NB: Providers shouldn't send this information, so this is a back-stop in case they do. • NB: there aren't any "extremely sensitive" items in the current list (we x-ref'd), but in theory one could be introduced in future as part of maintenance, so it's best to have this function in from the outset so we don't forget. d. Supplier guidance is to prioritise the ECDS sub set in the interface. e. Supplier guidance is to send ALL investigations / treatments to SUS because the grouper can handle unlimited values • NB: this is not a problem for SUS and HES in future will be able to bring across either everything, or prioritise and/or de-duplicate	Originates from A&E CDS Type 010	It is recommended that diagnosis is captured according to the SNOMED subset (ECDS Diagnostic Data Set) locally. These are the codes which will need to flow as part of the A&E CDS.
EMERGENCY CARE DIAGNOSIS (SNOMED CT)	CODED CLINICAL ENTRY SEQUENCE NUMBER	The sequence of the diagnosis in order of relevance to the emergency department attendance.	M	Y	1..1	max n5	DM&D		n/a	n/a	F	n/a	NEW' A&E data item	This should be captured for each diagnosis recorded.
EMERGENCY CARE DIAGNOSIS (SNOMED CT)	EMERGENCY CARE DIAGNOSIS QUALIFIER (SNOMED CT)	The qualifier allows the clinician to express the (un) certainty of each of the diagnoses.	M	Y	1..1	min n6 max n18	SNOMED CT	A qualifier enables users to express their certainty/ lack of certainty regarding a diagnosis.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	This should be captured for each diagnosis recorded.

ECDS_UniqueID	Sort1	Sort2	Sort3	ECDS_Group1	ECDS_Group2	ECDS_Group3	ECDS_Description	ECDS_SearchTerms	SNOMED_Code	SNOMED_Description	Flag_Inj	Flag_AEC	Flag_Allergy	Flag_NotifiableDisease	Flag_Male	Flag_Female	Notes
1111111000	11	11	11	Soft tissue inj / wound	Wound : lac / incised / bite	Head	Wound : lac / incised / bite : head	wound lac incised bite head laceration face	38354005	open wound of head (disorder)	1	0	0	0	1	1	
1111121000	11	11	21	Soft tissue inj / wound	Wound : lac / incised / bite	Face	Wound : lac / incised / bite : face	wound lac incised bite face laceration head	210339009	open wound of face (disorder)	1	0	0	0	1	1	
1111123000	11	11	23	Soft tissue inj / wound	Wound : lac / incised / bite	Neck	Wound : lac / incised / bite : neck	wound lac incised bite neck laceration face head	125644007	open wound of neck (disorder)	1	0	0	0	1	1	
1111130000	11	11	30	Soft tissue inj / wound	Wound : lac / incised / bite	Shoulder	Wound : lac / incised / bite : shoulder	wound lac incised bite shoulder laceration neck thorax trunk	125645008	open wound shoulder region (disorder)	1	0	0	0	1	1	
1111131000	11	11	31	Soft tissue inj / wound	Wound : lac / incised / bite	Upper arm	Wound : lac / incised / bite : upper arm	wound lac incised bite upper arm laceration forearm	125648005	open wound of upper arm (disorder)	1	0	0	0	1	1	
1111133000	11	11	33	Soft tissue inj / wound	Wound : lac / incised / bite	Forearm	Wound : lac / incised / bite : forearm	wound lac incised bite forearm laceration wrist arm	125649002	open wound of forearm (disorder)	1	0	0	0	1	1	
1111135000	11	11	35	Soft tissue inj / wound	Wound : lac / incised / bite	Hand	Wound : lac / incised / bite : hand	wound lac incised bite hand laceration finger thumb	125652005	open wound of hand (disorder)	1	0	0	0	1	1	
1111137000	11	11	37	Soft tissue inj / wound	Wound : lac / incised / bite	Thumb	Wound : lac / incised / bite : thumb	wound lac incised bite thumb laceration finger tip	125654006	open wound of thumb (disorder)	1	0	0	0	1	1	
1111139000	11	11	39	Soft tissue inj / wound	Wound : lac / incised / bite	Finger	Wound : lac / incised / bite : finger	wound lac incised bite finger laceration thumb tip	125653000	open wound of finger (disorder)	1	0	0	0	1	1	
1111151000	11	11	51	Soft tissue inj / wound	Wound : lac / incised / bite	Thigh	Wound : lac / incised / bite : thigh	wound lac incised bite thigh laceration groin leg femur	125659001	open wound of thigh (disorder)	1	0	0	0	1	1	
1111153000	11	11	53	Soft tissue inj / wound	Wound : lac / incised / bite	Knee	Wound : lac / incised / bite : knee	wound lac incised bite knee laceration patella kneecap	125660006	open wound of knee (disorder)	1	0	0	0	1	1	
1111155000	11	11	55	Soft tissue inj / wound	Wound : lac / incised / bite	Lower leg	Wound : lac / incised / bite : lower leg	wound lac incised bite lower leg laceration ankle	125661005	open wound of lower leg (disorder)	1	0	0	0	1	1	
1111157000	11	11	57	Soft tissue inj / wound	Wound : lac / incised / bite	Foot	Wound : lac / incised / bite : foot	wound lac incised bite foot laceration toe	125663008	open wound of foot (disorder)	1	0	0	0	1	1	
1111159000	11	11	59	Soft tissue inj / wound	Wound : lac / incised / bite	Toe	Wound : lac / incised / bite : toe	wound lac incised bite toe laceration foot	125664002	open wound of toe (disorder)	1	0	0	0	1	1	
1111181000	11	11	81	Soft tissue inj / wound	Wound : lac / incised / bite	Back	Wound : lac / incised / bite : back	wound lac incised bite thorax laceration back trunk	269169002	open wound of back (disorder)	1	0	0	0	1	1	
1111185000	11	11	85	Soft tissue inj / wound	Wound : lac / incised / bite	Thorax	Wound : lac / incised / bite : thorax	wound lac incised bite thorax laceration back trunk	127314000	open wound of chest wall (disorder)	1	0	0	0	1	1	
1111191000	11	11	91	Soft tissue inj / wound	Wound : lac / incised / bite	Abdomen	Wound : lac / incised / bite : abdomen	wound lac incised bite abdomen laceration stomach tummy trunk	274170000	open wound of abdominal wall (disorder)	1	0	0	0	1	1	
1111195000	11	11	95	Soft tissue inj / wound	Wound : lac / incised / bite	Perineum	Wound : lac / incised / bite : perineum	wound lac incised bite perineum laceration genital penis vagina vulva testis testes balls	210484005	open wound of perineum (disorder)	1	0	0	0	1	1	
1112111000	11	21	11	Soft tissue inj / wound	Sprain / ligament injury	Cervical spine	Sprain / ligament injury : cervical spine	sprain ligament neck spine cervical whiplash soft tissue injury neck vertebral	209557005	neck sprain (disorder)	1	0	0	0	1	1	
1112112000	11	21	12	Soft tissue inj / wound	Sprain / ligament injury	Thoracic spine	Sprain / ligament injury : thoracic spine	sprain ligament injury thoracic spine lumbago back pain vertebral	274162005	thoracic back sprain (disorder)	1	0	0	0	1	1	
1112113000	11	21	13	Soft tissue inj / wound	Sprain / ligament injury	Lumbar spine	Sprain / ligament injury : lumbar spine	sprain ligament injury lumbar spine lumbago back pain sciatica vertebral	209565008	lumbar sprain (disorder)	1	0	0	0	1	1	
1112131000	11	21	31	Soft tissue inj / wound	Sprain / ligament injury	Shoulder joint	Sprain / ligament injury : shoulder joint	sprain ligament injury shoulder joint clavicle scapula rotator cuff humerus	3199001	sprain of shoulder (disorder)	1	0	0	0	1	1	
1112133000	11	21	33	Soft tissue inj / wound	Sprain / ligament injury	Elbow joint	Sprain / ligament injury : elbow joint	sprain ligament injury elbow joint ulna humerus radius radial olecranon	263128001	sprain of ligament of elbow (disorder)	1	0	0	0	1	1	
1112135000	11	21	35	Soft tissue inj / wound	Sprain / ligament injury	Wrist joint	Sprain / ligament injury : wrist joint	sprain ligament injury wrist joint colles smiths	70704007	sprain of wrist (disorder)	1	0	0	0	1	1	
1112137000	11	21	37	Soft tissue inj / wound	Sprain / ligament injury	Hand	Sprain / ligament injury : hand	sprain ligament injury hand thumb finger digit	87778004	sprain of hand (disorder)	1	0	0	0	1	1	
1112139000	11	21	39	Soft tissue inj / wound	Sprain / ligament injury	Thumb	Sprain / ligament injury : thumb	sprain ligament injury thumb finger hand digit	263130004	Sprain of ligament of thumb (disorder)	1	0	0	0	1	1	
1112143000	11	21	43	Soft tissue inj / wound	Sprain / ligament injury	Finger	Sprain / ligament injury : finger	sprain ligament injury finger thumb hand digit ring index middle little	263129009	Sprain of ligament of finger (disorder)	1	0	0	0	1	1	
1112151000	11	21	51	Soft tissue inj / wound	Sprain / ligament injury	Hip joint	Sprain / ligament injury : hip joint	sprain ligament injury hip joint pelvis trochanter buttock	17883008	sprain of hip (disorder)	1	0	0	0	1	1	
1112153000	11	21	53	Soft tissue inj / wound	Sprain / ligament injury	Knee joint	Sprain / ligament injury : knee joint	sprain ligament injury knee joint patella condyle tibia femur kneecap	54888009	sprain of knee (disorder)	1	0	0	0	1	1	
1112155000	11	21	55	Soft tissue inj / wound	Sprain / ligament injury	Ankle joint	Sprain / ligament injury : ankle joint	sprained ligament injury ankle joint twisted malleolus deltoid talofibular calcaneofibular fibula calcaneum tibia talus achilles	44465007	sprain of ankle (disorder)	1	0	0	0	1	1	
1112157000	11	21	57	Soft tissue inj / wound	Sprain / ligament injury	Foot	Sprain / ligament injury : foot	sprain ligament injury foot toe arch flat lisfranc	49388007	sprain of foot (disorder)	1	0	0	0	1	1	
1112159000	11	21	59	Soft tissue inj / wound	Sprain / ligament injury	Toe	Sprain / ligament injury : toe	sprain ligament injury foot toe big	262998001	sprain of toe joint (disorder)	1	0	0	0	1	1	
1113111000	11	31	11	Soft tissue inj / wound	Bruise / contusion / abrasion	Head	Bruise / contusion / abrasion : head	bruise contusion abrasion head face soft tissue injury	283025007	superficial injury of head (disorder)	1	0	0	0	1	1	
1113115000	11	31	15	Soft tissue inj / wound	Bruise / contusion / abrasion	Face	Bruise / contusion / abrasion : face	bruise contusion abrasion face head soft tissue injury	125668004	contusion of face (disorder)	1	0	0	0	1	1	
1113121000	11	31	21	Soft tissue inj / wound	Bruise / contusion / abrasion	Neck	Bruise / contusion / abrasion : neck	bruise contusion neck throat whiplash head soft tissue injury neck vertebral	274182009	superficial injury of neck (disorder)	1	0	0	0	1	1	
1113135000	11	31	35	Soft tissue inj / wound	Bruise / contusion / abrasion	Thorax	Bruise / contusion / abrasion : thorax	bruise contusion abrasion thorax back trunk soft tissue injury	274187003	superficial injury of chest (disorder)	1	0	0	0	1	1	
1113137000	11	31	37	Soft tissue inj / wound	Bruise / contusion / abrasion	Back	Bruise / contusion / abrasion : back	bruise contusion abrasion back thorax trunk soft tissue injury	274184005	superficial injury of back (disorder)	1	0	0	0	1	1	
1113141000	11	31	41	Soft tissue inj / wound	Bruise / contusion / abrasion	Abdomen	Bruise / contusion / abrasion : abdomen	bruise contusion abrasion abdomen trunk soft tissue injury	274183004	superficial injury of abdominal wall (disorder)	1	0	0	0	1	1	
1113145000	11	31	45	Soft tissue inj / wound	Bruise / contusion / abrasion	Perineum	Bruise / contusion / abrasion : perineum	bruise contusion abrasion pelvic groin perineum penis vagina vulva testes balls testis soft tissue injury	274188008	superficial injury of perineum (disorder)	1	0	0	0	1	1	
1113147000	11	31	47	Soft tissue inj / wound	Bruise / contusion / abrasion	Pelvic region	Bruise / contusion / abrasion : pelvic region	bruise contusion abrasion pelvic groin perineum penis vagina vulva testes balls testis soft tissue injury	283037009	superficial injury of pelvic region (disorder)	1	0	0	0	1	1	
1113151000	11	31	51	Soft tissue inj / wound	Bruise / contusion / abrasion	Shoulder	Bruise / contusion / abrasion : shoulder	bruise contusion abrasion shoulder neck thorax trunk soft tissue injury	274191008	superficial injury of shoulder (disorder)	1	0	0	0	1	1	
1113153000	11	31	53	Soft tissue inj / wound	Bruise / contusion / abrasion	Upper arm	Bruise / contusion / abrasion : upper arm	bruise contusion abrasion upper arm soft tissue injury	283031005	superficial injury of upper arm (disorder)	1	0	0	0	1	1	
1113155000	11	31	55	Soft tissue inj / wound	Bruise / contusion / abrasion	Elbow	Bruise / contusion / abrasion : elbow	bruise contusion abrasion elbow olecranon soft tissue injury	283032003	superficial injury of elbow (disorder)	1	0	0	0	1	1	
1113157000	11	31	57	Soft tissue inj / wound	Bruise / contusion / abrasion	Forearm	Bruise / contusion / abrasion : forearm	bruise contusion abrasion forearm arm soft tissue injury	283033008	superficial injury of forearm (disorder)	1	0	0	0	1	1	
1113159000	11	31	59	Soft tissue inj / wound	Bruise / contusion / abrasion	Wrist	Bruise / contusion / abrasion : wrist	bruise contusion abrasion hand wrist soft tissue injury	274192001	superficial injury of wrist (disorder)	1	0	0	0	1	1	
1113161000	11	31	61	Soft tissue inj / wound	Bruise / contusion / abrasion	Hand	Bruise / contusion / abrasion : hand	bruise contusion abrasion hand wrist soft tissue injury	283034002	superficial injury of hand (disorder)	1	0	0	0	1	1	
1113164000	11	31	64	Soft tissue inj / wound	Bruise / contusion / abrasion	Thumb	Bruise / contusion / abrasion : thumb	bruise contusion abrasion thumb soft tissue injury	274194000	superficial injury of thumb (disorder)	1	0	0	0	1	1	
1113168000	11	31	68	Soft tissue inj / wound	Bruise / contusion / abrasion	Finger	Bruise / contusion / abrasion : finger	bruise contusion abrasion finger soft tissue injury	274193006	superficial injury of finger (disorder)	1	0	0	0	1	1	
1113171000	11	31	71	Soft tissue inj / wound	Bruise / contusion / abrasion	Hip	Bruise / contusion / abrasion : hip	bruise contusion abrasion hip soft tissue injury	274196003	superficial injury of hip (disorder)	1	0	0	0	1	1	
1113175000	11	31	75	Soft tissue inj / wound	Bruise / contusion / abrasion	Thigh	Bruise / contusion / abrasion : thigh	bruise contusion abrasion thigh soft tissue injury	274198002	superficial injury of thigh (disorder)	1	0	0	0	1	1	
1113179000	11	31	79	Soft tissue inj / wound	Bruise / contusion / abrasion	Knee	Bruise / contusion / abrasion : knee	bruise contusion abrasion knee soft tissue injury	283040009	superficial injury of knee (disorder)	1	0	0	0	1	1	
1113183000	11	31	83	Soft tissue inj / wound	Bruise / contusion / abrasion	Lower leg	Bruise / contusion / abrasion : lower leg	bruise contusion abrasion lower leg soft tissue injury	283041008	superficial injury of lower leg (disorder)	1	0	0	0	1	1	
1113185000	11	31	85	Soft tissue inj / wound	Bruise / contusion / abrasion	Ankle	Bruise / contusion / abrasion : ankle	bruise contusion abrasion ankle foot soft tissue injury	274195004	superficial injury of ankle (disorder)	1	0	0	0	1	1	
1113187000	11	31	87	Soft tissue inj / wound	Bruise / contusion / abrasion	Foot	Bruise / contusion / abrasion : foot	bruise contusion abrasion foot ankle sprain toe soft tissue injury	274199005	superficial injury of foot (disorder)	1	0	0	0	1	1	
1113189000	11	31	89	Soft tissue inj / wound	Bruise / contusion / abrasion	Toe	Bruise / contusion / abrasion : toe	bruise contusion abrasion toe subungal haematoma soft tissue injury	274200008	superficial injury of toe (disorder)	1	0	0	0	1	1	
1114111000	11	41	11	Soft tissue inj / wound	Muscle injury	Neck	Muscle injury : neck	whiplash muscle neck injury cervical	360450007	strain of neck muscle (disorder)	1	0	0	0	1	1	
1114121000	11	41	21	Soft tissue inj / wound	Muscle injury	Upper back	Muscle injury : upper back	muscle injury upper back soft tissue injury	812501000000108	injury of muscle of upper back (disorder)	1	0	0	0	1	1	
1114122000	11	41	22	Soft tissue inj / wound	Muscle injury	Lower back	Muscle injury : lower back	muscle injury lower back lumbago pain mechanical soft tissue injury	813411000000100	injury of muscle of lower back (disorder)	1	0	0	0	1	1	
1114131000	11	41	31	Soft tissue inj / wound	Muscle injury	Shoulder	Muscle injury : shoulder	muscle injury shoulder soft tissue injury	812471000000101	injury of muscle of shoulder (disorder)	1	0	0	0	1	1	
1114132000	11	41	32	Soft tissue inj / wound	Muscle injury	Upper arm	Muscle injury : upper arm	muscle injury upper arm soft tissue injury	812511000000105	injury of muscle of upper arm (disorder)	1	0	0	0	1	1	
1114133000	11	41	33	Soft tissue inj / wound	Muscle injury	Forearm	Muscle injury : forearm	muscle injury forearm soft tissue injury	812531000000102	injury of muscle of forearm (disorder)	1	0	0	0	1	1	
1114134000	11	41	34	Soft tissue inj / wound	Muscle injury	Hand	Muscle injury : hand	muscle injury hand soft tissue injury	812721000000109	injury of muscle of hand (disorder)	1	0	0	0	1	1	
1114141000	11	41	41	Soft tissue inj / wound	Muscle injury	Thigh	Muscle injury : thigh	muscle injury thigh soft tissue injury	812741000000102	injury of muscle of thigh (disorder)	1	0	0	0	1	1	
1114142000	11	41	42	Soft tissue inj / wound	Muscle injury	Lower Leg	Muscle injury : lower leg	muscle injury lower leg soft tissue injury	812751000000104	injury of muscle of lower leg (disorder)	1	0	0	0	1	1	
1114145000	11	41	45	Soft tissue inj / wound	Muscle injury	Foot	Muscle injury : foot	muscle injury foot soft tissue injury	812761000000101	injury of muscle of foot (disorder)	1	0	0	0	1	1	
1115111000	11	51	11	Soft tissue inj / wound	Tendon injury	Shoulder joint	Tendon injury : shoulder joint	tendon injury shoulder joint painful arc	813331000000101	injury of tendon of shoulder joint (disorder)	1	0	0	0	1	1	
1115121000	11	51	21	Soft tissue inj / wound	Tendon injury	Elbow joint	Tendon injury : elbow joint	tendon injury elbow joint arm	813101000000105	injury of tendon of elbow joint (disorder)	1	0	0	0	1	1	
1115125000	11	51	25	Soft tissue inj / wound	Tendon injury	Wrist joint	Tendon injury : wrist joint	tendon injury wrist joint hand	813111000000107	injury of tendon of wrist joint (disorder)	1	0	0	0	1	1	
1115131000	11	51	31	Soft tissue inj / wound	Tendon injury	Hand	Tendon injury : hand	tendon injury hand finger digit	262971000	tendon injury of hand (disorder)	1	0	0	0	1	1	
1115141000	11	51	41	Soft tissue inj / wound	Tendon injury	Thumb	Tendon injury : thumb	tendon injury thumb finger digit	813231000000107	injury of tendon of thumb (disorder)	1	0	0	0	1	1	
1115145000	11	51	45	Soft tissue inj / wound	Tendon injury	Finger	Tendon injury : finger	tendon injury finger digit ring middle index little hand	813121000000101	injury of tendon of finger (disorder)	1	0	0	0	1	1	
1115151000	11	51	51	Soft tissue inj / wound	Tendon injury	Patellar tendon	Tendon injury : patellar tendon	tendon injury patellar tendon dislocation dislocated knee	209508007	strain of patellar tendon (disorder)	1	0	0	0	1	1	
1115155000	11	51	55	Soft tissue inj / wound	Tendon injury	Achilles tendon	Tendon injury : achilles tendon	tendon injury achilles tendon ankle	22817005	strain of Achilles tendon (disorder)	1	0	0	0	1	1	
1115159000	11	51	59	Soft tissue inj / wound	Tendon injury	Ankle	Tendon injury : ankle	tendon injury ankle foot	828981000000104	injury of tendon of ankle (disorder)	1	0	0	0	1	1	
1115161000	11	51	61	Soft tissue inj / wound	Tendon injury	Foot	Tendon injury : foot	tendon injury foot toe	813311000000109	injury of tendon of foot (disorder)	1	0	0	0	1	1	
1115171000	11	51	71	Soft tissue inj / wound	Tendon injury	Toe	Tendon injury : toe	tendon injury toe foot	813321000000103	injury of tendon of toe (disorder)	1	0	0	0	1	1	
1116111000	11	61	11	Soft tissue inj / wound	Crush injury	Head	Crush injury : head	crush injury head	262576002	crushing injury of skull and intracranial contents (disorder)	1	0	0	0	1	1	
1116115000	11	61	15	Soft tissue inj / wound	Crush injury	Face	Crush injury : face	crush injury face	90465004	crushing injury of face (disorder)	1	0	0	0	1	1	
1116119000	11	61	19	Soft tissue inj / wound	Crush injury	Traumatic asphyxiation	Traumatic asphyxiation	trauma asphyxiation strangle strangling hanging hanged traumatic obstruction breathing	386732003	traumatic asphyxiation (event)	1	0	0	0	1	1	
1116121000	11	61	21	Soft tissue inj / wound	Crush injury	Neck	Crush injury : neck	crush injury neck	50001009	crushing injury of neck (disorder)	1	0	0	0	1	1	
1116131000	11	61	31	Soft tissue inj / wound	Crush injury	Thorax	Crush injury : thorax	crush injury thorax chest	33847006	crushing injury of chest (disorder)	1	0	0	0	1	1	
1116135000	11	61	35	Soft tissue inj / wound	Crush injury	Back	Crush injury : back	crush injury back	59038002	crushing injury of back (disorder)	1	0	0	0	1	1	
1116141000	11	61	41	Soft tissue inj / wound	Crush injury	Abdomen	Crush injury : abdomen	crush injury abdomen	68565009	crushing injury of abdomen (disorder)	1	0	0	0	1	1	
1116145000	11	61	45	Soft tissue inj / wound	Crush injury	Pelvis	Crush injury : pelvis	crush injury pelvis pelvic groin perineum penis vagina vulva testes balls testis genital	283859007	crush injury of pelvic region (disorder)	1	0	0	0	1	1	
1116147000	11	61	47	Soft tissue inj / wound	Crush injury	Hand	Crush injury : hand	crush injury hand thumb finger digit	50793006	crushing injury of hand (disorder)	1	0	0	0	1	1	
1116148000	11	61	48	Soft tissue inj / wound	Crush injury	Thumb	Crush injury : thumb	crush injury thumb finger digit	283858004	crush injury of thumb (disorder)	1	0	0	0	1	1	
1116149000	11	61	49	Soft tissue inj / wound	Crush injury	Finger	Crush injury : finger	crush injury finger digit hand thumb ring middle little index	10380004	crushing injury of finger (disorder)	1	0	0	0	1	1	
1116151000	11	61	51	Soft tissue inj / wound	Crush injury	Shoulder	Crush injury : shoulder	crush injury shoulder	2591000	crushing injury of shoulder region (disorder)	1	0	0	0	1	1	
1116153000	11	61	53	Soft tissue inj / wound	Crush injury	Upper arm	Crush injury : upper arm	crush injury upper arm	19180002	crushing injury of upper arm (disorder)	1	0	0	0	1	1	
1116155000	11	61	55	Soft tissue inj / wound	Crush injury	Forearm	Crush injury : forearm	crush injury forearm arm	111693009	crushing injury of forearm (disorder)	1	0	0	0	1	1	
1116161000	11	61	61	Soft tissue inj / wound	Crush injury	Thigh	Crush injury : thigh	crush injury thigh leg	74270009	crushing injury of thigh (disorder)	1	0	0	0	1	1	
1116163000	11	61	63	Soft tissue inj / wound	Crush injury	Lower leg	Crush injury : lower leg	crush injury lower leg	40874009	crushing injury of lower leg (disorder)	1	0	0	0	1	1	
1116165000	11	61	65	Soft tissue inj / wound	Crush injury	Ankle	Crush injury : ankle	crush injury ankle foot	65896005	crushing injury of ankle (disorder)	1	0	0	0	1	1	
1116167000	11	61	67	Soft tissue inj / wound	Crush injury	Foot	Crush injury : foot	crush injury foot toe	43422002	crushing injury of foot (disorder)	1	0	0	0	1	1	
1116169000	11	61	69	Soft tissue inj / wound	Crush injury	Toe	Crush injury : toe	crush injury toe foot	74682007	crushing injury of toe (disorder)	1	0	0	0	1	1	
1117111000	11	71	11	Soft tissue inj / wound	Degloving injury	Head	Degloving injury : head	degloving injury head	82271004	injury of head (disorder)	1	0	0	0	1	1	
1117117000	11	71	17	Soft tissue inj / wound	Degloving injury	Neck	Degloving injury : neck	degloving injury neck	283843007	degloving injury of neck (disorder)	1	0	0	0	1	1	
1117125000	11	71	25	Soft tissue inj / wound	Degloving injury	Thorax	Degloving injury : thorax	degloving injury chest thorax back	210408006	degloving injury chest wall (disorder)	1	0	0	0	1	1	
1117131000	11	71	31	Soft tissue inj / wound	Degloving injury	Back	Degloving injury : back	degloving injury back chest thorax	210417006	degloving injury back (disorder)	1	0	0	0	1	1	
1117134000	11	71	34	Soft tissue inj / wound	Degloving injury	Abdomen	Degloving injury : abdomen	degloving injury abdomen	283846004	degloving injury of abdomen (disorder)	1	0	0	0	1	1	
1117138000	11	71	38	Soft tissue inj / wound	Degloving injury	Perineum	Degloving injury : perineum	degloving pelvis pelvic groin perineum penis vagina vulva testes balls testis genital	283848003	degloving injury of perineum (disorder)	1	0	0	0	1	1	
1117139000	11	71	39	Soft tissue inj / wound	Degloving injury	Buttock	Degloving injury : buttock	degloving injury buttock	210422006	degloving injury buttock (disorder)	1	0	0	0	1	1	
1117141000	11	71	41	Soft tissue inj / wound	Degloving injury	Shoulder	Degloving injury : shoulder	degloving injury shoulder	210524009	degloving injury, shoulder area (disorder)	1	0	0	0	1	1	
1117145000	11	71	45	Soft tissue inj / wound	Degloving injury	Upper arm	Degloving injury : upper arm	degloving injury upper arm	210527002	degloving injury, upper arm (disorder)	1	0	0	0	1	1	
1117147000	11	71	47	Soft tissue inj / wound	Degloving injury	Forearm	Degloving injury : forearm	degloving injury forearm wrist arm	210553005	degloving injury, forearm (disorder)	1	0	0	0	1	1	
1117155000	11	71	55	Soft tissue inj / wound	Degloving injury	Hand	Degloving injury : hand	degloving injury hand finger digit	210571003	degloving injury of hand (disorder)	1	0	0	0	1	1	
1117158000	11	71	58	Soft tissue inj / wound	Degloving injury	Thumb	Degloving injury : thumb	degloving injury thumb digit hand	210604001	degloving injury of thumb (disorder)	1	0	0	0	1	1	
1117159000	11	71	59	Soft tissue inj / wound	Degloving injury	Finger	Degloving injury : finger	degloving injury finger digit hand thumb index middle ring little	210597009	degloving injury of finger (disorder)	1	0	0	0	1	1	
1117167000	11	71	67	Soft tissue inj / wound	Degloving injury	Thigh	Degloving injury : thigh	degloving injury thigh knee leg	210678002	degloving injury of thigh (disorder)	1	0	0	0	1	1	
1117171000	11	71	71	Soft tissue inj / wound	Degloving injury	Lower leg	Degloving injury : lower leg	degloving injury lower leg ankle knee	210702006	degloving injury of lower leg (disorder)	1	0	0	0	1	1	
1117173000	11	71	73	Soft tissue inj / wound	Degloving injury	Ankle	Degloving injury : ankle	degloving injury ankle foot	210703001	degloving injury, ankle (disorder)	1	0	0	0	1	1	
1117177000	11	71	77	Soft tissue inj / wound	Degloving injury	Foot	Degloving injury : foot	degloving injury foot ankle	210720002	degloving injury of foot (disorder)	1	0	0	0	1	1	
1117179000	11	71	79	Soft tissue inj / wound	Degloving injury	Toe	Degloving injury : toe	degloving injury toe foot	210732003	degloving injury toe (disorder)	1	0	0	0	1	1	
1118111000	11	81	11	Soft tissue inj / wound	Burn	Head	Burn : head	burn head face	262581006	head burn (disorder)	1	0	0	0	1	1	
1118115000	11	81	15	Soft tissue inj / wound	Burn	Eye	Burn : eye	burn eye face head	274205003	burn of eye region (disorder)	1	0	0	0	1	1	NB this is burn = chemical thermal, UV is listed in eye section
1118118000	11	81	18	Soft tissue inj / wound	Burn	Airway	Burn : airway	burn airway head face neck	284188001	burn of respiratory tract (disorder)	1	0	0	0	1	1	
1118121000	11	81	21	Soft tissue inj / wound	Burn	Face	Burn : face	burn face head face neck	262582004	burn of face (disorder)	1	0	0	0	1	1	
1118125000	11	81	25	Soft tissue inj / wound	Burn	Neck	Burn : neck	burn neck head face neck	60713008	burn of neck (disorder)	1	0	0	0	1	1	
1118131000	11	81	31	Soft tissue inj / wound	Burn	Trunk	Burn : trunk	burn chest abdomen stomach back flank thorax loin	52405000	burn of trunk (disorder)	1	0	0	0	1	1	
1118141000	11	81	41	Soft tissue inj / wound	Burn	Perineum	Burn : perineum	burn pelvis pelvic groin perineum penis vagina vulva testes balls testis genital	284219006	burn of perineum (disorder)	1	0	0	0	1	1	
1118143000	11	81	43	Soft tissue inj / wound	Burn	Buttock	Burn : buttock	burn buttock bum lower back loin	284223003	burn of buttock (disorder)	1	0	0	0	1	1	
1118151000	11	81	51	Soft tissue inj / wound	Burn	Shoulder	Burn : shoulder	burn shoulder arm neck trunk thorax	57143002	burn of shoulder (disorder)	1	0	0	0	1	1	
1118155000	11	81	55	Soft tissue inj / wound	Burn	Upper arm	Burn : upper arm	burn upper arm shoulder	14261008	burn of upper arm (disorder)	1	0	0	0	1	1	
1118157000	11	81	57	Soft tissue inj / wound	Burn	Elbow	Burn : elbow	burn elbow arm	18084001	burn of elbow (disorder)	1	0	0	0	1	1	
1118161000	11	81	61	Soft tissue inj / wound	Burn	Forearm	Burn : forearm	burn forearm arm elbow	80827001	burn of forearm (disorder)	1	0	0	0	1	1	
1118165000	11	81	65	Soft tissue inj / wound	Burn	Hand	Burn : hand	burn hand forearm wrist	14893008	burn of hand (disorder)	1	0	0	0	1	1	
1118167000	11	81	67	Soft tissue inj / wound	Burn	Thumb	Burn : thumb	burn thumb digit finger	64090007	burn of thumb (disorder)	1	0	0	0	1	1	
1118168000	11	81	68	Soft tissue inj / wound	Burn	Finger	Burn : finger	burn finger thumb digit ring index middle little	31946005	burn of two OR more fingers not including thumb (disorder)	1	0	0	0	1	1	
1118171000	11	81	71	Soft tissue inj / wound	Burn	Thigh	Burn : thigh	burn thigh leg	6132001	burn of thigh (disorder)	1	0	0	0	1	1	
1118173000	11	81	73	Soft tissue inj / wound	Burn	Knee	Burn : knee	burn knee leg	19684007	burn of knee (disorder)	1	0	0	0	1	1	
1118175000	11	81	75	Soft tissue inj / wound	Burn	Lower Leg	Burn : lower leg	burn lower leg	37696000	burn of lower leg (disorder)	1	0	0	0	1	1	
1118177000	11	81	77	Soft tissue inj / wound	Burn	Foot	Burn : foot	burn foot toe	11980003	burn of foot (disorder)	1	0	0	0	1	1	
1118179000	11	81	79	Soft tissue inj / wound	Burn	Toe	Burn : toe	burn toe foot	88374002	burn of toe (disorder)	1	0	0	0	1	1	
1211111000	21	11	11	Fracture / dislocation	Closed fracture	Skull	Closed fracture : skull	closed fracture skull head injury	371162008	closed fracture of skull (disorder)	1	0	0	0	1	1	
1211118000	21	11	18	Fracture / dislocation	Closed fracture	Facial bones / mandible	Closed fracture : facial bones / mandible	closed fracture facial bones mandible jaw face	430984009	closed fracture of facial bone (disorder)	1	0	0	0	1	1	
1211125000	21	11	25	Fracture / dislocation	Closed fracture	Sternum	Closed fracture : sternum	closed fracture sternum breastbone	66112004	closed fracture sternum (disorder)	1	0	0	0	1	1	
1211127000	21	11	27	Fracture / dislocation	Closed fracture	Rib (s)	Closed fracture : rib	closed fracture rib chest flail segment pneumothorax	60667009	closed fracture of rib (disorder)	1	0	0	0	1	1	
1211131000	21	11	31	Fracture / dislocation	Closed fracture	Cervical spine	Closed fracture : cervical spine	closed fracture cervical spine neck hangmans	269062008	closed fracture of cervical spine (disorder)	1	1	0	0	1	1	
1211132000	21	11	32	Fracture / dislocation	Closed fracture	Thoracic spine	Closed fracture : thoracic spine	closed fracture thoracic spine chest	207938004	closed fracture thoracic vertebra (disorder)	1	1	0	0	1	1	
1211133000	21	11	33	Fracture / dislocation	Closed fracture	Lumbar spine	Closed fracture : lumbar spine	closed fracture lumbar spine back	207957008	closed fracture lumbar vertebra (disorder)	1	1	0	0	1	1	
1211135000	21	11	35	Fracture / dislocation	Closed fracture	Pubic rami	Closed fracture : pubic rami	closed fracture pubic rami pelvis	13695006	fracture of pubic rami (disorder)	1	1	0	0	1	1	
1211137000	21	11	37	Fracture / dislocation	Closed fracture	Sacrum	Closed fracture : sacrum	closed fracture sacrum pelvis	207974008	closed fracture of sacrum (disorder)	1	0	0	0	1	1	
1211138000	21	11	38	Fracture / dislocation	Closed fracture	Coccyx	Closed fracture : coccyx	closed fracture coccyx tailbone coccydynia pelvis	207980000	closed fracture pelvis, coccyx (disorder)	1	0	0	0	1	1	
1211139000	21	11	39	Fracture / dislocation	Closed fracture	Pelvis	Closed fracture : pelvis	closed fracture pelvis	91037003	closed fracture of pelvis (disorder)	1	0	0	0	1	1	
1211141000	21	11	41	Fracture / dislocation	Closed fracture	Clavicle	Closed fracture : clavicle	closed fracture clavicle collarbone	33173003	closed fracture of clavicle (disorder)	1	0	0	0	1	1	
1211143000	21	11	43	Fracture / dislocation	Closed fracture	Scapula	Closed fracture : scapula	closed fracture shoulder shoulderblade acromiom coracoid glenoid	29749002	closed fracture of scapula (disorder)	1	1	0	0	1	1	
1211145000	21	11	45	Fracture / dislocation	Closed fracture	Humerus	Closed fracture : humerus	closed fracture humerus arm	43295006	closed fracture of humerus (disorder)	1	1	0	0	1	1	
1211149000	21	11	49	Fracture / dislocation	Closed fracture	Elbow	Closed fracture : elbow joint	closed fracture elbow joint	302222008	elbow fracture - closed (disorder)	1	0	0	0	1	1	
1211151000	21	11	51	Fracture / dislocation	Closed fracture	Radius	Closed fracture : radius	closed fracture distal radius colles smiths bartons wrist forearm	111640008	closed fracture of radius (disorder)	1	1	0	0	1	1	
1211153000	21	11	53	Fracture / dislocation	Closed fracture	Ulna	Closed fracture : ulna	closed fracture ulna styloid wrist forearm	71555008	closed fracture of ulna (disorder)	1	1	0	0	1	1	
1211155000	21	11	55	Fracture / dislocation	Closed fracture	Radius AND ulna	Closed fracture : radius AND ulna	closed fracture radius ulna forearm	53627009	closed fracture of radius and ulna (disorder)	1	1	0	0	1	1	
1211158000	21	11	58	Fracture / dislocation	Closed fracture	Monteggia (frac ulna : disloc rad)	Closed fracture : Monteggia (frac ulna : disloc rad)	closed fracture monteggia dislocation galeazzi elbow forearm	29045004	closed Monteggia fracture (disorder)	1	0	0	0	1	1	
1211159000	21	11	59	Fracture / dislocation	Closed fracture	Galeazzi (frac rad : disloc ulna)	Closed fracture : Galeazzi (frac rad : disloc ulna)	closed fracture monteggia dislocation galeazzi forearm wrist	208322000	closed Galeazzi fracture (disorder)	1	0	0	0	1	1	
1211160000	21	11	60	Fracture / dislocation	Closed fracture	Scaphoid	Closed fracture : scaphoid	closed fracture scaphoid wrist carpal carpus	208371005	closed fracture of waist of scaphoid bone (disorder)	1	1	0	0	1	1	
1211161000	21	11	61	Fracture / dislocation	Closed fracture	Carpal bones	Closed fracture : carpal bones	closed fracture carpal bones wrist carpus	9468002	closed fracture carpal bone (disorder)	1	1	0	0	1	1	
1211165000	21	11	65	Fracture / dislocation	Closed fracture	Hand	Closed fracture : hand	closed fracture hand metacarpal carpal carpus	208394006	closed fracture of metacarpal bone (disorder)	1	0	0	0	1	1	
1211167000	21	11	67	Fracture / dislocation	Closed fracture	Thumb metacarpal	Closed fracture : thumb metacarpal	closed fracture thumb bennett rolando metacarpal thenar	208403005	closed fracture of thumb metacarpal (disorder)	1	0	0	0	1	1	
1211168000	21	11	68	Fracture / dislocation	Closed fracture	Thumb phalanx	Closed fracture : thumb phalanx	closed fracture thumb phalanx tip	704213001	closed fracture of phalanx of thumb (disorder)	1	0	0	0	1	1	

1211169000	21	11	69	Fracture / dislocation	Closed fracture	Finger	Closed fracture : finger	closed fracture finger phalanx tip	24424003	closed fracture of phalanx of finger (disorder)	1	0	0	0	1	1
1211171000	21	11	71	Fracture / dislocation	Closed fracture	Hip (NoF)	Closed fracture : hip (NoF)	closed fracture neck of femur intertrochanteric trochanter nof subcapital transcervical garden pertrochanteric subtrochanteric	359817006	closed fracture of hip (disorder)	1	0	0	0	1	1
1211175000	21	11	75	Fracture / dislocation	Closed fracture	Femur (not NoF)	Closed fracture : femur (not NoF)	closed fracture femur shaft supracondylar	25415003	closed fracture of femur (disorder)	1	0	0	0	1	1
1211178000	21	11	78	Fracture / dislocation	Closed fracture	Knee	Closed fracture : knee	closed fracture knee	428151000	closed fracture of bone of knee joint (disorder)	1	0	0	0	1	1
1211179000	21	11	79	Fracture / dislocation	Closed fracture	Patella	Closed fracture : patella	closed fracture patella knee cap kneecap	80756009	closed fracture of patella (disorder)	1	0	0	0	1	1
1211181000	21	11	81	Fracture / dislocation	Closed fracture	Tibia (not ankle)	Closed fracture : tibia (not ankle)	closed fracture tibia lower leg	447139008	closed fracture of tibia (disorder)	1	1	0	0	1	1
1211183000	21	11	83	Fracture / dislocation	Closed fracture	Fibula (not ankle)	Closed fracture : fibula (not ankle)	closed fracture fibula fibular	447395005	closed fracture of fibula (disorder)	1	1	0	0	1	1
1211185000	21	11	85	Fracture / dislocation	Closed fracture	Tibia AND fibula (not ankle)	Closed fracture : tibia AND fibula (not ankle)	closed fracture tibia fibula fibular	413877007	closed fracture of tibia and fibula (disorder)	1	1	0	0	1	1
1211189000	21	11	89	Fracture / dislocation	Closed fracture	Ankle	Closed fracture : ankle	closed fracture ankle bimalleolar trimalleolar plafond pilon	42188001	closed fracture of ankle (disorder)	1	1	0	0	1	1
1211191000	21	11	91	Fracture / dislocation	Closed fracture	Heel	Closed fracture : heel	closed fracture ankle foot calcaneum heel	64665009	closed fracture of calcaneum (disorder)	1	1	0	0	1	1
1211193000	21	11	93	Fracture / dislocation	Closed fracture	Foot	Closed fracture : foot	closed fracture foot	342070009	closed fracture of foot (disorder)	1	1	0	0	1	1
1211197000	21	11	97	Fracture / dislocation	Closed fracture	Toe	Closed fracture : toe	closed fracture toe	81576005	closed fracture of phalanx of foot (disorder)	1	0	0	0	1	1
1212111000	21	21	11	Fracture / dislocation	Open fracture	Skull	Open fracture : skull	open fracture skull head injury	371161001	open fracture of skull (disorder)	1	0	0	0	1	1
1212118000	21	21	18	Fracture / dislocation	Open fracture	Facial bones / mandible	Open fracture : facial bones / mandible	open fracture facial bones mandible jaw	111609001	open fracture of facial bones (disorder)	1	0	0	0	1	1
1212125000	21	21	25	Fracture / dislocation	Open fracture	Sternum	Open fracture : sternum	open fracture sternum breastbone	87225004	open fracture of sternum (disorder)	1	0	0	0	1	1
1212127000	21	21	27	Fracture / dislocation	Open fracture	Rib (s)	Open fracture : rib (s)	open fracture rib chest pneumothrorax sucking wound	45910007	open fracture of rib (disorder)	1	0	0	0	1	1
1212131000	21	21	31	Fracture / dislocation	Open fracture	Cervical spine	Open fracture : cervical spine	open fracture cervical spine neck	269070003	open fracture of cervical spine (disorder)	1	0	0	0	1	1
1212132000	21	21	32	Fracture / dislocation	Open fracture	Thoracic spine	Open fracture : thoracic spine	open fracture thoracic spine chest	207949005	open fracture thoracic vertebra (disorder)	1	0	0	0	1	1
1212133000	21	21	33	Fracture / dislocation	Open fracture	Lumbar spine	Open fracture : lumbar spine	open fracture lumbar spine	207965006	open fracture lumbar vertebra (disorder)	1	0	0	0	1	1
1212136000	21	21	36	Fracture / dislocation	Open fracture	Sacrum	Open fracture : sacrum	open fracture sacrum pelvis	207977001	open fracture sacrum (disorder)	1	0	0	0	1	1
1212137000	21	21	37	Fracture / dislocation	Open fracture	Coccyx	Open fracture : coccyx	open fracture pelvis coccyx	207981001	open fracture pelvis, coccyx (disorder)	1	0	0	0	1	1
1212139000	21	21	39	Fracture / dislocation	Open fracture	Pelvis	Open fracture : pelvis	open fracture pelvis open book shear	15474008	open fracture of pelvis (disorder)	1	0	0	0	1	1
1212141000	21	21	41	Fracture / dislocation	Open fracture	Clavicle	Open fracture : clavicle	open fracture shoulder clavicle collarbone	111637008	open fracture of clavicle (disorder)	1	0	0	0	1	1
1212143000	21	21	43	Fracture / dislocation	Open fracture	Scapula	Open fracture : scapula	open fracture shoulder scapula shoulderblade acromiom coracoid glenoid	47864008	open fracture of scapula (disorder)	1	0	0	0	1	1
1212145000	21	21	45	Fracture / dislocation	Open fracture	Humerus	Open fracture : humerus	open fracture humerus arm	89294002	open fracture of humerus (disorder)	1	0	0	0	1	1
1212149000	21	21	49	Fracture / dislocation	Open fracture	Elbow	Open fracture : elbow joint	open fracture elbow joint olecranon supracondylar	302232001	open fracture of elbow (disorder)	1	0	0	0	1	1
1212151000	21	21	51	Fracture / dislocation	Open fracture	Radius	Open fracture : radius	open fracture radius colles smiths bartons forearm wrist	42945005	open fracture of radius (disorder)	1	0	0	0	1	1
1212153000	21	21	53	Fracture / dislocation	Open fracture	Ulna	Open fracture : ulna	open fracture ulna forearm	37449000	open fracture of ulna (disorder)	1	0	0	0	1	1
1212156000	21	21	56	Fracture / dislocation	Open fracture	Radius AND ulna	Open fracture : radius AND ulna	open fracture radius ulna banana forearm	81966000	open fracture of radius and ulna (disorder)	1	0	0	0	1	1
1212158000	21	21	58	Fracture / dislocation	Open fracture	Monteggia (frac ulna : disloc rad)	Open fracture : Monteggia (frac ulna : disloc rad)	open fracture monteggia galeazzi radius ulna elbow dislocation forearm	34578006	open Monteggia fracture (disorder)	1	0	0	0	1	1
1212159000	21	21	59	Fracture / dislocation	Open fracture	Galeazzi (frac rad : disloc ulna)	Open fracture : Galeazzi (frac rad : disloc ulna)	open fracture monteggia galeazzi radius ulna wrist dislocation forearm	208341002	open Galeazzi fracture (disorder)	1	0	0	0	1	1
1212160000	21	21	60	Fracture / dislocation	Open fracture	Carpal bones (wrist)	Open fracture : carpal bones	open fracture carpal bones wrist	29014003	open fracture of carpal bone (disorder)	1	0	0	0	1	1
1212161000	21	21	61	Fracture / dislocation	Open fracture	Hand	Open fracture : hand	open fracture metacarpal	1370007	open fracture of metacarpal bone (disorder)	1	0	0	0	1	1
1212165000	21	21	65	Fracture / dislocation	Open fracture	Thumb metacarpal	Open fracture : thumb metacarpal	open fracture thumb bennett rolando	208420009	open fracture of metacarpal of thumb (disorder)	1	0	0	0	1	1
1212166000	21	21	66	Fracture / dislocation	Open fracture	Thumb phalanx	Open fracture : thumb phalanx	open fracture thumb phalanx tip	704236005	open fracture of phalanx of thumb (disorder)	1	0	0	0	1	1
1212167000	21	21	67	Fracture / dislocation	Open fracture	Finger	Open fracture : finger	open fracture finger	21698002	open fracture of phalanx of finger (disorder)	1	0	0	0	1	1
1212169000	21	21	69	Fracture / dislocation	Open fracture	Hip (NoF)	Open fracture : hip (NoF)	open fracture hip nof neck of femur subcapital trochanteric	361118003	open fracture of hip (disorder)	1	0	0	0	1	1
1212171000	21	21	71	Fracture / dislocation	Open fracture	Femur (not NoF)	Open fracture : femur	open fracture femur leg supracondylar	28576007	open fracture of femur (disorder)	1	0	0	0	1	1
1212175000	21	21	75	Fracture / dislocation	Open fracture	Knee	Open fracture : knee	open fracture knee tibia leg	428019004	open fracture of bone of knee joint (disorder)	1	0	0	0	1	1
1212178000	21	21	78	Fracture / dislocation	Open fracture	Patella	Open fracture : patella	open fracture patella knee cap kneecap	111643005	open fracture of patella (disorder)	1	0	0	0	1	1
1212181000	21	21	81	Fracture / dislocation	Open fracture	Tibia (not ankle)	Open fracture : tibia (not ankle)	open fracture lower leg tibia fibula tibial plateau	446979005	open fracture of tibia (disorder)	1	0	0	0	1	1
1212183000	21	21	83	Fracture / dislocation	Open fracture	Fibula (not ankle)	Open fracture : fibula (not ankle)	open fracture lower leg tibia fibula fibular	447017008	open fracture of fibula (disorder)	1	0	0	0	1	1
1212185000	21	21	85	Fracture / dislocation	Open fracture	Tibia AND fibula	Open fracture : tibia AND fibula (not ankle)	open fracture lower leg tibia fibula	414943006	open fracture of tibia and fibula (disorder)	1	0	0	0	1	1
1212189000	21	21	89	Fracture / dislocation	Open fracture	Ankle	Open fracture : ankle	open fracture ankle bimalleolar trimalleolar plafond pilon	48187004	open fracture of ankle (disorder)	1	0	0	0	1	1
1212191000	21	21	91	Fracture / dislocation	Open fracture	Calcaneum	Open fracture : calcaneum	open fracture ankle foot calcaneum heel	24948002	open fracture of calcaneum (disorder)	1	0	0	0	1	1
1212193000	21	21	93	Fracture / dislocation	Open fracture	Foot	Open fracture : foot	open fracture foot toe	367527001	open fracture of foot (disorder)	1	0	0	0	1	1
1212197000	21	21	97	Fracture / dislocation	Open fracture	Toe	Open fracture : toe	open fracture toe foot	74395007	open fracture of phalanx of foot (disorder)	1	0	0	0	1	1
1213111000	21	31	11	Fracture / dislocation	Dislocation	Cervical spine	Dislocation : cervical spine	dislocation cervical spine	44264009	traumatic dislocation of joint of cervical vertebra (disorder)	1	0	0	0	1	1
1213112000	21	31	12	Fracture / dislocation	Dislocation	Thoracic spine	Dislocation : thoracic spine	dislocation thoracic spine	129165008	traumatic dislocation of joint of thoracic vertebra (disorder)	1	0	0	0	1	1
1213113000	21	31	13	Fracture / dislocation	Dislocation	Lumbar spine	Dislocation : lumbar spine	dislocation lumbar spine	129166009	traumatic dislocation of joint of lumbar vertebra (disorder)	1	0	0	0	1	1
1213121000	21	31	21	Fracture / dislocation	Dislocation	Shoulder joint	Dislocation : shoulder joint	dislocation shoulder joint	125615005	traumatic dislocation of shoulder region (disorder)	1	1	0	0	1	1
1213123000	21	31	23	Fracture / dislocation	Dislocation	Elbow joint	Dislocation : elbow joint	dislocation elbow joint monteggia	417558002	dislocation of elbow joint (disorder)	1	1	0	0	1	1
1213131000	21	31	31	Fracture / dislocation	Dislocation	Wrist	Dislocation : wrist	dislocation wrist galeazzi	824071000000106	traumatic dislocation of intercarpal joint (disorder)	1	0	0	0	1	1
1213133000	21	31	33	Fracture / dislocation	Dislocation	Hand	Dislocation : hand	dislocation hand	281503004	dislocation of carpometacarpal joint (disorder)	1	0	0	0	1	1
1213141000	21	31	41	Fracture / dislocation	Dislocation	Thumb	Dislocation : thumb	dislocation of thumb rolando bennett	125620005	traumatic dislocation of joint of thumb (disorder)	1	0	0	0	1	1
1213144000	21	31	44	Fracture / dislocation	Dislocation	Finger	Dislocation : finger	dislocation of finger	125619004	traumatic dislocation of joint of finger (disorder)	1	0	0	0	1	1
1213151000	21	31	51	Fracture / dislocation	Dislocation	Hip (prosthetic joint)	Dislocation : hip (prosthetic joint)	dislocation hip prosthetic joint	314201008	dislocation of hip joint prosthesis (disorder)	1	1	0	0	1	1
1213152000	21	31	52	Fracture / dislocation	Dislocation	Hip (natural joint)	Dislocation : hip (natural joint)	dislocation hip natural joint	125621009	traumatic dislocation of hip joint (disorder)	1	0	0	0	1	1
1213155000	21	31	55	Fracture / dislocation	Dislocation	Knee joint	Dislocation : knee joint	dislocation knee joint	58320001	traumatic dislocation of knee joint (disorder)	1	0	0	0	1	1
1213157000	21	31	57	Fracture / dislocation	Dislocation	Patella	Dislocation : patella	dislocation patella knee cap kneecap	263029007	dislocation of patellofemoral joint (disorder)	1	0	0	0	1	1
1213161000	21	31	61	Fracture / dislocation	Dislocation	Ankle joint	Dislocation : ankle joint	dislocation ankle joint	125622002	traumatic dislocation of ankle joint (disorder)	1	0	0	0	1	1
1213165000	21	31	65	Fracture / dislocation	Dislocation	Foot	Dislocation : foot	dislocation tarsometatarsal joint lisfranc subtarsal forefoot hind	208986008	dislocation or subluxation of foot (disorder)	1	0	0	0	1	1
1213171000	21	31	71	Fracture / dislocation	Dislocation	Toe	Dislocation : toe	dislocation toe	263030002	dislocation of toe joint (disorder)	1	0	0	0	1	1
1311111000	31	11	11	Trauma / FB	Head injury	Minor traumatic brain injury : no LOC	Minor traumatic brain injury (GCS more than 12) : no LOC	concussion syndrome concussive minor head injury concussion gcs LOC loss of consciousness traumatic brain injury	127302008	traumatic brain injury with no loss of consciousness (disorder)	1	1	0	0	1	1
1311113000	31	11	13	Trauma / FB	Head injury	Minor traumatic brain injury : LOC less than 30s	Minor traumatic brain injury (GCS more than 12) : LOC less than 30s	concussion syndrome concussive minor head injury concussion gcs LOC loss of consciousness traumatic brain injury	127299008	traumatic brain injury with brief loss of consciousness (disorder)	1	1	0	0	1	1
1311115000	31	11	15	Trauma / FB	Head injury	Minor traumatic brain injury : LOC more than 30s	Minor traumatic brain injury (GCS more than 12) : LOC more than 30s	concussion syndrome concussive minor head injury concussion gcs LOC loss of consciousness traumatic brain injury	127300000	traumatic brain injury with moderate loss of consciousness (disorder)	1	1	0	0	1	1
1311118000	31	11	18	Trauma / FB	Head injury	Post concussion syndrome	Post concussion syndrome (more than 1 day post incident)	concussion syndrome concussive minor head injury concussion gcs LOC loss of consciousness traumatic brain injury	40425004	postconcussion syndrome (disorder)	1	0	0	0	1	1
1311121000	31	11	21	Trauma / FB	Head injury	Subdural hematoma	Subdural hematoma	subdural hematoma sdh major head injury trauma haemorrhage bleed brain	262952002	traumatic intracranial subdural hematoma (disorder)	1	0	0	0	1	1
1311131000	31	11	31	Trauma / FB	Head injury	Extradural haematoma	Extradural haematoma	extradural haematoma epidural edh major head injury head injury trauma haemorrhage bleed brain	262949005	traumatic extradural haematoma (disorder)	1	0	0	0	1	1
1311141000	31	11	41	Trauma / FB	Head injury	Traumatic subarachnoid haemorrhage	Traumatic subarachnoid haemorrhage	traumatic subarachnoid haemorrhage sah major head injury bleed brain	262955000	traumatic intracranial subarachnoid hemorrhage (disorder)	1	0	0	0	1	1
1311145000	31	11	45	Trauma / FB	Head injury	Traumatic intracerebral haemorrhage	Traumatic intracerebral haemorrhage	head injury trauma intracerebral haemorrhage bleed brain	450418003	traumatic intracerebral haemorrhage (disorder)	1	0	0	0	1	1
1311151000	31	11	51	Trauma / FB	Head injury	Diffuse axonal injury	Diffuse axonal injury	diffuse brain axonal injury major head trauma haemorrhage bleed brain	262693007	diffuse brain injury (disorder)	1	0	0	0	1	1
1311161000	31	11	61	Trauma / FB	Head injury	Contusion of brain	Contusion of brain	contusion of brain cerebral cerebellar cerebrum cerebellum bruising trauma haemorrhage bleed brain	34663006	contusion of brain (disorder)	1	0	0	0	1	1
1311181000	31	11	81	Trauma / FB	Head injury	Moderate traumatic brain injury (GCS less than 13)	Moderate traumatic brain injury (GCS less than 13)	concussion syndrome concussive minor moderate severe head injury concussion gcs LOC loss of consciousness traumatic brain injury	314661000	moderate head injury (disorder)	1	0	0	0	1	1
1311185000	31	11	85	Trauma / FB	Head injury	Severe traumatic brain injury (GCS less than 9)	Severe traumatic brain injury (GCS less than 9)	concussion syndrome concussive minor moderate severe head injury concussion gcs LOC loss of consciousness traumatic brain injury	314662007	major head injury (disorder)	1	0	0	0	1	1
1312111000	31	21	11	Trauma / FB	Dental injury	Simple tooth fracture	Fracture of tooth (simple)	simple tooth fracture	42744004	broken tooth without complication (disorder)	1	0	0	0	1	1
1312121000	31	21	21	Trauma / FB	Dental injury	Complicated tooth fracture	Fracture of tooth (complex)	complicated tooth fracture	58411009	broken tooth with complication (disorder)	1	0	0	0	1	1
1312131000	31	21	31	Trauma / FB	Dental injury	Loose tooth	Loose tooth / teeth	luxation of tooth loose teeth ligament	109678002	extrusive luxation of tooth (disorder)	1	0	0	0	1	1
1312141000	31	21	41	Trauma / FB	Dental injury	Tooth removed from socket	Tooth/ teeth removed from socket	avulsion of tooth teeth removed out	109671008	complete avulsion of tooth (disorder)	1	0	0	0	1	1
1313111000	31	31	11	Trauma / FB	Neck injury	Airway injury	Airway injury	neck injury airway injury	125588009	injury of larynx (disorder)	1	0	0	0	1	1
1313121000	31	31	21	Trauma / FB	Neck injury	Vascular injury	Vascular injury	neck injury vascular injury	262937009	injury to blood vessel of neck (disorder)	1	0	0	0	1	1
1314111000	31	41	11	Trauma / FB	Thoracic injury	Traumatic pneumothorax	Traumatic pneumothorax	thoracic injury traumatic pneumothorax	90070003	traumatic pneumothorax (disorder)	1	0	0	0	1	1
1314121000	31	41	21	Trauma / FB	Thoracic injury	Tension pneumothorax	Tension pneumothorax	tension pneumothorax	233645004	tension pneumothorax (disorder)	1	0	0	0	1	1
1314122000	31	41	22	Trauma / FB	Thoracic injury	Flail chest	Flail chest	thoracic injury flail chest	78011002	flail chest (disorder)	1	0	0	0	1	1
1314123000	31	41	23	Trauma / FB	Thoracic injury	Open chest wound	Open chest wound	thoracic injury open chest wound	127315004	sucking chest wound (disorder)	1	0	0	0	1	1
1314131000	31	41	31	Trauma / FB	Thoracic injury	Haemopneumothorax	Haemopneumothorax	thoracic injury haemopneumothorax	42434002	traumatic pneumohemothorax (disorder)	1	0	0	0	1	1
1314132000	31	41	32	Trauma / FB	Thoracic injury	Massive haemothorax	Massive haemothorax	thoracic injury massive haemothorax	42458003	traumatic hemothorax (disorder)	1	0	0	0	1	1
1314171000	31	41	71	Trauma / FB	Thoracic injury	Lung contusion	Lung contusion	lung contusion flail	262784001	contusion of lung (disorder)	1	0	0	0	1	1
1314181000	31	41	81	Trauma / FB	Thoracic injury	Injury of heart	Injury of heart	injury heart cardiac tamponade	86175003	injury of heart (disorder)	1	0	0	0	1	1
1314182000	31	41	82	Trauma / FB	Thoracic injury	Injury of thoracic aorta	Injury of thoracic aorta	aorta dissection rupture tear	59568004	injury of thoracic aorta (disorder)	1	0	0	0	1	1
1315111000	31	51	11	Trauma / FB	Abdominal injury	Injury of bowel	Injury of bowel	bowel intestine perforation	125625000	injury of intestine (disorder)	1	0	0	0	1	1
1315121000	31	51	21	Trauma / FB	Abdominal injury	Injury of spleen	Injury of spleen	spleen splenic	23589004	injury of spleen (disorder)	1	0	0	0	1	1
1315122000	31	51	22	Trauma / FB	Abdominal injury	Injury of liver	Injury of liver	liver hepatic segment lobe	39400004	injury of liver (disorder)	1	0	0	0	1	1
1315131000	31	51	31	Trauma / FB	Abdominal injury	Injury of stomach	Injury of stomach	injury stomach	125626004	injury of stomach (disorder)	1	0	0	0	1	1
1315135000	31	51	35	Trauma / FB	Abdominal injury	Injury of pancreas	Injury of pancreas	injury pancreas	61823004	injury of pancreas (disorder)	1	0	0	0	1	1
1315141000	31	51	41	Trauma / FB	Abdominal injury	Injury of abdominal aorta	Injury of abdominal aorta	injury abdominal aorta	10392004	injury of abdominal aorta (disorder)	1	0	0	0	1	1
1315151000	31	51	51	Trauma / FB	Abdominal injury	Injury of kidney	Injury of kidney	kidney renal injury	40095003	injury of kidney (disorder)	1	0	0	0	1	1
1315161000	31	51	61	Trauma / FB	Abdominal injury	Injury of bladder	Injury of bladder	injury of bladder	77165001	injury of bladder (disorder)	1	0	0	0	1	1
1315171000	31	51	71	Trauma / FB	Abdominal injury	Abdominal trauma in pregnancy	Abdominal trauma in pregnancy	abdominal trauma pregnancy gravid pregnant	426997005	traumatic injury during pregnancy (disorder)	1	0	0	0	1	1
1316111000	31	61	11	Trauma / FB	Amputation / partial amputation	Ear	Amputation / partial amputation : ear	amputation ear	210305005	traumatic amputation of ear (disorder)	1	0	0	0	1	1
1316113000	31	61	13	Trauma / FB	Amputation / partial amputation	Nose	Amputation / partial amputation : nose	amputation nose	722704008	traumatic amputation of nose (disorder)	1	0	0	0	1	1
1316115000	31	61	15	Trauma / FB	Amputation / partial amputation	Tongue	Amputation / partial amputation : tongue	amputation tongue	813131000000104	traumatic amputation of tongue (disorder)	1	0	0	0	1	1
1316131000	31	61	31	Trauma / FB	Amputation / partial amputation	Shoulder	Amputation / partial amputation : shoulder	amputation shoulder forequarter limb	210649003	traumatic amputation, through shoulder (disorder)	1	0	0	0	1	1
1316133000	31	61	33	Trauma / FB	Amputation / partial amputation	Upper arm	Amputation / partial amputation : upper arm	amputation upper arm limb	210650003	traumatic amputation, above elbow (disorder)	1	0	0	0	1	1
1316135000	31	61	35	Trauma / FB	Amputation / partial amputation	Forearm	Amputation / partial amputation : forearm	amputation forearm limb	210642007	traumatic amputation, below elbow (disorder)	1	0	0	0	1	1
1316137000	31	61	37	Trauma / FB	Amputation / partial amputation	Hand	Amputation / partial amputation : hand	amputation hand limb	95856002	traumatic amputation of hand (disorder)	1	0	0	0	1	1
1316139000	31	61	39	Trauma / FB	Amputation / partial amputation	Thumb	Amputation / partial amputation : thumb	amputation thumb limb	210611002	traumatic amputation of thumb (disorder)	1	0	0	0	1	1
1316141000	31	61	41	Trauma / FB	Amputation / partial amputation	Finger	Amputation / partial amputation : finger	amputation digits finger ring middle index	95855003	traumatic amputation of finger (disorder)	1	0	0	0	1	1
1316151000	31	61	51	Trauma / FB	Amputation / partial amputation	Genital	Amputation / partial amputation : genital	amputation genital	211548006	traumatic amputation of external genital organs (disorder)	1	0	0	0	1	1
1316161000	31	61	61	Trauma / FB	Amputation / partial amputation	Hip	Amputation / partial amputation : hip	amputation lower limb extremity hindquarter	210762009	traumatic amputation, through hip (disorder)	1	0	0	0	1	1
1316163000	31	61	63	Trauma / FB	Amputation / partial amputation	Femur	Amputation / partial amputation : femur	amputation femur limb	824061000000104	traumatic amputation above knee (disorder)	1	0	0	0	1	1
1316165000	31	61	65	Trauma / FB	Amputation / partial amputation	Tibia / fibula	Amputation / partial amputation : tibia/ fibula	amputation partial amputation tibia fibula limb	812431000000103	traumatic amputation below knee (disorder)	1	0	0	0	1	1
1316167000	31	61	67	Trauma / FB	Amputation / partial amputation	Foot	Amputation / partial amputation : foot	amputation foot	95859009	traumatic amputation of foot (disorder)	1	0	0	0	1	1
1316169000	31	61	69	Trauma / FB	Amputation / partial amputation	Toe	Amputation / partial amputation : toe	amputation partial amputation toe	95858001	traumatic amputation of toe (disorder)	1	0	0	0	1	1
1317111000	31	71	11	Trauma / FB	Foreign body	In / under skin	Foreign body : in / under skin	open wound fb	213282006	foreign body left in wound (disorder)	1	0	0	0	1	1
1317113000	31	71	13	Trauma / FB	Foreign body	Ear canal	Foreign body : ear canal	foreign body ear fb	75441006	foreign body in ear (disorder)	1	0	0	0	1	1
1317115000	31	71	15	Trauma / FB	Foreign body	Nose	Foreign body : nose	nose foreign body nasal fb	74699008	foreign body in nose (disorder)	1	0	0	0	1	1
1317121000	31	71	21	Trauma / FB	Foreign body	Respiratory tract	Foreign body : respiratory tract	respiratory foreign body inhaled lung bronchus trachea fb	262599003	foreign body in respiratory tract (disorder)	1	0	0	0	1	1
1317131000	31	71	31	Trauma / FB	Foreign body	Alimentary tract	Foreign body : alimentary tract	foreign body digestive tract swallowed gi tract fb alimentary	33334006	foreign body in digestive tract (disorder)	1	0	0	0	1	1
1317141000	31	71	41	Trauma / FB	Foreign body	Vulva / vagina	Foreign body : vulva / vagina	foreign body female genitalia vagina vulva fb	34124000	foreign body in vagina (disorder)	1	0	0	0	0	1
1317142000	31	71	42	Trauma / FB	Foreign body	Penis	Foreign body : penis	foreign body male genitalia penis fb	73830004	foreign body in penis (disorder)	1	0	0	0	1	1
1317151000	31	71	51	Trauma / FB	Foreign body	Rectum	Foreign body : rectum	foreign body rectum fb	70176004	foreign body in rectum (disorder)	1	0	0	0	1	0
1317171000	31	71	71	Trauma / FB	Foreign body	Ring too tight on digit / extremity	Ring too tight on digit / extremity	ring tight on finger thumb toe digit penis	248406004	ring tight on fingers (finding)	1	0	0	0	1	1
1318111000	31	81	11	Trauma / FB	Complication of injury	Injury of blood vessel	Complication of soft tissue injury : vascular	complication injury vascular vessel artery vein	57662003	injury of blood vessel (disorder)	1	0	0	0	1	1
1318141000	31	81	41	Trauma / FB	Complication of injury	Injury of nerve	Complication of soft tissue injury : neurological	complication injury neurological nerve neurapraxia axonotmesis neurotmesis	57182000	nerve injury (disorder)	1	0	0	0	1	1
1318142000	31	81	42	Trauma / FB	Complication of injury	Spinal cord injury	Spinal cord injury	spinal cord injury cervical thoracic lumbar paralysis	90584004	spinal cord injury (disorder)	1	0	0	0	1	1
1318151000	31	81	51	Trauma / FB	Complication of injury	Injury of tendon	Complication of soft tissue injury : tendon	complication injury tendon	240037007	tendon injury (disorder)	1	0	0	0	1	1
1318161000	31	81	61	Trauma / FB	Complication of injury	Rhabdomyolysis	Rhabdomyolysis	rhabdomyolysis muscle	240131006	rhabdomyolysis (disorder)	0	0	0	0	1	1
1318171000	31	81	71	Trauma / FB	Complication of injury	Compartment syndrome	Complication of soft tissue injury : compartment syndrome	complication injury rhabdomyolysis compartment syndrome plaster pop leg pain calf	111245009	muscle crush syndrome (disorder)	1	0	0	0	1	1
1411111000	41	11	11	Medical	Cardiac	Acute coronary syndrome (ACS)	Acute coronary syndrome (ACS)	angina chest pain heart attack ami myocardial infarction costochondritis ACS acute coronary syndrome	394659003	acute coronary syndrome (disorder)	0	1	0	0	1	1
1411112000	41	11	12	Medical	Cardiac	Myocardial infarction (STEMI)	Myocardial infarction (STEMI)	angina chest pain heart attack ami myocardial infarction costochondritis ACS acute coronary syndrome	401303003	acute ST segment elevation myocardial infarction (disorder)	0	0	0	0	1	1
1411113000	41	11	13	Medical	Cardiac	Myocardial infarction (NSTEMI)	Myocardial infarction (NSTEMI)	angina chest pain heart attack ami myocardial infarction costochondritis ACS acute coronary syndrome	401314000	acute non-ST segment elevation myocardial infarction (disorder)	0	0	0	0	1	1
1411118000	41	11	18	Medical	Cardiac	Angina - unstable	Angina (unstable)	angina chest pain heart attack ami myocardial infarction costochondritis ACS acute coronary syndrome	4557003	pre-infarction syndrome (disorder)	0	0	0	0	1	1
1411119000	41	11	19	Medical	Cardiac	Angina - stable	Angina (stable)	angina chest pain heart attack ami myocardial infarction costochondritis ACS acute coronary syndrome	233819005	stable angina (disorder)	0	1	0	0	1	1
1411121000	41	11	21	Medical	Cardiac	Congestive cardiac failure	Congestive cardiac failure	ccf heart failure cardiac failure angina chest pain heart attack ami myocardial infarction	42343007	congestive heart failure (disorder)	0	1	0	0	1	1
1411123000	41	11	23	Medical	Cardiac	Left-sided heart failure	Left ventricular failure	left ventricular failure lvf cardiac heart attack myocardial infarction	85232009	left heart failure (disorder)	0	1	0	0	1	1
1411127000	41	11	27	Medical	Cardiac	Acute pulmonary oedema	Acute pulmonary oedema	pulmonary oedema edema angina chest pain heart attack ami myocardial infarction costochondritis	40541001	acute pulmonary edema (disorder)	0	0	0	0	1	1
1411129000	41	11	29	Medical	Cardiac	Cardiogenic shock	Cardiogenic shock	cardiogenic shock chest pain ami myocardial infarction heart attack	89138009	cardiogenic shock (disorder)	0	0	0	0	1	1
1411131000	41	11	31	Medical	Cardiac	Postural hypotension	Postural hypotension	postural hypotension faint vasovagal syncope	28651003	orthostatic hypotension (disorder)	0	1	0	0	1	1
1411133000	41	11	33	Medical	Cardiac	Vasovagal syncope	Vasovagal syncope	collapse vasovagal faint syncope postural hypotension	398665005	vasovagal syncope (disorder)	0	1	0	0	1	1
1411137000	41	11	37	Medical	Cardiac	Micturition syncope	Micturition syncope	collapse vasovagal faint syncope	234168001	micturition syncope (disorder)	0	1	0	0	1	1
1411151000	41	11	51	Medical	Cardiac	Hypertension	Hypertension	hypertension high blood pressure	38341003	hypertensive disorder, systemic arterial (disorder)	0	0	0	0	1	1
1411153000	41	11	53	Medical	Cardiac	Pulmonary hypertension	Pulmonary hypertension	pulmonary hypertension	70995007	pulmonary hypertension (disorder)	0	0	0	0	1	1
1411155000	41	11	55	Medical	Cardiac	Malignant hypertension	Malignant hypertension	malignant hypertension crisis accelerated blood pressure BP	70272006	malignant hypertension (disorder)	0	0	0	0	1	1
1411161000	41	11	61	Medical	Cardiac	Heart valve disorder	Heart valve disorder	aortic rheumatic pulmonary tricuspid mitral	368009	heart valve disorder (disorder)	0	0	0	0	1	1
1411181000	41	11	81	Medical	Cardiac	Pericarditis	Pericarditis	pericarditis pericardial effusion	3238004	pericarditis (disorder)	0	0	0	0	1	1
1411182000	41	11	82	Medical	Cardiac	Pericardial effusion	Pericardial effusion	pericardial effusion pericarditis myocarditis	373945007	pericardial effusion (disorder)	0	0	0	0	1	1
1411183000	41	11	83	Medical	Cardiac	Myocarditis	Myocarditis	myocarditis endocarditis pericarditis	50920009	myocarditis (disorder)	0	0	0	0	1	1
1411185000	41	11	85	Medical	Cardiac	Endocarditis	Endocarditis	endocarditis myocarditis pericarditis	56819008	endocarditis (disorder)	0	0	0	0	1	1
1411188000	41	11	88	Medical	Cardiac	Cardiomyopathy	Cardiomyopathy	cardiomyopathy myocarditis	85898001	cardiomyopathy (disorder)	0	0	0	0	1	1
1411311000	41	13	11	Medical	Cardiac electrical	Atrial fibrillation/ flutter	Atrial fibrillation / flutter	af fibrillation flutter	49436004	atrial fibrillation (disorder)	0	1	0	0	1	1
1411315000	41	13	15	Medical	Cardiac electrical	Supraventricular tachycardia	Supraventricular tachycardia	svt supraventricular tachycardia	6456007	supraventricular tachycardia (disorder)	0	1	0	0	1	1
1411319000	41	13	19	Medical	Cardiac electrical	Multi-focal atrial tachycardia	Multifocal atrial tachycardia	multifocal atrial tachycardia atrial fibrillation flutter	49982000	multifocal atrial tachycardia (disorder)	0	0	0	0	1	1
1411331000	41	13	31	Medical	Cardiac electrical	Ventricular tachycardia	Ventricular tachycardia	ventricular tachycardia	25569003	ventricular tachycardia (disorder)	0	0	0	0	1	1
1411339000	41	13	39	Medical	Cardiac electrical	Ventricular extrasystole	Ventricular extrasystole	ectopic extrasystole premature	29717002	premature beats (disorder)	0	0	0	0	1	1
1411351000	41	13	51	Medical	Cardiac electrical	Heart block - first degree	Heart block : first degree	heart block - first degree trifasicular atrioventricular	270492004	atrioventricular block first degree (disorder)	0	0	0	0	1	1
1411353000	41	13	53	Medical	Cardiac electrical	Heart block - second degree - Mobitz type I	Heart block : second degree : Mobitz type I	heart block - second degree mobitz type i 1 atrioventricular wenkebach	54016002	partial atrioventricular block Mobitz I (disorder)	0	0	0	0	1	1
1411354000	41	13	54	Medical	Cardiac electrical	Heart block - second degree - Mobitz type II	Heart block : second degree : Mobitz type II	heart block - second degree mobitz type ii 2 atrioventricular	28189009	partial atrioventricular block Mobitz II (disorder)	0	0	0	0	1	1
1411355000	41	13	55	Medical	Cardiac electrical	Heart block - third degree (complete)	Heart block : third degree (complete)	heart block - third degree complete atrioventricular	27885002	complete atrioventricular block (disorder)	0	0	0	0	1	1
1411357000	41	13	57	Medical	Cardiac electrical	Right bundle branch block	Right bundle branch block	right bundle branch block fasicle	59118001	right bundle branch block (disorder)	0	0	0	0	1	1

1411358000	41	13	58	Medical	Cardiac electrical	Left bundle branch block	Left bundle branch block	left bundle branch block fasicle	63467002	left bundle branch block (disorder)	0	0	0	0	1	1
1411361000	41	13	61	Medical	Cardiac electrical	Bifasicular block	Bifasicular block	bifasicular block rbbb lad right bundle fasicle branch block left axis deviation	74021003	bifasicular block (disorder)	0	0	0	0	1	1
1411362000	41	13	62	Medical	Cardiac electrical	Trifasicular block	Trifasicular block	trifasicular block rbbb lad right bundle branch block fasicle left axis deviation	86014007	trifasicular block (disorder)	0	0	0	0	1	1
1411365000	41	13	65	Medical	Cardiac electrical	Conduction disorder / heart block	Conduction disorder / heart block	heart conduction disorder	418341009	atrioventricular conduction disorder (disorder)	0	1	0	0	1	1
1411367000	41	13	67	Medical	Cardiac electrical	Sinus node dysfunction	Sinus node dysfunction	sinus node dysfunction sick brady tachy syndrome	36083008	sick sinus syndrome (disorder)	0	1	0	0	1	1
1411369000	41	13	69	Medical	Cardiac electrical	Bradycardia	Bradycardia	bradycardia	48867003	bradycardia (disorder)	0	0	0	0	1	1
1411371000	41	13	71	Medical	Cardiac electrical	Pre-excitation syndrome	Pre-excitation (WPW / LGL)	wolff parkinson white lown ganong levine pre-excitation kent accessory	195060002	ventricular pre-excitation (disorder)	0	0	0	0	1	1
1411373000	41	13	73	Medical	Cardiac electrical	Brugada syndrome	Brugada syndrome	brugada syndrome mitochodria channelopathy	418818005	Brugada syndrome (disorder)	0	0	0	0	1	1
1411375000	41	13	75	Medical	Cardiac electrical	Long QT syndrome	Long QT syndrome	long qt syndrome qtc	9651007	long QT syndrome (disorder)	0	0	0	0	1	1
1411379000	41	13	79	Medical	Cardiac electrical	Arrhythmia : other	Arrhythmia : other	arrhythmia rhythm cardiac heart	44808001	conduction disorder of the heart (disorder)	0	0	0	0	1	1
1411391000	41	13	91	Medical	Cardiac electrical	Mechanical complication of cardiac electronic device	Mechanical complication of cardiac electronic device	complication electronic pacemaker implantable device cardiac icd ppm event recorder	271966006	disorder of cardiovascular prostheses and implants (disorder)	1	0	0	0	1	1
1411395000	41	13	95	Medical	Cardiac electrical	Discharge of implantable cardiac defibrillator	Discharge of implantable cardiac defibrillator	discharge implantable cardiac defibrillator icd	431415002	management of internal defibrillation (procedure)	0	0	0	0	1	1
1411399000	41	13	99	Medical	Cardiac electrical	Cardiac arrest	Cardiac arrest	cardiac arrest heart	410429000	cardiac arrest (disorder)	0	0	0	0	1	1
1412111000	41	21	11	Medical	Gastroenterology	Gastro-oesophageal reflux	Gastro-oesophageal reflux	gastroesophageal reflux gord	235595009	gastroesophageal reflux disease (disorder)	0	0	0	0	1	1
1412112000	41	21	12	Medical	Gastroenterology	Gastritis	Gastritis	gastritis ulcer peptic	4556007	gastritis (disorder)	0	0	0	0	1	1
1412115000	41	21	15	Medical	Gastroenterology	Gastroduodenal ulcer	Gastroduodenal ulcer	gastroduodenal peptic ulcer gastritis	13200003	Peptic ulcer (disorder)	0	0	0	0	1	1
1412117000	41	21	17	Medical	Gastroenterology	Constipation	Constipation	constipation	14760008	constipation (disorder)	0	0	0	0	1	1
1412119000	41	21	19	Medical	Gastroenterology	Complication of gastrostomy (PEG tube)	Complication of gastrostomy (PEG tube)	gastrostomy stoma stroke peg tube fall out fell	309773000	complication of gastrostomy (disorder)	0	1	0	0	1	1
1412121000	41	21	21	Medical	Gastroenterology	Upper gastrointestinal hemorrhage	Upper gastrointestinal hemorrhage	upper gastrointestinal hemorrhage haematemesis gi bleed	37372002	upper gastrointestinal hemorrhage (disorder)	0	1	0	0	1	1
1412122000	41	21	22	Medical	Gastroenterology	Lower gastrointestinal hemorrhage	Lower gastrointestinal hemorrhage	lower gastrointestinal hemorrhage melaena gi bleed	87763006	lower gastrointestinal hemorrhage (disorder)	0	1	0	0	1	1
1412141000	41	21	41	Medical	Gastroenterology	Oesophageal spasm	Oesophageal spasm	oesophagus spasm	79962008	diffuse spasm of esophagus (disorder)	0	0	0	0	1	1
1412142000	41	21	42	Medical	Gastroenterology	Oesophageal stricture	Oesophageal stricture	oesophagus stricture oesophageal	63305008	stricture of esophagus (disorder)	0	1	0	0	1	1
1412144000	41	21	44	Medical	Gastroenterology	Ingestion of corrosive acid / alkali	Ingestion of corrosive acid / alkali	ingestion of corrosive acid or caustic alkali bleach cleaning	418409002	Poisoning of undetermined intent by corrosive, acid or caustic alkali (disorder)	1	0	0	0	1	1
1412147000	41	21	47	Medical	Gastroenterology	Oesophageal perforation	Oesophageal perforation	oesophagus perforation	23387001	perforation of esophagus (disorder)	0	0	0	0	1	1
1412149000	41	21	49	Medical	Gastroenterology	Oesophageal varices with bleeding	Oesophageal varices with bleeding	oesophageal varices with bleeding liver	17709002	bleeding esophageal varices (disorder)	0	0	0	0	1	1
1412161000	41	21	61	Medical	Gastroenterology	Hepatitis	Hepatitis	hepatitis liver	128241005	inflammatory disease of liver (disorder)	0	0	0	0	1	1
1412163000	41	21	63	Medical	Gastroenterology	Chronic liver disease	Chronic liver disease	chronic liver disease hepatic	328383001	chronic liver disease (disorder)	0	0	0	0	1	1
1412166000	41	21	66	Medical	Gastroenterology	Ascites	Ascites	ascites	389026000	ascites (disorder)	0	0	0	0	1	1
1412168000	41	21	68	Medical	Gastroenterology	Hepatic failure or coma	Hepatic failure or coma	liver failure hepatic failure jaundice encephalopathy	59927004	hepatic failure (disorder)	0	0	0	0	1	1
1412181000	41	21	81	Medical	Gastroenterology	Crohns disease	Crohns disease	crohns disease uc ulcerative colitis inflammatory bowel	34000006	Crohn's disease (disorder)	0	0	0	0	1	1
1412185000	41	21	85	Medical	Gastroenterology	Ulcerative colitis	Ulcerative colitis	uc ulcerative colitis crohns disease inflammatory bowel	64766004	ulcerative colitis (disorder)	0	0	0	0	1	1
1412191000	41	21	91	Medical	Gastroenterology	Irritable bowel syndrome	Irritable bowel syndrome	irritable bowel	10743008	irritable bowel syndrome (disorder)	0	0	0	0	1	1
1413111000	41	31	11	Medical	Neurology	Migraine	Migraine	headache migraine	37796009	migraine (disorder)	0	1	0	0	1	1
1413112000	41	31	12	Medical	Neurology	Tension headache	Tension headache	headache tension	398057008	tension-type headache (disorder)	0	0	0	0	1	1
1413114000	41	31	14	Medical	Neurology	Ventriculoperitoneal shunt : complication	Ventriculoperitoneal shunt : complication	ventricular peritoneal drain catheter complication	371077002	ventriculoperitoneal shunt malfunction (disorder)	0	0	0	0	1	1
1413121000	41	31	21	Medical	Neurology	Stroke	Stroke	stroke cva cerebrovascular accident tia transient ischaemic weakness	230690007	cerebrovascular accident (disorder)	0	1	0	0	1	1
1413122000	41	31	22	Medical	Neurology	Transient ischaemic attack	Transient ischaemic attack	transient ischemic attack tia stroke weakness	266257000	transient ischemic attack (disorder)	0	1	0	0	1	1
1413123000	41	31	23	Medical	Neurology	Subarachnoid haemorrhage	Subarachnoid haemorrhage	subarachnoid sah stroke brain bleed headache	21454007	subarachnoid hemorrhage (disorder)	0	0	0	0	1	1
1413124000	41	31	24	Medical	Neurology	Intracerebral haemorrhage	Intracerebral haemorrhage	cerebral haemorrhage bleed brain stroke headache	274100004	cerebral hemorrhage (disorder)	0	0	0	0	1	1
1413131000	41	31	31	Medical	Neurology	Status epilepticus	Status epilepticus	status epilepticus fit tonic clonic grand mal seizure	230456007	status epilepticus (disorder)	0	1	0	0	1	1
1413132000	41	31	32	Medical	Neurology	Epilepsy : generalised	Epilepsy : generalised	epilepsy status fit seizure tonic clonic grand mal epilepticus	352818000	tonic-clonic epilepsy (disorder)	0	1	0	0	1	1
1413134000	41	31	34	Medical	Neurology	Epilepsy : absence	Epilepsy : absence	epilepsy petit mal absence seizure fit grand	79631006	absence seizure (disorder)	0	1	0	0	1	1
1413136000	41	31	36	Medical	Neurology	Epilepsy : focal	Epilepsy : focal	epilepsy focal partial local seizure fit grand mal petit status	29753000	focal seizure (disorder)	0	1	0	0	1	1
1413139000	41	31	39	Medical	Neurology	Pseudoseizure	Pseudoseizure	pseudo-fit pseudo seizure hysteria functional somatoform non epileptiform epileptic attack disorder status epilepticus	191714002	dissociative convulsions (disorder)	0	0	0	0	1	1
1413141000	41	31	41	Medical	Neurology	Bell palsy	Bell palsy	bell palsy stroke face weakness bells	193093009	Bell's palsy (disorder)	0	0	0	0	1	1
1413142000	41	31	42	Medical	Neurology	Trigeminal neuralgia	Trigeminal neuralgia	trigeminal neuralgia face facial pain	31681005	trigeminal neuralgia (disorder)	0	0	0	0	1	1
1413143000	41	31	43	Medical	Neurology	Cranial nerve disorder	Cranial nerve palsy	isolated cranial nerve palsy disorder	73013002	cranial nerve disorder (disorder)	0	0	0	0	1	1
1413147000	41	31	47	Medical	Neurology	Carpal tunnel syndrome	Carpal tunnel syndrome	carpal tunnel median nerve	57406009	carpal tunnel syndrome (disorder)	0	0	0	0	1	1
1413149000	41	31	49	Medical	Neurology	Meralgia parasthetica	Meralgia parasthetica	lateral cutaneous nerve thigh meralgia parasthetica	85007004	meralgia paresthetica (disorder)	0	0	0	0	1	1
1413151000	41	31	51	Medical	Neurology	Guillain-Barre syndrome	Guillain-Barre syndrome	guillan barre polyneuropathy	40956001	Guillain-Barré syndrome (disorder)	0	0	0	0	1	1
1413160000	41	31	60	Medical	Neurology	Dystonic reaction	Dystonic reaction	oculogyric crisis dystonic reaction	230316009	drug-induced acute dystonia (disorder)	0	0	0	0	1	1
1413161000	41	31	61	Medical	Neurology	Parkinson's disease	Parkinson's disease	parkinson disease tremor	32798002	parkinsonism (disorder)	0	0	0	0	1	1
1413162000	41	31	62	Medical	Neurology	Multiple sclerosis	Multiple sclerosis	ms multiple sclerosis optic atrophy	24700007	multiple sclerosis (disorder)	0	0	0	0	1	1
1413181000	41	31	81	Medical	Neurology	Intracranial space occupying lesion	Intracranial space occupying lesion	brain tumour intracranial space occupying headache	254935002	intracranial tumor (disorder)	0	0	0	0	1	1
1413199000	41	31	99	Medical	Neurology	Other nervous system disorder (see free text)	Other nervous system disorder (see free text)	neurological neuro	118940003	disorder of nervous system (disorder)	0	0	0	0	1	1
1414111000	41	41	11	Medical	Respiratory	Asthma	Asthma	asthma wheeze COPD chronic obstructive pulmonary airways pulmonary bronchiolitis allergy anaphylaxis	195967001	asthma (disorder)	0	1	0	0	1	1
1414115000	41	41	15	Medical	Respiratory	Chronic obstructive pulmonary disease	Chronic obstructive pulmonary disease	copd chronic obstructive lung disease asthma airways pink puffer blue bloater	13645005	chronic obstructive lung disease (disorder)	0	1	0	0	1	1
1414121000	41	41	21	Medical	Respiratory	Pulmonary embolism	Pulmonary embolism	pe pulmonary embolism dvt deep venous thrombosis	59282003	pulmonary embolism (disorder)	0	1	0	0	1	1
1414131000	41	41	31	Medical	Respiratory	Spontaneous pneumothorax	Spontaneous pneumothorax	spontaneous pneumothorax pneumothorax	80423007	spontaneous pneumothorax (disorder)	0	1	0	0	1	1
1414135000	41	41	35	Medical	Respiratory	Aspiration pneumonia	Aspiration pneumonia	aspiration pneumonia	422588002	aspiration pneumonia (disorder)	0	0	0	0	1	1
1414137000	41	41	37	Medical	Respiratory	Pleural effusion	Pleural effusion	pleural effusion lung	60046008	pleural effusion (disorder)	0	1	0	0	1	1
1414139000	41	41	39	Medical	Respiratory	Empyema	Empyema	empyema	58554001	empyema of pleura (disorder)	0	0	0	0	1	1
1414147000	41	41	47	Medical	Respiratory	Respiratory failure	Respiratory failure	respiratory failure	409622000	respiratory failure (disorder)	0	0	0	0	1	1
1414149000	41	41	49	Medical	Respiratory	Respiratory arrest	Respiratory arrest	respiratory arrest cardiac cardiorespiratory	87317003	respiratory arrest (disorder)	0	0	0	0	1	1
1414175000	41	41	75	Medical	Respiratory	Cystic fibrosis	Cystic fibrosis	cystic fibrosis cf	190905008	cystic fibrosis (disorder)	0	0	0	0	1	1
1414189000	41	41	89	Medical	Respiratory	Haemoptysis	Haemoptysis	haemoptysis cough blood	66857006	hemoptysis (disorder)	0	0	0	0	1	1
1415111000	41	51	11	Medical	Haem / oncology	Anaemia	Anaemia	anaemia pale	271737000	anemia (disorder)	0	1	0	0	1	1
1415113000	41	51	13	Medical	Haem / oncology	Anaemia - iron deficiency	Anaemia : iron deficiency	anaemia iron deficiency pale	87522002	iron deficiency anemia (disorder)	0	1	0	0	1	1
1415115000	41	51	15	Medical	Haem / oncology	Idiopathic thrombocytopenic purpura	Idiopathic thrombocytopenic purpura	idiopathic thrombocytopenic purpura itp	32273002	idiopathic thrombocytopenic purpura (disorder)	0	0	0	0	1	1
1415121000	41	51	21	Medical	Haem / oncology	Neutropenic sepsis	Neutropenic sepsis	neutropenic sepsis chemotherapy septic shock	443980004	neutropenic sepsis (disorder)	0	0	0	0	1	1
1415122000	41	51	22	Medical	Haem / oncology	Neutropenia	Neutropenia	neutropenia WCC white chemo sepsis septic	165517008	neutropenia (finding)	0	0	0	0	1	1
1415131000	41	51	31	Medical	Haem / oncology	Haemophilia	Haemophilia	haemophilia hemophilia	90935002	hemophilia (disorder)	0	0	0	0	1	1
1415135000	41	51	35	Medical	Haem / oncology	Bleeding / bruising tendency / coagulation defect	Bleeding / bruising tendency / coagulation defect	coagulation abnormality bleeding tendency	64779008	blood coagulation disorder (disorder)	0	0	0	0	1	1
1415141000	41	51	41	Medical	Haem / oncology	Thrombocytopenia	Thrombocytopenia	thrombocytopenia platelet disorder low platelets	302215000	thrombocytopenic disorder (disorder)	0	0	0	0	1	1
1415151000	41	51	51	Medical	Haem / oncology	Sickle cell anaemia	Sickle cell anaemia	sickle cell disease sickling sickle cell crisis	127040003	hereditary hemoglobinopathy disorder homozygous for hemoglobin S (disorder)	0	0	0	0	1	1
1415152000	41	51	52	Medical	Haem / oncology	Sickle cell crisis	Sickle cell crisis	sickle cell disease sickling sickle cell crisis	417425009	hemoglobin SS disease with crisis (disorder)	0	0	0	0	1	1
1415155000	41	51	55	Medical	Haem / oncology	Thalassaemia	Thalassaemia	thalassaemia anaemia	40108008	thalassemia (disorder)	0	0	0	0	1	1
1415161000	41	51	61	Medical	Haem / oncology	Haemangioma / lymphangioma	Haemangioma / lymphangioma	strawberry angioma	56975005	strawberry nevus of skin (disorder)	0	0	0	0	1	1
1415181000	41	51	81	Medical	Haem / oncology	Malignant tumour	Malignant tumour	malignant tumour carcinoma mesothelioma sarcoma basal cell cancer melanoma squamous	372087000	malignant neoplastic disease (disorder)	0	0	0	0	1	1
1415182000	41	51	82	Medical	Haem / oncology	Myeloid leukaemia	Myeloid leukaemia	myeloid leukaemia AML CML	188732008	myeloid leukemia (disorder)	0	0	0	0	1	1
1415183000	41	51	83	Medical	Haem / oncology	Multiple myeloma	Multiple myeloma	multiple myeloma	109989006	multiple myeloma (disorder)	0	0	0	0	1	1
1415184000	41	51	84	Medical	Haem / oncology	Lymphoid leukaemia	Lymphoid leukaemia	lymphoid leukaemia	188725004	lymphoid leukemia (disorder)	0	0	0	0	1	1
1415185000	41	51	85	Medical	Haem / oncology	Lymphoma	Lymphoma	lymphoma non-hodgkins lymphoma hodgkins	118601006	non-Hodgkin's lymphoma (disorder)	0	0	0	0	1	1
1415186000	41	51	86	Medical	Haem / oncology	Hodgkin's disease	Hodgkin's disease	hodgkins disease lymphoma	118599009	Hodgkin's disease (disorder)	0	0	0	0	1	1
1415199000	41	51	99	Medical	Haem / oncology	Haematological condition not listed above	Haematological condition not listed above	haematological blood dyscrasia haem heme myelodysplasia leukaemia lymphoma	414022008	disorder of cellular component of blood (disorder)	0	0	0	0	1	1
1416111000	41	61	11	Medical	Endocrine / metabolic	Type 1 diabetes mellitus	Type 1 diabetes mellitus	dka diabetes type 1	46635009	diabetes mellitus type 1 (disorder)	0	1	0	0	1	1
1416115000	41	61	15	Medical	Endocrine / metabolic	Diabetic ketoacidosis	Diabetic ketoacidosis	dka diabetes type 1	420422005	ketoacidosis in diabetes mellitus (disorder)	0	0	0	0	1	1
1416121000	41	61	21	Medical	Endocrine / metabolic	Type 2 diabetes mellitus	Type 2 diabetes mellitus	diabetes type 2 II	44054006	diabetes mellitus type 2 (disorder)	0	1	0	0	1	1
1416125000	41	61	25	Medical	Endocrine / metabolic	Hyperosmolar hyperglycaemic state (HHS)	Hyperosmolar hyperglycaemic state (HHS)	honk hhs hyperosmolar non ketotic	310505005	diabetic hyperosmolar non-ketotic state (disorder)	0	0	0	0	1	1
1416131000	41	61	31	Medical	Endocrine / metabolic	Hypoglycaemia without coma	Hypoglycaemia without coma	hypoglycaemia	302866003	hypoglycemia (disorder)	0	1	0	0	1	1
1416141000	41	61	41	Medical	Endocrine / metabolic	Hyperthyroidism / thyrotoxicosis	Hyperthyroidism / thyrotoxicosis	hyperthyroidism tyrotoxicosis Graves storm thyroid	90739004	thyrotoxicosis (disorder)	0	0	0	0	1	1
1416143000	41	61	43	Medical	Endocrine / metabolic	Hypothyroidism / myxoedema	Hypothyroidism / myxoedema	hypothyroidism myxoedema myxoedema coma hashimoto thyroid	40930008	hypothyroidism (disorder)	0	0	0	0	1	1
1416151000	41	61	51	Medical	Endocrine / metabolic	Adrenocortical insufficiency (Addisonian crisis)	Adrenocortical insufficiency (Addisonian crisis)	addisons crisis adrenal insufficiency adrenocortical	24867002	severe adrenal insufficiency (disorder)	0	0	0	0	1	1
1416161000	41	61	61	Medical	Endocrine / metabolic	Syndrome of inappropriate anti-diuretic hormone secretion (SIADH)	Syndrome of inappropriate anti-diuretic hormone (SIADH)	syndrome inappropriate anti-diuretic hormone secretion siadh	55004003	syndrome of inappropriate vasopressin secretion (disorder)	0	0	0	0	1	1
1416171000	41	61	71	Medical	Endocrine / metabolic	Hyperkalaemia	Hyperkalaemia	potassium hyperkalaemia	14140009	hyperkalemia (disorder)	0	0	0	0	1	1
1416173000	41	61	73	Medical	Endocrine / metabolic	Hypokalaemia	Hypokalaemia	potassium hypokalaemia	43339004	hypokalemia (disorder)	0	0	0	0	1	1
1416179000	41	61	79	Medical	Endocrine / metabolic	Hypercalcaemia	Hypercalcaemia	hypercalcaemia calcium	66931009	hypercalcemia (disorder)	0	0	0	0	1	1
1416198000	41	61	98	Medical	Endocrine / metabolic	Other endocrine disorder (see free text)	Other endocrine disorder (see free text)	endocrine endocrinology	362969004	disorder of endocrine system (disorder)	0	0	0	0	1	1
1416199000	41	61	99	Medical	Endocrine / metabolic	Fluid electrolyte or acid-base disorder (see free text)	Fluid electrolyte or acid-base disorder (see free text)	fluid electrolytes acid base inborn error metabolism	1860003	disorder of fluid AND/OR electrolyte (disorder)	0	0	0	0	1	1
1417111000	41	71	11	Medical	Skin and soft tissues	Dermatitis : atopic / eczema	Dermatitis : atopic / eczema	eczema dermatitis red rash atopic atopy allergic allergy	43116000	eczema (disorder)	0	0	0	0	1	1
1417113000	41	71	13	Medical	Skin and soft tissues	Dermatitis : contact	Dermatitis : contact	dermatitis contact dermatitis scaly red rash	40275004	contact dermatitis (disorder)	0	0	1	0	1	1
1417115000	41	71	15	Medical	Skin and soft tissues	Dermatitis : seborrhoeic	Dermatitis : seborrhoeic	seborrheic dermatitis scaly	50563003	seborrheic dermatitis (disorder)	0	0	0	0	1	1
1417121000	41	71	21	Medical	Skin and soft tissues	Urticaria	Urticaria	urticaria itchy allergic allergy reaction red rash	126485001	urticaria (disorder)	0	0	1	0	1	1
1417125000	41	71	25	Medical	Skin and soft tissues	Rash : drug induced	Rash : drug induced	urticaria drug reaction allergy allergic red rash	89322006	urticaria medicamentosa (disorder)	1	0	1	0	1	1
1417131000	41	71	31	Medical	Skin and soft tissues	Psoriasis	Psoriasis	psoriasis red scaly rash	9014002	psoriasis (disorder)	0	0	0	0	1	1
1417141000	41	71	41	Medical	Skin and soft tissues	Pityriasis rosea	Pityriasis rosea	pityriasis rosea red rash	77252004	pityriasis rosea (disorder)	0	0	0	0	1	1
1417143000	41	71	43	Medical	Skin and soft tissues	Erythema multiforme	Erythema multiforme	erythema multiforme red rash	36715001	erythema multiforme (disorder)	0	0	0	0	1	1
1417145000	41	71	45	Medical	Skin and soft tissues	Erythema nodosum	Erythema nodosum	erythema nodosum TB red rash lump	32861005	erythema nodosum (disorder)	0	0	0	0	1	1
1417151000	41	71	51	Medical	Skin and soft tissues	Sunburn	Sunburn	sunburn red rash	403194002	solar erythema (disorder)	1	0	0	0	1	1
1417152000	41	71	52	Medical	Skin and soft tissues	Heat rash	Heat rash	heat rash red rash	72658003	prickly heat (disorder)	0	0	0	0	1	1
1417161000	41	71	61	Medical	Skin and soft tissues	Sebaceous cyst	Sebaceous cyst	sebaceous cyst	419603000	epidermoid cyst of skin (disorder)	0	0	0	0	1	1
1417162000	41	71	62	Medical	Skin and soft tissues	Ingrowing nail of finger or toe	Ingrowing nail of finger or toe	ingrowing toenail nail	400097005	ingrowing nail (disorder)	0	0	0	0	1	1
1417165000	41	71	65	Medical	Skin and soft tissues	Bedsore / pressure sore	Bedsore / pressure sore	bedsore decubitus ulcer pressure sore	399912005	pressure sore (disorder)	1	0	0	0	1	1
1417171000	41	71	71	Medical	Skin and soft tissues	Pyogenic granuloma	Pyogenic granuloma	pyogenic granuloma	200722003	pyogenic granuloma (disorder)	1	0	0	0	1	1
1418111000	41	81	11	Medical	Renal	Pyelonephritis	Pyelonephritis	pyelonephritis kidney infection	45816000	pyelonephritis (disorder)	0	0	0	0	1	1
1418115000	41	81	15	Medical	Renal	Hydronephrosis	Hydronephrosis	hydronephrosis	43064006	hydronephrosis (disorder)	0	0	0	0	1	1
1418121000	41	81	21	Medical	Renal	Acute Renal failure	Acute renal failure	arf acute renal failure	14669001	acute renal failure syndrome (disorder)	0	0	0	0	1	1
1418125000	41	81	25	Medical	Renal	Chronic Renal failure	Chronic renal failure	chronic renal failure	90688005	chronic renal failure syndrome (disorder)	0	0	0	0	1	1
1418131000	41	81	31	Medical	Renal	Nephrotic syndrome	Nephrotic syndrome	nephrotic syndrome	52254009	nephrotic syndrome (disorder)	0	0	0	0	1	1
1418155000	41	81	55	Medical	Renal	Glomerulonephritis	Glomerulonephritis	glomerulonephritis	36171008	glomerulonephritis (disorder)	0	0	0	0	1	1
1418199000	41	81	99	Medical	Renal	Other renal system disorder (see free text)	Other renal system disorder (see free text)	kidney disease renal	90708001	kidney disease (disorder)	0	0	0	0	1	1
1419111000	41	91	11	Medical	Allergy	Hayfever	Hayfever	hayfever atopic	367498001	seasonal allergic rhinitis (disorder)	0	0	0	0	1	1
1419121000	41	91	21	Medical	Allergy	Anaphylaxis	Anaphylaxis	anaphylaxis	39579001	anaphylaxis (disorder)	0	0	1	0	1	1
1419131000	41	91	31	Medical	Allergy	ACEI related angioedema	ACEI related angioedema	angioedema angiotensin converting enzyme inhibitor ace acei	403607004	angioedema due to angiotensin-converting-enzyme inhibitor (disorder)	1	0	1	0	1	1
1419135000	41	91	35	Medical	Allergy	Angioneurotic oedema (C1 esterase inhibitor deficiency)	Angioneurotic oedema (C1 esterase inhibitor deficiency)	angioedema due to disorder of c1 esterase inhibitor	402602000	angioedema due to disorder of C1 esterase inhibitor (disorder)	0	0	1	0	1	1
1419151000	41	91	51	Medical	Allergy	Angioneurotic oedema	Angioneurotic oedema	angioedema angioneurotic oedema	41291007	angioedema (disorder)	0	0	1	0	1	1
1419171000	41	91	71	Medical	Allergy	Scombroid toxin [ND]	Scombroid toxin [ND]	scombroid scombrotoxin food fish shellfish poisoning	83227006	scombroid fish poisoning (disorder)	1	0	0	1	1	1
1419181000	41	91	81	Medical	Allergy	Drug reaction	Drug reaction	drug reaction adverse	62014003	adverse reaction to drug (disorder)	1	0	1	0	1	1
1419191000	41	91	91	Medical	Allergy	Other allergic reaction (see free text)	Other allergic reaction (see free text)	allergic reaction allergy urticaria anaphylaxis	609328004	allergic disposition (disorder)	0	0	1	0	1	1

ECDS_UniqueID	Sort 1	ECDS_Group	ECDS_Description	SNOMED_Code	SNOMED_Description	Notes
2018110000	n/a	n/a	Suspected diagnosis	415684004	Suspected (qualifier value)	
2018210000	n/a	n/a	Confirmed diagnosis	410605003	Confirmed present (qualifier value)	

DATA GROUP: EMERGENCY CARE INVESTIGATIONS (SNOMED CT)

FUNCTION: To carry the details of SNOMED CT coded Clinical Investigations
Group Status: R
Group Repeats: 0..*

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	CQUIN DATA ITEM REQUIRED (Y/N)	DATA ITEM REPEATS	FORMAT	SNOMED CT / DM&D /ODS	JUSTIFICATION	ECDS CODE SET	LINK TO CURRENT CDS Type 010 INFORMATION ONLY	VALIDATION RULES		DATA ITEM PROVENANCE	NOTES
											POPULATION VALIDATION F - Format is validated V - Validated against an explicit list of permitted values as defined in the NHS Data Dictionary	POST SCHEMA VALIDATION		
EMERGENCY CARE INVESTIGATIONS	EMERGENCY CARE CLINICAL INVESTIGATION (SNOMED CT)	The investigations performed while the person is under the care of the Emergency Care facility.	M	N	1..1	min n6 max n18	SNOMED CT	As per CDS 6.2 Type 010. Amended to include new investigations codes. Amended to be collected in SNOMED CT.	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/accident_and_emergency_investigation_-_first_de.asp?shownav=0	F	a. For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for record X, field Y is not in the acceptable range". In addition, any normal business logic for IG reasons shall be followed. b. If one of the items corresponds to the "extremely sensitive" list of items then the record MUST be anonymised. c. The "extremely sensitive" list of SNOMED values must be added to SUS so that it can cross-check, and then follow existing IG rules appropriately (flagging / warning to the user for feedback). • NB: Providers shouldn't send this information, so this is a back-stop in case they do. • NB: there aren't any "extremely sensitive" items in the current list (we x-ref'd), but in theory one could be introduced in future as part of maintenance, so it's best to have this function in from the outset so we don't forget. d. Supplier guidance is to prioritise the ECDS sub set in the interface. e. Supplier guidance is to send ALL investigations / treatments to SUS because the grouper can handle unlimited values • NB: this is not a problem for SUS and HES in future will be able to bring across either everything, or prioritise and/or de-duplicate	Originates from A&E CDS Type 010	
EMERGENCY CARE INVESTIGATIONS	PROCEDURE DATE (EMERGENCY CARE CLINICAL INVESTIGATION)	The date on which investigations were performed while the person was under the care of the Emergency Care facility.	R	N	0..1	an10 CCYY-MM-DD	DM&D		n/a	n/a	F	n/a	NEW' A&E data item	This data item should be recorded when an investigation is performed.
EMERGENCY CARE INVESTIGATIONS	PROCEDURE TIME (EMERGENCY CARE CLINICAL INVESTIGATION)	The time at which investigations were performed while the person was under the care of the Emergency Care facility.	R	N	0..1	an8 HH:MM:SS	DM&D		n/a	n/a	F	n/a	NEW' A&E data item	This data item should be recorded when an investigation is performed.

ECDS_UniqueID	Sort1	Sort2	ECDS_Group	ECDS_Description	SNOMED_Code	SNOMED_Description	CDS_Code mapping used for HRG Grouping	PbR_Category	CDS_Investigation mapping that is used for HRG Grouping	Notes
1171110000	71	11	Radiology	X-ray plain film	168537006	Plain radiography (procedure)	01	2	X-ray plain film	
1171610000	71	61	Radiology	Image intensifier	179929004	Examination of joint under image intensifier (procedure)	01	2	X-ray plain film	
1171210000	71	21	Radiology	Ultrasound	16310003	Diagnostic ultrasonography (procedure)	10	3	Ultrasound	
1171250000	71	25	Radiology	Echocardiography	40701008	Echocardiography (procedure)	10	3	Ultrasound	
1171510000	71	51	Radiology	Magnetic Resonance Imaging	113091000	Magnetic resonance imaging (procedure)	11	3	Magnetic Resonance Imaging	
1171410000	71	41	Radiology	Computerised Tomography	77477000	Computerized axial tomography (procedure)	12	3	Computerised Tomography (excludes genitourinary contrast examination / tomography)	
1141210000	41	21	Haematology	Clotting studies	3116009	Blood coagulation panel (procedure)	14	2	Clotting studies	
1121810000	21	81	Biochemistry	Immunology	252375001	Immunology profile (procedure)	15	2	Immunology	
1121250000	21	25	Biochemistry	Cardiac enzymes	74500006	Cardiac enzymes/isoenzymes measurement (procedure)	16	2	Cardiac enzymes	
1111550000	11	55	Bedside	Arterial / capillary blood gas	60170009	Analysis of arterial blood gases and pH (procedure)	17	1	Arterial / capillary blood gas	
1111510000	11	51	Bedside	Venous blood gas	61911006	Blood gases, venous measurement (procedure)	17	1	Arterial / capillary blood gas	
1111590000	11	59	Bedside	Lactate	270982000	Serum lactate measurement (procedure)	17	1	Arterial / capillary blood gas	
1121310000	21	31	Biochemistry	Toxicology	269874008	Serum paracetamol measurement (procedure)	18	2	Toxicology	
1151310000	51	31	Microbiology	Blood culture	30088009	Blood culture (procedure)	19	2	Blood culture	
1111210000	11	21	Bedside	Electrocardiogram	29303009	Electrocardiographic procedure (procedure)	02	1	Electrocardiogram	
1121910000	21	91	Biochemistry	Serology	68793005	Serologic test (procedure)	20	2	Serology	
1121390000	21	39	Biochemistry	Pregnancy test	67900009	Human chorionic gonadotropin measurement (procedure)	21	1	Pregnancy test	
1161810000	61	81	Eyes / dental	Dental investigation	53115007	Diagnostic dental procedure (procedure)	22	2	Dental investigation	
1161210000	61	21	Eyes / dental	Refraction, orthoptic tests and computerised visual fields	86944008	Visual field study (procedure)	23	2	Refraction, orthoptic tests and computerised visual fields	
1161610000	61	61	Eyes / dental	Ocular coherence tomography	392010000	Optical coherence tomography (procedure)	23	2	Refraction, orthoptic tests and computerised visual fields	
1161510000	61	51	Eyes / dental	Intra-ocular fluid sampling	363255004	Paracentesis of eye (procedure)	23	2	Refraction, orthoptic tests and computerised visual fields	
1161710000	61	71	Eyes / dental	Ocular photography	282096008	Retinal photography (procedure)	23	2	Refraction, orthoptic tests and computerised visual fields	
1161150000	61	15	Eyes / dental	Tonometry	164729009	Tonometry (procedure)	23	2	Refraction, orthoptic tests and computerised visual fields	
1161110000	61	11	Eyes / dental	Visual acuity testing	16830007	Visual acuity testing (procedure)	23	2	Refraction, orthoptic tests and computerised visual fields	
1141110000	41	11	Haematology	Haematology	26604007	Complete blood count (procedure)	03	2	Haematology	
1141510000	41	51	Haematology	D-dimer	70648006	D-dimer assay (procedure)	03	2	Haematology	
1141810000	41	81	Haematology	Erythrocyte sedimentation rate (ESR)	416838001	Erythrocyte sedimentation rate measurement (procedure)	03	2	Haematology	
1141910000	41	91	Haematology	Thromboelastography	56027003	Thromboelastography (procedure)	03	2	Haematology	
1141410000	41	41	Haematology	Cross match blood / group and save serum for later cross match	252316009	Group and save (procedure)	04	2	Cross match blood / group and save serum for later cross match	
1121110000	21	11	Biochemistry	Biochemistry	252167001	Urea and electrolytes (procedure)	05	1	Biochemistry	
1121150000	21	15	Biochemistry	Amylase	89659001	Amylase measurement, serum (procedure)	05	1	Biochemistry	
1121290000	21	29	Biochemistry	Bone profile	167036008	Bone profile (procedure)	05	1	Biochemistry	
1121510000	21	51	Biochemistry	C reactive protein (CRP)	55235003	C-reactive protein measurement (procedure)	05	1	Biochemistry	
1121550000	21	55	Biochemistry	Creatine kinase	397798009	Creatine kinase measurement (procedure)	05	1	Biochemistry	
1111310000	11	31	Bedside	Glucose	104686004	Glucose measurement, blood, test strip (procedure)	05	1	Biochemistry	
1121450000	21	45	Biochemistry	Glycosolated haemoglobin (HbA1c)	43396009	Hemoglobin A1c measurement (procedure)	05	1	Biochemistry	
1121130000	21	13	Biochemistry	Liver function tests (LFTs)	26958001	Hepatic function panel (procedure)	05	1	Biochemistry	
1121410000	21	41	Biochemistry	Lipid profile	16254007	Lipid panel (procedure)	05	1	Biochemistry	
1121160000	21	16	Biochemistry	Lipase	271232007	Serum lipase measurement (procedure)	05	1	Biochemistry	
1121610000	21	61	Biochemistry	Thyroid function tests	35650009	Thyroid panel (procedure)	05	1	Biochemistry	
1121210000	21	21	Biochemistry	Troponin	105000003	Troponin measurement (procedure)	05	1	Biochemistry	
1121830000	21	83	Biochemistry	Mast cell tryptase	62847008	Tryptase release from mast cell measurement (procedure)	05	1	Biochemistry	
1111110000	11	11	Bedside	Urinalysis	27171005	Urinalysis (procedure)	06	1	Urinalysis	
1151110000	51	11	Microbiology	Bacteriology	168338000	Urine sent for culture (situation)	07	2	Bacteriology	
1151210000	51	21	Microbiology	Swab for culture and sensitivities	401294003	Wound microscopy, culture and sensitivities (procedure)	07	2	Bacteriology	
1111710000	11	71	Bedside	Dementia screening test	165320004	Dementia test (procedure)	99	1	Other	
1111410000	11	41	Bedside	Peak expiratory flow	29893006	Peak expiratory flow measurement (procedure)	99	1	Other	

DATA GROUP: EMERGENCY CARE TREATMENTS (SNOMED CT)

FUNCTION: To carry the details of SNOMED CT coded Procedures.
Group Status: R
Group Repeats: 0..*

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	CQUIN DATA ITEM REQUIRED (Y/N)	DATA ITEM REPEATS	FORMAT	SNOMED CT / DM&D /ODS	JUSTIFICATION	ECDS CODE SET	LINK TO CURRENT CDS Type 010 INFORMATION ONLY	VALIDATION RULES		DATA ITEM PROVENANCE	NOTES
											POPULATION VALIDATION F - Format is validated V - Validated against an explicit list of permitted values as defined in the NHS Data Dictionary	POST SCHEMA VALIDATION		
EMERGENCY CARE TREATMENTS	EMERGENCY CARE PROCEDURE (SNOMED CT)	The treatments performed while the person is under the care of the Emergency Care facility.	M	N	1..1	min n6 max n18	SNOMED CT	As per CDS 6.2 Type 010. Amended to include new treatment codes. Amended to be collected in SNOMED CT.	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/accident_and_emergency_treatment_-_first_de.asp?shownav=0	F	a. For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for record X, field Y is not in the acceptable range". In addition, any normal business logic for IG reasons shall be followed. b. If one of the items corresponds to the "extremely sensitive" list of items then the record MUST be anonymised. c. The "extremely sensitive" list of SNOMED values must be added to SUS so that it can cross-check, and then follow existing IG rules appropriately (flagging / warning to the user for feedback). • NB: Providers shouldn't send this information, so this is a back-stop in case they do. • NB: there aren't any "extremely sensitive" items in the current list (we x-ref'd), but in theory one could be introduced in future as part of maintenance, so it's best to have this function in from the outset so we don't forget. d. Supplier guidance is to prioritise the ECDS sub set in the interface. e. Supplier guidance is to send ALL investigations / treatments to SUS because the grouper can handle unlimited values • NB: this is not a problem for SUS and HES in future will be able to bring across either everything, or prioritise and/or de-duplicate	Originates from A&E CDS Type 010	
EMERGENCY CARE TREATMENTS	PROCEDURE DATE	The date on which treatments were performed while the person was under the care of the Emergency Care facility.	R	N	0..1	an10 CCYY-MM-DD	DM&D		n/a	n/a	F	n/a	NEW' A&E data item	This data item should be recorded when an treatment is performed.
EMERGENCY CARE TREATMENTS	PROCEDURE TIME	The time at which treatments were performed while the person was under the care of the Emergency Care facility.	R	N	0..1	an8 HH:MM:SS	DM&D		n/a	n/a	F	n/a	NEW' A&E data item	This data item should be recorded when an treatment is performed.

ECDS_UniqueID	Sort1	Sort2	ECDS_Group	ECDS_Description	SNOMED_Code	SNOMED_Description	CDS_Code mapping used for HRG Grouping	PbR_Category	CDS_Treatment mapping that is used for HRG Grouping	Notes
1111110000	11	11	Airway / Breathing	Supplemental oxygen	57485005	Oxygen therapy (procedure)	40	3-4	Supplemental oxygen	
1111310000	11	31	Airway / Breathing	Nebuliser / spacer	56251003	Nebulizer therapy (procedure)	25	3-4	Nebuliser / spacer	
1111350000	11	35	Airway / Breathing	Metered dose inhaler + spacer	243132000	Inhaled drug administration (procedure)	25	3-4	Nebuliser / spacer	
1111410000	11	41	Airway / Breathing	Nasal airway	182692007	Nasopharyngeal airway insertion (procedure)	38	1-2	Nasal airway	
1111510000	11	51	Airway / Breathing	Non-invasive ventilation	428311008	Noninvasive ventilation (procedure)	41	3-4	Continuous positive airways pressure / nasal intermittent positive pressure ventilation / bag valve mask	
1111650000	11	65	Airway / Breathing	Intubation : ETT or LMA	112798008	Insertion of endotracheal tube (procedure)	15	3-4	Intubation & Endotracheal tubes / laryngeal mask airways / rapid sequence induction	
1111810000	11	81	Airway / Breathing	Chest drain	264957007	Insertion of pleural tube drain (procedure)	16	3-4	Chest drain	
1121110000	21	11	Circulation	Observation / cardiac monitor, pulse oximetry / head injury / trends	88140007	Cardiac monitor surveillance (regime/therapy)	21	1-2	Observation / cardiac monitor, pulse oximetry / head injury / trends	
1121130000	21	13	Circulation	Intravenous cannula	392231009	Intravenous cannulation (procedure)	12	1-2	Intravenous cannula	
1121150000	21	15	Circulation	Intraosseous cannula	430824005	Intraosseous cannulation (procedure)	12	1-2	Intravenous cannula	
1121210000	21	21	Circulation	Infusion fluids	103744005	Administration of intravenous fluids (procedure)	43	1-2	Infusion fluids	
1121310000	21	31	Circulation	Blood product transfusion	116859006	Transfusion of blood product (procedure)	44	3-4	Blood product transfusion	
1121510000	21	51	Circulation	Arterial line	392247006	Insertion of catheter into artery (procedure)	42	3-4	Arterial line	
1121610000	21	61	Circulation	Central line	233527006	Central venous cannula insertion (procedure)	13	3	Central line	
1121710000	21	71	Circulation	External pacing	18590009	Cardiac pacing (procedure)	182	3-4	External pacing	
1131110000	31	11	Resuscitation	Defibrillation	250980009	Cardioversion (procedure)	181	3-4	Defibrillation	
1131310000	31	31	Resuscitation	Resuscitation / cardiopulmonary resuscitation	439569004	Resuscitation (procedure)	19	5	Resuscitation / cardiopulmonary resuscitation	
1131710000	31	71	Resuscitation	Active rewarming of the hypothermic patient	241740008	Active warming of patient (procedure)	49	3-4	Active rewarming of the hypothermic patient	
1131750000	31	75	Resuscitation	Cooling : control body temperature	182660006	Cold therapy (procedure)	50	1-2	Cooling : control body temperature	
1131810000	31	81	Resuscitation	Percutaneous vascular occlusion (e.g.REBOA)	240943006	Percutaneous non-embolic vascular occlusion (procedure)	19	5	Resuscitation / cardiopulmonary resuscitation	
1131910000	31	91	Resuscitation	Resuscitative thoracotomy	36936009	Major thoracotomy with cardiac massage (procedure)	19	5	Resuscitation / cardiopulmonary resuscitation	
1135110000	35	11	Analgesia	Anaesthesia : local anaesthetic	386761002	Local anaesthesia (procedure)	232	1-2	Anaesthesia : local anaesthetic	
1135210000	35	21	Analgesia	Anaesthesia : entonox	427035008	Nitrous oxide and oxygen gas analgesia (procedure)	234	1-2	Anaesthesia : entonox	
1135410000	35	41	Analgesia	Anaesthesia : regional block	27372005	Regional anesthesia (procedure)	233	1-2	Anaesthesia : regional block	
1135610000	35	61	Analgesia	Anaesthesia : sedation	50697003	General anesthesia (procedure)	235	3-4	Anaesthesia : sedation	This value should be used where sedation or anesthesia is used. In Oct 2017 we will add in 398239001 Monitored anesthesia care sedation (procedure) to go alongside General anesthesia (procedure) to allow differentiation of sedation and anesthesia.
1141110000	41	11	Medication	Administration of medication	18629005	Administration of medication (procedure)	511	1-2	Medication : oral	
1141210000	41	21	Medication	Intravenous drug : bolus	433215005	Administration of drug or medicament by intravenous push (procedure)	291	3-4	Intravenous drug : bolus	
1141210000	41	21	Medication	Intravenous antibiotics	281790008	Intravenous antibiotic therapy (procedure)	291	3-4	Intravenous drug : bolus	
1141250000	41	25	Medication	Intravenous drug : infusion	432054008	Infusion of drug or medicament via intravenous route (procedure)	292	3-4	Intravenous drug : infusion	
1141310000	41	31	Medication	Prescription / medicines prepared to take away	266712008	New medication commenced (finding)	57	1-2	Prescription / medicines prepared to take away	
1141610000	41	61	Medication	Lavage / emesis / charcoal / eye irrigation	226871000000103	Administration of activated charcoal (procedure)	14	2	Lavage / emesis / charcoal / eye irrigation	
1141810000	41	81	Medication	Parenteral thrombolysis : tPA	307521008	Intravenous infusion of thrombolytic (procedure)	282	5	Parenteral thrombolysis : tPA	
1145110000	45	11	Procedures	Urinary catheter / suprapubic	410024004	Insertion of catheter into urinary bladder (procedure)	17	3-4	Urinary catheter / suprapubic	
1145210000	45	21	Procedures	Nasogastric tube	87750000	Insertion of nasogastric tube (procedure)	27	1-2	Other (consider alternatives)	
1145310000	45	31	Procedures	Minor surgery	711580002	Minor ambulatory surgery (procedure)	20	3-4	Minor surgery	
1145410000	45	41	Procedures	Lumbar puncture	265232001	Diagnostic lumbar puncture (procedure)	46	3-4	Lumbar puncture	
1145510000	45	51	Procedures	Removal foreign body	10849003	Removal of foreign body (procedure)	08	3	Removal foreign body	
1145610000	45	61	Procedures	Pleural aspiration	91602002	Thoracentesis (procedure)	16	3-4	Chest drain	
1145620000	45	62	Procedures	Pleural drainage	278296000	Drainage of pleural cavity (procedure)	16	3-4	Chest drain	
1145650000	45	65	Procedures	Ascitic aspiration	178016006	Diagnostic aspiration of peritoneal cavity (procedure)	27	1-2	Other (consider alternatives)	
1145660000	45	66	Procedures	Ascitic drainage	178012008	Percutaneous drainage of ascites (procedure)	27	1-2	Other (consider alternatives)	
1145690000	45	69	Procedures	Gastrostomy tube change	6125005	Change of gastrostomy tube (procedure)	17	3-4	Urinary catheter / suprapubic	
1151110000	51	11	Wound Management	Dressing : wound / burn / eye	15631002	Application of dressing, minor (procedure)	011	2	Dressing : minor / burn / eye	
1151310000	51	31	Wound Management	Wound closure : steristrips	71810007	Closure of skin wound by tape (procedure)	041	2	Wound closure : steristrips	
1151350000	51	35	Wound Management	Wound closure : glue	284182000	Gluing of wound (procedure)	042	2	Wound closure : glue	
1151390000	51	39	Wound Management	Wound closure : other e.g. staples	50015006	Closure by staple (procedure)	043	1-3	Wound closure : other e.g. staples	
1151510000	51	51	Wound Management	Sutures : primary	18557009	Closure by suture (procedure)	031	3	Sutures : primary	
1151550000	51	55	Wound Management	Sutures : complex / secondary	71539001	Suture of fascia (procedure)	032	3-4	Sutures : complex / secondary	
1151590000	51	59	Wound Management	Removal of sutures / clips	30549001	Removal of suture (procedure)	033	1-2	Removal of sutures / clips	
1151710000	51	71	Wound Management	Tetanus : toxoid - booster	127786006	Tetanus vaccination (procedure)	243	1-2	Tetanus : toxoid - booster	
1151750000	51	75	Wound Management	Tetanus : immunoglobulin	117092006	Administration of Tetanus immune globulin, human (procedure)	244	1-2	Tetanus : immunoglobulin	
1155110000	55	11	Orthopaedic	Plaster of Paris : applied	180289009	Application of plaster cast (procedure)	051	1-3	Plaster of Paris : applied	
1155150000	55	15	Orthopaedic	Plaster of Paris : removed	180291001	Removal of plaster cast (procedure)	052	1-3	Plaster of Paris : removed	
1155210000	55	21	Orthopaedic	Splint	179208004	Apply Thomas splint traction (procedure)	06	1-3	Splint	
1155230000	55	23	Orthopaedic	Sling / collar cuff / broad arm sling	52037006	Application of sling (procedure)	36	1-2	Sling / collar cuff / broad arm sling	
1155250000	55	25	Orthopaedic	Provision of walking aid (e.g. crutches)	243751002	Provision of mobility device (procedure)	53	1-2	Loan of walking aid (crutches)	
1155310000	55	31	Orthopaedic	Manipulation upper limb fracture	267765006	Closed reduction of fracture of upper limb (procedure)	101	3-4	Manipulation upper limb fracture	
1155350000	55	35	Orthopaedic	Manipulation lower limb fracture	150617003	Closed reduction of fracture of lower limb (procedure)	102	4	Manipulation lower limb fracture	
1155410000	55	41	Orthopaedic	Manipulation dislocation	122944000	Reduction of dislocation (procedure)	103	4	Manipulation dislocation	
1155810000	55	81	Orthopaedic	Joint aspiration	90131007	Arthrocentesis (procedure)	47	3-4	Joint aspiration	
1171110000	71	11	ENT / eye / dental	Epistaxis control	35807001	Control of hemorrhage of nose (procedure)	37	1-2	Epistaxis control	
1171310000	71	31	ENT / eye / dental	Dental treatment	81733005	Dental surgical procedure (procedure)	56	1-2	Dental treatment	
1171510000	71	51	ENT / eye / dental	Eye : irrigation	49999004	Irrigation of eye (procedure)	14	2	Lavage / emesis / charcoal / eye irrigation	
1171550000	71	55	ENT / eye / dental	Eye : orthoptic exercises	266740003	Orthoptic treatment (procedure)	551	1-2	Eye : orthoptic exercises	
1171610000	71	61	ENT / eye / dental	Eye : epilation of lashes	74004007	Epilation of eyelid by forceps (procedure)	554	3-4	Eye : epilation of lashes	
1171710000	71	71	ENT / eye / dental	Eye : laser of retina / iris or posterior capsule	35631009	Laser surgery (procedure)	552	5	Eye : laser of retina / iris or posterior capsule	
1171810000	71	81	ENT / eye / dental	Eye : subconjunctival injection	74410004	Subconjunctival injection (procedure)	555	3-4	Eye : subconjunctival injection	
1171850000	71	85	ENT / eye / dental	Eye : retrobulbar injection	121005	Retrobulbar injection of therapeutic agent (procedure)	553	3-4	Eye : retrobulbar injection	
1181110000	81	11	Discharge Planning	Guidance / advice - written	413334001	Patient given written advice (situation)	221	1-2	Guidance / advice - written	
1181150000	81	15	Discharge Planning	Psychosocial assessment	371585000	Psychosocial assessment (procedure)	27	1-2	Other (consider alternatives)	
1181210000	81	21	Discharge Planning	Occupational therapy : functional assessment	304492001	Activities of daily living assessment (procedure)	521	3-4	Occupational therapy : functional assessment	
1181250000	81	25	Discharge Planning	Occupational therapy : equipment provision / training	410267000	Mobility/transfers education, guidance, and counselling (procedure)	522	1-2	Occupational therapy : equipment provision / training	
1181310000	81	31	Discharge Planning	Physiotherapy : falls prevention	391027005	Osteoporosis - falls prevention (procedure)	092	2	Physiotherapy : falls prevention	
1181410000	81	41	Discharge Planning	Physiotherapy : general	430481008	Assessment of mobility (procedure)	091	2	Physiotherapy : general	
1181510000	81	51	Discharge Planning	Medication review	182836005	Pharmacological assessment (procedure)	27	1-2	Other (consider alternatives)	
1181610000	81	61	Discharge Planning	Social work intervention	406551008	Social assessment (procedure)	54	3-4	Social work intervention	

DATA GROUP: REFERRALS TO OTHER SERVICES

FUNCTION: To carry the details of referrals to other services.
Group Status: R
Group Repeats: 0..*

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	CQUIN DATA ITEM REQUIRED (Y/N)	DATA ITEM REPEATS	FORMAT	SNOMED CT / DM&D /ODS	JUSTIFICATION	ECDS CODE SET	LINK TO CURRENT CDS Type 010 INFORMATION ONLY	VALIDATION RULES		DATA ITEM PROVENANCE	NOTES
											POPULATION VALIDATION F - Format is validated V - Validated against an explicit list of permitted values as defined in the NHS Data Dictionary	POST SCHEMA VALIDATION		
REFERRALS TO OTHER SERVICES	REFERRED TO SERVICE (SNOMED CT)	An inpatient service to which the patient was referred for admission or opinion by the treating clinician.	R	N	0..1	min n6 max n18	SNOMED CT	This process data is necessary to understand and optimise the care process within emergency care. Current IT systems set up for CDS version 010 routinely collect the time and specialty of referral of a patient. This information is essential to plan bed capacity within the hospital and is also used by commissioners to understand patient flow. Therefore what is proposed will not provide an additional burden but is just standardising and flowing information that is generally already collected. The time and speciality of 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.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	
REFERRALS TO OTHER SERVICES	ACTIVITY SERVICE REQUEST DATE (EMERGENCY CARE)	The DATE that a PATIENT was referred to another SERVICE during an Emergency Care Attendance.	M	N	1..1	an10 CCYY-MM-DD	DM&D	The date and time paired with the speciality of initial referral is valuable as it helps understand internal bottlenecks within the care process. Capturing this data will allow better benchmarking and standardisation of care processes and implementation of care protocols for specific conditions/ situations e.g. reverse queuing when exit block occurs. This data also helps inform commissioners as to what services and specialty support is necessary to commission to enable efficient emergency care.	n/a	n/a	F	n/a	NEW' A&E data item	This data item should be recorded when a patient is referred to a service.
REFERRALS TO OTHER SERVICES	ACTIVITY SERVICE REQUEST TIME (EMERGENCY CARE)	The TIME that a PATIENT was referred to another SERVICE during an Emergency Care Attendance.	M	N	1..1	an8 HH:MM:SS	DM&D	The date and time paired with the speciality of initial referral is valuable as it helps understand internal bottlenecks within the care process. Capturing this data will allow better benchmarking and standardisation of care processes and implementation of care protocols for specific conditions/ situations e.g. reverse queuing when exit block occurs. This data also helps inform commissioners as to what services and specialty support is necessary to commission to enable efficient emergency care.	n/a	n/a	F	n/a	NEW' A&E data item	This data item should be recorded when a patient is referred to a service.
REFERRALS TO OTHER SERVICES	REFERRED TO SERVICE ASSESSMENT DATE	A Referred To Service Assessment Date is the date that a CARE PROFESSIONAL from a SERVICE which a PATIENT has been referred to, assesses the PATIENT.	R	N	0..1	an10 CCYY-MM-DD	DM&D	ECDS has incorporated a date stamp for date of referral to inpatient / specialist services. When we explored this further, there was feedback from existing data collection standards e.g. trauma (TARN) and the Mental Health Services Data set, that what matters in terms of patient outcome, patient flow and patient experience is the time interval from referral to time of physical assessment by the inpatient team.	n/a	n/a	F	n/a	NEW' A&E data item	This is not the date at which the inpatient unit clinician is collecting information regarding the patient e.g. old notes, radiology or pathology requests. It should be the date the clinician is physically in the same room as the patient and clinical examination is occurring.
REFERRALS TO OTHER SERVICES	REFERRED TO SERVICE ASSESSMENT TIME	A Referred To Service Assessment Time is the time that a CARE PROFESSIONAL from a SERVICE which a PATIENT has been referred to, assesses the PATIENT.	R	N	0..1	an8 HH:MM:SS	DM&D	ECDS has incorporated a timestamp for time of referral to inpatient / specialist services. When we explored this further, there was feedback from existing data collection standards e.g. trauma (TARN) and the Mental Health Services Data set, that what matters in terms of patient outcome, patient flow and patient experience is the time interval from referral to time of physical assessment by the inpatient team.	n/a	n/a	F	n/a	NEW' A&E data item	This is not the date at which the inpatient unit clinician is collecting information regarding the patient e.g. old notes, radiology or pathology requests. It should be the date the clinician is physically in the same room as the patient and clinical examination is occurring.

ECDS_UniqueID	Sort1	Sort2	ECDS_Group	ECDS_Description	SNOMED_Code	SNOMED_Description	Notes
1111100000	11	11	Medical	Acute medicine	1064851000000104	Referral to acute internal medicine service (procedure)	
1111300000	11	13	Medical	Ambulatory care	898791000000105	Referral for ambulatory care (procedure)	
1111500000	11	15	Medical	General medicine	183516009	Referral to general medical service (procedure)	
1112100000	11	21	Medical	Care of the elderly	183522000	Referral to care of the elderly service (procedure)	
1112500000	11	25	Medical	Respiratory medicine	306114008	Referral to respiratory medicine service (procedure)	
1113100000	11	31	Medical	Cardiology	183519002	Referral to cardiology service (procedure)	
1113500000	11	35	Medical	Gastroenterology	183523005	Referral to gastroenterology service (procedure)	
1114100000	11	41	Medical	Infectious disease	306124000	Referral to infectious diseases service (procedure)	
1114500000	11	45	Medical	Endocrinology	306118006	Referral to endocrinology service (procedure)	
1115100000	11	51	Medical	Clinical oncology	306140002	Referral to clinical oncology service (procedure)	
1115500000	11	55	Medical	Haematology	306148009	Referral to hematology service (procedure)	
1116100000	11	61	Medical	Neurology	183521007	Referral to neurology service (procedure)	
1116500000	11	65	Medical	Stroke	306802002	Referral to stroke service (procedure)	
1116700000	11	67	Medical	Rehabilitation	307374004	Referral to rehabilitation service (procedure)	
1117100000	11	71	Medical	Palliative care	306237005	Referral to palliative care service (procedure)	
1117500000	11	75	Medical	Nephrology	306125004	Referral to nephrology service (procedure)	
1117700000	11	77	Medical	Rheumatology	306127007	Referral to rheumatology service (procedure)	
1118100000	11	81	Medical	Dermatology	183518005	Referral to dermatology service (procedure)	
1118500000	11	85	Medical	Clinical allergy	306111000	Referral to clinical allergy service (procedure)	
1118700000	11	87	Medical	Medical ophthalmology	306285006	Referral to medical ophthalmologist (procedure)	
1119100000	11	91	Medical	Genitourinary medicine	306123006	Referral to genitourinary medicine service (procedure)	
1211200000	21	12	Surgical	General surgery	183542009	Referral to general surgical service (procedure)	
1211500000	21	15	Surgical	Orthopaedic surgery	183545006	Referral to orthopedic service (procedure)	
1212000000	21	20	Surgical	Trauma surgery	306200004	Referral to trauma surgery service (procedure)	
1212500000	21	25	Surgical	Neurosurgery	183546007	Referral to neurosurgical service (procedure)	
1212800000	21	28	Surgical	Urology	306201000	Referral to urology service (procedure)	
1212900000	21	29	Surgical	Vascular surgery	306934005	Referral to vascular surgery service (procedure)	
1213000000	21	30	Surgical	Ear, nose and throat	183544005	Referral to ear, nose and throat service (procedure)	
1214000000	21	40	Surgical	Plastic surgery	306198005	Referral to plastic surgery service (procedure)	
1214200000	21	42	Surgical	Ophthalmology	183543004	Referral to ophthalmology service (procedure)	
1214500000	21	45	Surgical	Cardiothoracic surgery	306182003	Referral to cardiothoracic surgery service (procedure)	
1214500000	21	45	Surgical	Thoracic surgery	306184002	Referral to thoracic surgery service (procedure)	
1215000000	21	50	Surgical	Dental surgery	327121000000104	Referral to dental service (procedure)	
1215100000	21	51	Surgical	Oral surgery	384712002	Referral to oral surgery service (procedure)	
1215200000	21	52	Surgical	Maxillofacial surgery	384711009	Referral to maxillofacial surgery service (procedure)	
1311500000	31	15	Critical Care	Adult intensive care	306107006	Referral to adult intensive care service (procedure)	
1312100000	31	21	Critical Care	Paediatric critical care	975951000000109	Referral to paediatric critical care service (procedure)	
1313100000	31	31	Critical Care	Interventional radiology	382271000000102	Referral to interventional radiology service (procedure)	
1411100000	41	11	Paediatrics	General paediatrics	306128002	Referral to pediatric service (procedure)	
1411500000	41	15	Paediatrics	Paediatric surgical	183547003	Referral to pediatric surgical service (procedure)	
1412200000	41	22	Paediatrics	Neonatology	306132008	Referral to special care baby service (procedure)	
1413100000	41	31	Paediatrics	Paediatric orthopaedic	850281000000109	Referral to paediatric orthopaedic service (procedure)	
1413500000	41	35	Paediatrics	Paediatric ear, nose and throat	850231000000105	Referral to paediatric ear, nose and throat service (procedure)	
1413900000	41	39	Paediatrics	Paediatric cardiology	417311009	Referral to pediatric cardiology service (procedure)	
1415000000	41	50	Paediatrics	Paediatric dentistry	306188004	Referral to pediatric dentistry service (procedure)	
1415500000	41	55	Paediatrics	Paediatric dermatology	416076006	Referral to pediatric dermatology service (procedure)	
1415900000	41	59	Paediatrics	Paediatric eye care	344131000000108	Referral to paediatric eye care service (procedure)	
1416000000	41	60	Paediatrics	Paediatric gynaecology	700125004	Referral to pediatric gynecology service (procedure)	
1416500000	41	65	Paediatrics	Paediatric neurology	306130000	Referral to pediatric neurology service (procedure)	

1417000000	41	70	Paediatrics	Paediatric oncology	306131001	Referral to pediatric oncology service (procedure)
1419100000	41	91	Paediatrics	Paediatric allergy	885391000000103	Referral to paediatric allergy service (procedure)
1511100000	51	11	ObGyn	Gynaecology	183549000	Referral to gynecology service (procedure)
1511500000	51	15	ObGyn	Obstetrics	183548008	Referral to obstetrics service (procedure)
1611100000	61	11	Psychiatric	Mental Health Act assessment	202291000000107	Referral for mental health assessment (procedure)
1611300000	61	13	Psychiatric	Liaison psychiatry	306136006	Referral to liaison psychiatry service (procedure)
1611500000	61	15	Psychiatric	Child and adolescent mental health service	380241000000107	Refer to Child and Adolescent Mental Health Service (procedure)
1612000000	61	20	Psychiatric	Psychiatry (general)	183524004	Referral to psychiatry service (procedure)
1612500000	61	25	Psychiatric	Older persons mental health service	306138007	Referral to psychogeriatric service (procedure)
1614000000	61	40	Psychiatric	Learning disability team	413127007	Referral to learning disability team (procedure)
1711300000	71	13	Local Medical	General Practitioner	183561008	Referral to general practitioner (procedure)
1711500000	71	15	Local Medical	General practitioner out of hours	770411000000102	Referral to general practitioner out of hours service (procedure)
1713100000	71	31	Local Medical	Primary health care team	276490004	Refer to member of Primary Health Care Team (procedure)
1716100000	71	61	Local Medical	Occupational health	306152009	Referral to occupational health service (procedure)
1811100000	81	11	Community / OPD	Falls service	247541000000106	Referral to falls service (procedure)
1811200000	81	12	Community / OPD	Older people rapid assessment	818861000000107	Referral to older people rapid assessment service (procedure)
1811300000	81	13	Community / OPD	Community nursing out of hours	516511000000107	Referral to community nursing out of hours service (procedure)
1811400000	81	14	Community / OPD	Psychiatric aftercare	61801003	Patient referral for psychiatric aftercare (procedure)
1811500000	81	15	Community / OPD	Alcoholism rehabilitation	38670004	Patient referral for alcoholism rehabilitation (procedure)
1811600000	81	16	Community / OPD	Drug addiction rehabilitation	4266003	Patient referral for drug addiction rehabilitation (procedure)
1811700000	81	17	Community / OPD	Physical rehabilitation	78429003	Patient referral for rehabilitation, physical (procedure)
1811800000	81	18	Community / OPD	Anticoagulant clinic	415263003	Referral for warfarin monitoring (procedure)
1811900000	81	19	Community / OPD	Head injury rehabilitation	307375003	Referral to head injury rehabilitation (procedure)
1812000000	81	20	Community / OPD	Memory assessment service	823961000000102	Referral to memory assessment service (procedure)
1812100000	81	21	Community / OPD	Neurological rehabilitation	894171000000100	Referral to neurological rehabilitation service (procedure)
1814100000	81	41	Community / OPD	Community rapid response team	353961000000104	Referral to community rapid response team (procedure)
1814200000	81	42	Community / OPD	Community rehabilitation	307376002	Referral to community rehabilitation (procedure)
1814300000	81	43	Community / OPD	Community diabetes	811391000000104	Referral to community diabetes service (procedure)
1814400000	81	44	Community / OPD	Community paediatric	306129005	Referral to community pediatric service (procedure)
1814500000	81	45	Community / OPD	Community dermatology	785701000000106	Referral to community dermatology service (procedure)
1814600000	81	46	Community / OPD	Community cardiology	785761000000105	Referral to community cardiology service (procedure)
1816100000	81	61	Community / OPD	Swallow clinic	307380007	Referral to swallow clinic (procedure)
1816200000	81	62	Community / OPD	Community ophthalmology	785721000000102	Referral to community ophthalmology service (procedure)
1816400000	81	64	Community / OPD	Community gynaecology	785781000000101	Referral to community gynaecology service (procedure)
1816500000	81	65	Community / OPD	Community gastroenterology	785621000000108	Referral to community gastroenterology service (procedure)
1816600000	81	66	Community / OPD	Community ear, nose and throat	785681000000109	Referral to community ear, nose and throat service (procedure)

DATA GROUP: DISCHARGE FROM EMERGENCY CARE

FUNCTION: To carry the details of discharge from Emergency Care.
Group Status: R
Group Repeats: 0..1

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	CQUIN DATA ITEM REQUIRED (Y/N)	DATA ITEM REPEATS	FORMAT	SNOMED CT / DM&D /ODS	JUSTIFICATION	ECDS CODE SET	LINK TO CURRENT CDS Type 010 INFORMATION ONLY	VALIDATION RULES		DATA ITEM PROVENANCE	NOTES
											POPULATION VALIDATION F - Format is validated V - Validated against an explicit list of permitted values as defined in the NHS Data Dictionary	POST SCHEMA VALIDATION		
DISCHARGE FROM EMERGENCY CARE	DECIDED TO ADMIT DATE	The date a DECISION TO ADMIT was made.	R	N	0..1	an10 CCYY-MM-DD	DM&D	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.	n/a	n/a	F	n/a	NEW' A&E data item	This data item should be recorded in the ED record on the occasion whereby a decision is made to refer a patient to a service.
DISCHARGE FROM EMERGENCY CARE	DECIDED TO ADMIT TIME	The time a DECISION TO ADMIT was made.	R	N	0..1	an8 HH:MM:SS	DM&D	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.	n/a	n/a	F	n/a	NEW' A&E data item	This data item should be recorded in the ED record on the occasion whereby a decision is made to refer a patient to a service.
DISCHARGE FROM EMERGENCY CARE	ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT)	ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT) is the TREATMENT FUNCTION CODE of the SERVICE to which a PATIENT is to be admitted.	R	N	0..1	an3	DM&D	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.	Link to code set	n/a	F	n/a	NEW' A&E data item	
DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DISCHARGE STATUS (SNOMED CT)	The status of the PATIENT on discharge from an Emergency Care Department. Captures whether treatment took place within the ED, if the patient was streamed to another service or if the patient left before treatment was complete.	R	Y	0..1	min n6 max n18	SNOMED CT	This data item and its counterparts Emergency Care Discharge Destination and Emergency Care Discharge Follow-up are necessary to understand resource needs and transfer of responsibility between different organisations. 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 • Discharge Destination • 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.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	
DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE ATTENDANCE CONCLUSION DATE	The Emergency Care Attendance Conclusion Date may be either: • the Accident and Emergency Attendance Conclusion Date or • the Ambulatory Emergency Care Attendance Conclusion Date. Where the PATIENT dies in the Emergency Care Department, the Emergency Care Attendance Conclusion Date is the same as the PERSON DEATH DATE. An Accident and Emergency Attendance Conclusion Date is the date that a PATIENT's Accident and Emergency Attendance concludes or when treatment in the Accident and Emergency Department is completed (whichever is the later). For those PATIENTS admitted into hospital, the ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE is recorded as the date when the DECISION TO ADMIT was made.	R	N	0..1	an10 CCYY-MM-DD	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/accident_and_emergency_attendance_conclusion_date_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE ATTENDANCE CONCLUSION TIME	The Emergency Care Attendance Conclusion Time may be either: • the Accident and Emergency Attendance Conclusion Time or • the Ambulatory Emergency Care Attendance Conclusion Time. Where the PATIENT dies in the Emergency Care Department, the Emergency Care Attendance Conclusion Time is the same as the PERSON DEATH TIME. An Accident and Emergency Attendance Conclusion Time is the time, recorded using a 24 hour clock: • that a PATIENT's Accident and Emergency Attendance concludes or • when treatment in an Accident and Emergency Department is completed (whichever is the later). For those PATIENTS admitted into hospital, the A and E ATTENDANCE CONCLUSION TIME is recorded as the time when the DECISION TO ADMIT was made.	R	N	0..1	an8 HH:MM:SS	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/a_and_e_attendance_conclusion_time_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DEPARTURE DATE	The Emergency Care Departure Date may be either: • the Accident and Emergency Departure Date or • the Ambulatory Emergency Care Departure Date. An Accident and Emergency Departure Date is the date that a PATIENT leaves an Accident and Emergency Department after an Accident and Emergency Attendance has concluded.	R	N	0..1	an10 CCYY-MM-DD	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/accident_and_emergency_departure_date_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DEPARTURE TIME	An Emergency Care Departure Time is an ACTIVITY DATE TIME. The Emergency Care Departure Time may be either: • the Accident and Emergency Departure Time or • the Ambulatory Emergency Care Departure Time. An Accident and Emergency Departure Time is the time recorded using a 24 hour clock that a PATIENT leaves an Accident and Emergency Department after an Accident and Emergency Attendance has concluded.	R	N	0..1	an8 HH:MM:SS	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/a_and_e_departure_time_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
DISCHARGE FROM EMERGENCY CARE	SAFEGUARDING CONCERN (SNOMED CT)	SAFEGUARDING CONCERN (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE. SAFEGUARDING CONCERN (SNOMED CT) is the SNOMED CT® concept ID which is used to identify an unresolved issue or concern regarding adult and child safeguarding that requires communication to another ORGANISATION or care agency.	R	N	0..*	min n6 max n18	SNOMED CT	Safeguarding information is routinely collected at a local level as part of normal safeguarding requirements but is collected inconsistently and there is no consistent central information regarding number and nature of referrals for safeguarding.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	
DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT)	EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the intended destination of the PATIENT following discharge from the Emergency Care Department.	R	N	0..1	min n6 max n18	SNOMED CT	This data item and its counterparts Emergency Care Discharge Status and Emergency Care Discharge Follow-up are necessary to understand resource needs and transfer of responsibility between different organisations. 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 • Discharge Destination • 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.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	
DISCHARGE FROM EMERGENCY CARE	ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE)	ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE) is the ORGANISATION IDENTIFIER of the Organisation Site to which a PATIENT is discharged following an Emergency Care Attendance.	R	N	0..1	min an5 max an9	ODS	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.	n/a	n/a	F	n/a	NEW' A&E data item	
DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT)	EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the SERVICE to which a PATIENT was referred for continuing care following an Emergency Care Attendance.	R	N	0..1	min n6 max n18	SNOMED CT	This data item and its counterparts Emergency Care Discharge Destination and Emergency Care Discharge Follow-up are necessary to understand resource needs and transfer of responsibility between different organisations. 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 • Discharge Destination • 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.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	

DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DISCHARGE INFORMATION GIVEN (SNOMED CT)	EMERGENCY CARE DISCHARGE INFORMATION GIVEN (SNOMED CT) is the SNOMED CT® concept ID which is used to identify whether a copy of a letter to their GENERAL PRACTITIONER has been printed and given to the PATIENT on discharge from an Emergency Care Department.	R	N	0..1	min n6 max n18	SNOMED CT	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.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	

ECDS_UniqueID	Sort1	Sort2	ECDS_Group	ECDS_Description	DM&D_Code	DM&D_Description	Notes
2018151100	15	11	EM / critical care / anaesthesia	Accident & Emergency	180	Accident & Emergency	SERVICES to care for PATIENTS with urgent problems delivered as part of an Accident and Emergency Attendance or admission at an Accident and Emergency Department
2018815500	81	55	Mental health and cognition	Addiction Services	721	Addiction Services	The prevention and treatment of substance misuse including drugs and alcohol. If PATIENTS have both severe mental illness and problematic substance misuse, see TREATMENT FUNCTION CODE 726 Dual Diagnosis Service
2018394100	39	41	Medical subspecialties	Adult Cystic Fibrosis Service	343	Adult Cystic Fibrosis Service	Specialised, multidisciplinary SERVICE concerned with the diagnosis, assessment and management of PATIENTS with cystic fibrosis. This TREATMENT FUNCTION CODE should be used by recognised specialist centres only
2018811100	81	11	Mental health and cognition	Adult Mental Illness	710	Adult Mental Illness	SERVICES provided to adult PATIENTS for the assessment, diagnosis and treatment of mental illness
2018397300	39	73	Medical subspecialties	Allergy Service	317	Allergy Service	The diagnosis and management of allergic disease (abnormal immune responses to external substances) and the exclusion of allergic causes in other conditions
2018155100	15	51	EM / critical care / anaesthesia	Anaesthetics	190	Anaesthetics	This can be used in out-patients only. Pain Management should be recorded in 191
2018391100	39	11	Medical subspecialties	Anticoagulant Service	324	Anticoagulant Service	The monitoring and control of anticoagulant therapy including the initiation and/or supervision of oral anticoagulant therapy and the determination of anticoagulant dosage. This can be used in out-patients only
2018939100	93	91	Allied health services	Art Therapy	660	Art Therapy	The use of art techniques including clay, paint and paper for therapeutic purposes and as a means of communication
2018378100	37	81	Medical subspecialties	Audiological Medicine	310	Audiological Medicine	The medical specialty concerned with the investigation, diagnosis and management of patients with disorders of balance, hearing, tinnitus and auditory communication. Excludes audiology and hearing tests
2018933500	93	35	Allied health services	Audiology	840	Audiology	Physiological measurement and diagnosis of hearing disorders, and the rehabilitation of PATIENTS with hearing loss
2018372100	37	21	Medical subspecialties	Blood And Marrow Transplantation	308	Blood And Marrow Transplantation	Previously coded within Clinical Haematology (TREATMENT FUNCTION CODE 303). Includes haemopoietic stem cell transplantation
2018253100	25	31	Surgical subspecialties	Breast Surgery	103	Breast Surgery	Includes treatment for cancer, suspected neoplasms, cysts and post-cancer reconstructive surgery. Excludes cosmetic surgery
2018215500	21	55	Surgical specialties	Burns Care	161	Burns Care	To be used by recognised specialist units and associated outreach SERVICES only
2018557100	55	71	Social / rehabilitation care	Cardiac Rehabilitation	327	Cardiac Rehabilitation	Rehabilitation SERVICE for PATIENTS with or recovering from heart related conditions such as heart attacks or from procedures such as coronary artery bypass surgery to ensure that they achieve their full potential in terms of physical and psychological health
2018217100	21	71	Surgical specialties	Cardiac Surgery	172	Cardiac Surgery	Surgical treatment of the heart or great vessels
2018312500	31	25	Medical specialties	Cardiology	320	Cardiology	SERVICES treating diseases and abnormalities of the heart
2018217700	21	77	Surgical specialties	Cardiothoracic Surgery	170	Cardiothoracic Surgery	Should only be used where there are no separate SERVICES for Cardiac Surgery and Thoracic Surgery
2018255500	25	55	Surgical subspecialties	Cardiothoracic Transplantation	174	Cardiothoracic Transplantation	To be used by recognised specialist units and associated outreach services only. Includes pre- and post-operative services
2018373100	37	31	Medical subspecialties	Chemical Pathology	822	Chemical Pathology	To be used for clinical management only
2018812100	81	21	Mental health and cognition	Child And Adolescent Psychiatry	711	Child And Adolescent Psychiatry	SERVICES providing diagnosis, treatment, and prevention of psychopathological disorders of children and adolescents
2018378500	37	85	Medical subspecialties	Clinical Genetics	311	Clinical Genetics	Diagnosis of disorders caused by genetic mechanisms and counselling SERVICE to PATIENTS and affected family members. To be used by recognised specialist units and associated outreach SERVICES only
2018319500	31	95	Medical specialties	Clinical Haematology	303	Clinical Haematology	Excludes Anticoagulant Service - see TREATMENT FUNCTION CODE 324
2018373300	37	33	Medical subspecialties	Clinical Immunology	316	Clinical Immunology	The treatment of disorders of the immune system
2018397100	39	71	Medical subspecialties	Clinical Immunology And Allergy Service	313	Clinical Immunology And Allergy Service	Should only be used where there are no separate SERVICES for Clinical Immunology and Allergy
2018373500	37	35	Medical subspecialties	Clinical Microbiology	322	Clinical Microbiology	SERVICES to treat diseases caused by bacteria, viruses, fungi and parasites
2018378700	37	87	Medical subspecialties	Clinical Neurophysiology	401	Clinical Neurophysiology	The study of the central and peripheral nervous systems through the recording of bioelectrical activity. Includes Electroencephalogram (EEG)
2018319300	31	93	Medical specialties	Clinical Oncology (Previously Radiotherapy)	800	Clinical Oncology (Previously Radiotherapy)	The diagnosis and treatment, typically with Radiotherapy, of PATIENTS with cancer.
2018379200	37	92	Medical subspecialties	Clinical Pharmacology	305	Clinical Pharmacology	SERVICES providing drug information, medication safety and other aspects of pharmacy practice
2018379100	37	91	Medical subspecialties	Clinical Physiology	304	Clinical Physiology	Physiological measurement including ECG (e.g. exercise testing, stress testing), gastrointestinal physiology, cardiac physiology, vascular technology, urodynamics, and ophthalmic and vision science. Excludes Clinical Neurophysiology - see TREATMENT FUNCTION CODE 401, Audiology - see TREATMENT FUNCTION CODE 840 or Respiratory Physiology - see TREATMENT FUNCTION CODE 341
2018935100	93	51	Allied health services	Clinical Psychology	656	Clinical Psychology	The diagnosis and treatment of emotional and behavioural disorders
2018211700	21	17	Surgical specialties	Colorectal Surgery	104	Colorectal Surgery	Surgical treatment of disorders of the lower intestine (colon, anus and rectum)
2018671100	67	11	Paediatric subspecialties	Community Paediatrics	290	Community Paediatrics	Includes routine health surveillance, health promotion, behavioural paediatrics and Looked After Children. Excludes Paediatric Neuro-Disability
2018559200	55	92	Social / rehabilitation care	Complex Specialised Rehabilitation Service	344	Complex Specialised Rehabilitation Service	Complex specialised rehabilitation SERVICE which meets the NHS Specialised Services Rehabilitation Services' criteria and is registered as a Level 1 service. For further information see the NHS Specialised Services website
2018396100	39	61	Medical subspecialties	Congenital Heart Disease Service	331	Congenital Heart Disease Service	The management and treatment of congenital heart disease, this includes the ongoing care of children in to adulthood
2018152100	15	21	EM / critical care / anaesthesia	Critical Care Medicine	192	Critical Care Medicine	also known as Intensive Care Medicine
2018818500	81	85	Mental health and cognition	Dementia Assessment Service	727	Dementia Assessment Service	SERVICES for the assessment of PATIENTS with dementia, which may complicate care giving and can occur at any stage of the illness. In addition to memory impairment, dementia may include behavioural and psychological problems
2018519100	51	91	Maxillo-facial / oral surgery	Dental Medicine Specialties	450	Dental Medicine Specialties	Includes Oral Medicine.
2018351500	35	15	Medical subspecialties	Dermatology	330	Dermatology	SERVICES for the treatment of diseases of the skin
2018934500	93	45	Allied health services	Diabetic Education Service	920	Diabetic Education Service	SERVICES providing dedicated small group education courses regarding self management for diabetic PATIENTS
2018354100	35	41	Medical subspecialties	Diabetic Medicine	307	Diabetic Medicine	SERVICES to diagnose, treat and support PATIENTS with diabetes
2018751100	75	11	Imaging	Diagnostic Imaging	812	Diagnostic Imaging	The production and interpretation of high quality images of the body to diagnose injuries and disease, e.g. x-rays, Ultrasound Scan, MRI Scan, PET Scan or CT Scan.
2018934100	93	41	Allied health services	Dietetics	654	Dietetics	The application of the science of nutrition to devise eating plans for PATIENTS to treat medical conditions. The promotion of good health by helping to facilitate a positive change in food choices amongst individuals, groups and communities
2018939300	93	93	Allied health services	Drama Therapy	659	Drama Therapy	The use of drama and theatre techniques including role play, voice work and storytelling for therapeutic purposes
2018815100	81	51	Mental health and cognition	Eating Disorders	720	Eating Disorders	A specialist SERVICE for the diagnosis and treatment of eating disorders including anorexia, bulimia and compulsive overeating
2018313500	31	35	Medical specialties	Endocrinology	302	Endocrinology	The treatment of disorders of the endocrine system
2018216700	21	67	Surgical specialties	ENT	120	ENT	Ear, nose and throat
2018817100	81	71	Mental health and cognition	Forensic Psychiatry	712	Forensic Psychiatry	SERVICES to assess PATIENTS who have committed an offence and are receiving treatment in high, medium and low secure units or prisons
2018313100	31	31	Medical specialties	Gastroenterology	301	Gastroenterology	The treatment of disorders of the digestive system
2018311100	31	11	Medical specialties	General Medicine	300	General Medicine	Includes sub-categories not elsewhere listed e.g. Metabolic Medicine.
2018211100	21	11	Surgical specialties	General Surgery	100	General Surgery	Includes sub-categories not elsewhere listed e.g. endocrine surgery
2018374100	37	41	Medical subspecialties	Genitourinary Medicine	360	Genitourinary Medicine	Primarily related to medicine dealing with sexually transmitted diseases
2018311500	31	15	Medical specialties	Geriatric Medicine	430	Geriatric Medicine	SERVICES to treat diseases and disabilities in older adults. There is no set age at which PATIENTS may be under the care of Geriatric Medicine, this decision should be determined by the individual PATIENT's needs
2018457500	45	75	Obstetrics / gynaecology	Gynaecological Oncology	503	Gynaecological Oncology	SERVICES to treat cancers of the female reproductive system
2018457100	45	71	Obstetrics / gynaecology	Gynaecology	502	Gynaecology	Disorders of the female reproductive system. Includes planned terminations
2018393100	39	31	Medical subspecialties	Haemophilia Service	309	Haemophilia Service	Previously coded within Clinical Haematology (TREATMENT FUNCTION CODE 303).
2018251100	25	11	Surgical subspecialties	Hepatobiliary & Pancreatic Surgery	105	Hepatobiliary & Pancreatic Surgery	Includes liver surgery, but liver transplantation should be recorded in 102 Transplantation Surgery
2018355100	35	51	Medical subspecialties	Hepatology	306	Hepatology	Also known as liver medicine
2018314100	31	41	Medical specialties	Infectious Diseases	350	Infectious Diseases	SERVICES to diagnose and treat contagious or communicable diseases
2018552100	55	21	Social / rehabilitation care	Intermediate Care	318	Intermediate Care	Intermediate care encompasses a range of multi-disciplinary SERVICES designed to safeguard independence by maximising rehabilitation and recovery after illness or injury
2018752100	75	21	Imaging	Interventional Radiology	811	Interventional Radiology	Diagnosis and treatment of diseases utilising minimally-invasive image-guided procedures. Not to be used for Diagnostic Imaging - see TREATMENT FUNCTION CODE 812
2018818100	81	81	Mental health and cognition	Learning Disability	700	Learning Disability	SERVICES provided to PATIENTS with a Learning Disability
2018814100	81	41	Mental health and cognition	Liaison Psychiatry	722	Liaison Psychiatry	The provision of psychiatric treatment to PATIENTS attending general hospitals including out-patient clinics, Accident and Emergency Departments and admission to wards. Deals with the interface between physical and psychological health.
2018559300	55	93	Social / rehabilitation care	Local Specialist Rehabilitation Service	346	Local Specialist Rehabilitation Service	Local specialist rehabilitation SERVICE which meets the NHS Specialised Services Rehabilitation Services' criteria and is registered as a Level 2b service. For further information see the NHS Specialised Services website
2018511100	51	11	Maxillo-facial / oral surgery	Maxillo-Facial Surgery	144	Maxillo-Facial Surgery	Mouth, jaw and face related surgery
2018319100	31	91	Medical specialties	Medical Oncology	370	Medical Oncology	The diagnosis and treatment, typically with Chemotherapy, of PATIENTS with cancer
2018378300	37	83	Medical subspecialties	Medical Ophthalmology	460	Medical Ophthalmology	SERVICES to diagnose and treat medical conditions affecting the eye, orbits, and visual pathways
2018373700	37	37	Medical subspecialties	Medical Virology	834	Medical Virology	The diagnosis and management and prevention of virus and related infections, in hospital and in the community including HIV/AIDS, other blood-borne infections like hepatitis B and C and viruses such as SARS and avian flu
2018819100	81	91	Mental health and cognition	Mental Health Dual Diagnosis Service	726	Mental Health Dual Diagnosis Service	SERVICES to provide support to PATIENTS with both severe mental illness and substance misuse problems. Personality disorder may coexist with psychiatric illness and/or substance misuse
2018819500	81	95	Mental health and cognition	Mental Health Recovery And Rehabilitation Service	725	Mental Health Recovery And Rehabilitation Service	SERVICES provided to support recovery from mental illness that maximises the PATIENT's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy
2018452100	45	21	Obstetrics / gynaecology	Midwifery Service	560	Midwifery Service	SERVICES provided under the direct care of a MIDWIFE. Excludes Obstetrics see TREATMENT FUNCTION CODE 501
2018939200	93	92	Allied health services	Music Therapy	661	Music Therapy	The use of music and all of its facets to help clients to improve or maintain their health
2018611900	61	19	Paediatric specialties	Neonatology	422	Neonatology	Special Care, High Dependency and Intensive Care
2018314500	31	45	Medical specialties	Nephrology	361	Nephrology	SERVICES to treat kidney conditions and abnormalities
2018318100	31	81	Medical specialties	Neurology	400	Neurology	SERVICES to diagnose and treat conditions and diseases of the central nervous system

2018216100	21	61	Surgical specialties	Neurosurgery	150	Neurosurgery	The prevention, diagnosis, treatment, and rehabilitation of disorders which affect any portion of the nervous system including the brain, spinal cord, peripheral nerves, and extra-cranial cerebrovascular system
2018755100	75	51	Imaging	Nuclear Medicine	371	Nuclear Medicine	The treatment of PATIENTS through the use of radioactive substances
2018451100	45	11	Obstetrics / gynaecology	Obstetrics	501	Obstetrics	The management of pregnancy and childbirth including miscarriages and still births but excluding planned terminations. Excludes Midwifery Service see TREATMENT FUNCTION CODE 560
2018931100	93	11	Allied health services	Occupational Therapy	651	Occupational Therapy	The use of specific activities to limit the effects of disability and promote independence in all aspects of daily life
2018813100	81	31	Mental health and cognition	Old Age Psychiatry	715	Old Age Psychiatry	SERVICES providing the diagnosis, treatment, and prevention of mental and emotional disorders in older adult PATIENTS
2018216500	21	65	Surgical specialties	Ophthalmology	130	Ophthalmology	The surgical treatment of disorders and diseases of the eye. Excludes Medical Ophthalmology - see TREATMENT FUNCTION CODE 460
2018936500	93	65	Allied health services	Optometry	662	Optometry	The diagnosis and non-surgical treatment of disorders of the eye and vision care
2018511500	51	15	Maxillo-facial / oral surgery	Oral Surgery	140	Oral Surgery	The diagnosis and surgical treatment of diseases, injuries and defects involving both the functional and aesthetic aspects of the hard and soft tissues of the head, mouth, teeth, gums, jaws and neck
2018513100	51	31	Maxilla-facial / oral surgery	Orthodontics	143	Orthodontics	The treatment of malocclusions (improper bites). Orthodontic treatment can focus on dental displacement only, or can deal with the control and modification of facial growth
2018936600	93	66	Allied health services	Orthoptics	655	Orthoptics	The diagnosis and treatment of visual problems involving eye movement and alignment
2018937200	93	72	Allied health services	Orthotics	658	Orthotics	The supply of orthoses for PATIENTS
2018674900	67	49	Paediatric subspecialties	Paediatric Audiological Medicine	254	Paediatric Audiological Medicine	The medical specialty concerned with the investigation, diagnosis and management of patients with disorders of balance, hearing, tinnitus and auditory communication. Excludes audiology and hearing tests
2018614200	61	42	Paediatric specialties	Paediatric Burns Care	220	Paediatric Burns Care	To be used by recognised specialist units and associated outreach SERVICES only
2018614500	61	45	Paediatric specialties	Paediatric Cardiac Surgery	221	Paediatric Cardiac Surgery	Surgical treatment of the heart or great vessels
2018615500	61	55	Paediatric specialties	Paediatric Cardiology	321	Paediatric Cardiology	Dedicated SERVICES to children with diseases and abnormalities of the heart, with appropriate facilities and support staff
2018617300	61	73	Paediatric specialties	Paediatric Clinical Haematology	253	Paediatric Clinical Haematology	Excludes Anticoagulant Service - see TREATMENT FUNCTION CODE 324
2018674700	67	47	Paediatric subspecialties	Paediatric Clinical Immunology And Allergy Service	255	Paediatric Clinical Immunology And Allergy Service	Clinical Immunology is the treatment of disorders of the immune system. Allergy Service is the diagnosis and management of allergic disease
2018673500	67	35	Paediatric subspecialties	Paediatric Cystic Fibrosis	264	Paediatric Cystic Fibrosis	Specialised, multidisciplinary SERVICE concerned with the diagnosis, assessment and management of PATIENTS with cystic fibrosis. This TREATMENT FUNCTION CODE should be used by recognised specialist centres only
2018613800	61	38	Paediatric specialties	Paediatric Dentistry	142	Paediatric Dentistry	Dentistry SERVICES dedicated to children with appropriate facilities and support staff
2018674100	67	41	Paediatric subspecialties	Paediatric Dermatology	257	Paediatric Dermatology	SERVICES for the treatment of diseases of the skin
2018673100	67	31	Paediatric subspecialties	Paediatric Diabetic Medicine	263	Paediatric Diabetic Medicine	SERVICES to diagnose, treat and support PATIENTS with diabetes
2018613500	61	35	Paediatric specialties	Paediatric Ear Nose And Throat	215	Paediatric Ear Nose And Throat	Ear, nose and throat
2018616100	61	61	Paediatric specialties	Paediatric Endocrinology	252	Paediatric Endocrinology	The treatment of disorders of the endocrine system
2018673700	67	37	Paediatric subspecialties	Paediatric Epilepsy	223	Paediatric Epilepsy	Designated clinic which provides SERVICES to children led by CONSULTANT paediatrician with expertise in epilepsy supported by specialist staff
2018615300	61	53	Paediatric specialties	Paediatric Gastroenterology	251	Paediatric Gastroenterology	The treatment of disorders of the digestive system
2018612300	61	23	Paediatric specialties	Paediatric Gastrointestinal Surgery	213	Paediatric Gastrointestinal Surgery	Surgical treatment of disorders of the gastrointestinal tract
2018617100	61	71	Paediatric specialties	Paediatric Infectious Diseases	256	Paediatric Infectious Diseases	SERVICES to diagnose and treat contagious or communicable diseases
2018611500	61	15	Paediatric specialties	Paediatric Intensive Care	242	Paediatric Intensive Care	Only to be used by designated Paediatric Intensive Care Units
2018677100	67	71	Paediatric subspecialties	Paediatric Interventional Radiology	280	Paediatric Interventional Radiology	Diagnosis and treatment of diseases utilising minimally-invasive image-guided procedures. Not to be used for Diagnostic Imaging - see TREATMENT FUNCTION CODE 812
2018613700	61	37	Paediatric specialties	Paediatric Maxillo-Facial Surgery	217	Paediatric Maxillo-Facial Surgery	Mouth, jaw and face related surgery
2018617500	61	75	Paediatric specialties	Paediatric Medical Oncology	260	Paediatric Medical Oncology	The diagnosis and treatment, typically with Chemotherapy of PATIENTS with cancer
2018674500	67	45	Paediatric subspecialties	Paediatric Metabolic Disease	261	Paediatric Metabolic Disease	The diagnosis and management of inherited metabolic conditions
2018616900	61	69	Paediatric specialties	Paediatric Nephrology	259	Paediatric Nephrology	SERVICES to treat kidney conditions and abnormalities
2018672100	67	21	Paediatric subspecialties	Paediatric Neuro-Disability	291	Paediatric Neuro-Disability	Dedicated SERVICES for children with Cerebral Palsy and non-progressive handicapping neurological conditions, with or without Learning Disability
2018616500	61	65	Paediatric specialties	Paediatric Neurology	421	Paediatric Neurology	Dedicated SERVICES to children to diagnose and treat conditions and diseases of the central nervous system, with appropriate facilities and support staff
2018613100	61	31	Paediatric specialties	Paediatric Neurosurgery	218	Paediatric Neurosurgery	The prevention, diagnosis, treatment, and rehabilitation of disorders which affect any portion of the nervous system including the brain, spinal cord, peripheral nerves, and extra-cranial cerebrovascular system
2018613300	61	33	Paediatric specialties	Paediatric Ophthalmology	216	Paediatric Ophthalmology	The surgical treatment of disorders and diseases of the eye.
2018672500	67	25	Paediatric subspecialties	Paediatric Pain Management	241	Paediatric Pain Management	Complex pain disorders requiring diagnosis and treatment by a specialist multi-professional team
2018614100	61	41	Paediatric specialties	Paediatric Plastic Surgery	219	Paediatric Plastic Surgery	SERVICES to correct or restore form and function. In addition to cosmetic or aesthetic surgery, plastic surgery includes many types of reconstructive surgery, and the treatment of burns
2018615100	61	51	Paediatric specialties	Paediatric Respiratory Medicine	258	Paediatric Respiratory Medicine	Also known as Thoracic Medicine
2018616700	61	67	Paediatric specialties	Paediatric Rheumatology	262	Paediatric Rheumatology	SERVICES to treat rheumatism, arthritis, and other disorders of the joints, muscles and ligaments
2018612100	61	21	Paediatric specialties	Paediatric Surgery	171	Paediatric Surgery	This is paediatric general surgery
2018614600	61	46	Paediatric specialties	Paediatric Thoracic Surgery	222	Paediatric Thoracic Surgery	Surgical treatment of diseases affecting organs inside the thorax (the chest). Generally treatment of conditions of the lungs, chest wall, and diaphragm
2018676100	67	61	Paediatric subspecialties	Paediatric Transplantation Surgery	212	Paediatric Transplantation Surgery	Includes pre- and post-operative care for major organ transplants except heart and lung (see Cardiothoracic Transplantation). Excludes corneal grafts
2018612700	61	27	Paediatric specialties	Paediatric Trauma And Orthopaedics	214	Paediatric Trauma And Orthopaedics	Surgery to treat injuries, congenital and acquired disorders of the bones, joints, and their associated soft tissues, including ligaments, nerves and muscles. Excludes Spinal Surgery Service - see TREATMENT FUNCTION CODE 108
2018612500	61	25	Paediatric specialties	Paediatric Urology	211	Paediatric Urology	Surgical treatment of disorders of the urinary system and male reproductive system
2018611100	61	11	Paediatric specialties	Paediatrics	420	Paediatrics	SERVICES to treat infants, children, and adolescents
2018157100	15	71	EM / critical care / anaesthesia	Pain Management	191	Pain Management	Complex pain disorders requiring diagnosis and treatment by a specialist multi-professional team
2018352100	35	21	Medical subspecialties	Palliative Medicine	315	Palliative Medicine	The treatment for curable illnesses and those living with chronic diseases, as well as PATIENTS who are nearing the end of life
2018816100	81	61	Mental health and cognition	Perinatal Psychiatry	724	Perinatal Psychiatry	A specialist psychiatric SERVICE for the diagnosis and treatment of ante-natal and post-natal psychiatric problems
2018932100	93	21	Allied health services	Physiotherapy	650	Physiotherapy	The treatment of human function and movement to help people to achieve their full physical potential. The use of physical approaches to promote, maintain and restore wellbeing
2018215100	21	51	Surgical specialties	Plastic Surgery	160	Plastic Surgery	SERVICES to correct or restore form and function. In addition to cosmetic or aesthetic surgery, plastic surgery includes many types of reconstructive surgery, and the treatment of burns
2018937500	93	75	Allied health services	Podiatric Surgery	663	Podiatric Surgery	The treatment of foot problems, including soft tissue, bone and joint surgery of the foot, ankle and associated structures, excludes Podiatry see TREATMENT FUNCTION CODE - 653
2018937600	93	76	Allied health services	Podiatry	653	Podiatry	Also known as Chiropody. The diagnosis and treatment of disorders, diseases and deformities of the feet. Excludes Podiatric Surgery see TREATMENT FUNCTION CODE 663
2018557500	55	75	Social / rehabilitation care	Programmed Pulmonary Rehabilitation	342	Programmed Pulmonary Rehabilitation	A multidisciplinary programme of care for PATIENTS with chronic respiratory impairment that is individually tailored and designed to optimise the individual's physical and social performance and autonomy
2018937100	93	71	Allied health services	Prosthetics	657	Prosthetics	The supply of prosthetics for PATIENTS
2018817500	81	75	Mental health and cognition	Psychiatric Intensive Care	723	Psychiatric Intensive Care	The provision of psychiatric SERVICES to vulnerable individuals who are admitted to Psychiatric Intensive Care Units from open acute wards and forensic settings
2018935500	93	55	Allied health services	Psychotherapy	713	Psychotherapy	SERVICES providing therapy used to treat emotional problems and mental health conditions
2018555100	55	51	Social / rehabilitation care	Rehabilitation Service	314	Rehabilitation Service	SERVICES to enhance and restore functional ability and quality of life to those with physical impairments or disabilities. Excludes Mental Health Recovery and Rehabilitation Service - see TREATMENT FUNCTION CODE 725
2018312100	31	21	Medical specialties	Respiratory Medicine	340	Respiratory Medicine	Also known as Thoracic Medicine
2018394500	39	45	Medical subspecialties	Respiratory Physiology	341	Respiratory Physiology	Physiological measurement of the function of the respiratory system. Includes Sleep Studies (the diagnosis and treatment of sleep disordered breathing, including upper airway resistance syndrome and sleep apnoea)
2018551100	55	11	Social / rehabilitation care	Respite Care	319	Respite Care	SERVICES providing temporary care of a dependant person, providing relief for their usual caregivers
2018515100	51	51	Maxillo-facial / oral surgery	Restorative Dentistry	141	Restorative Dentistry	Endodontics, Periodontics and Prosthodontics are all part of Restorative Dentistry
2018351100	35	11	Medical subspecialties	Rheumatology	410	Rheumatology	SERVICES to treat rheumatism, arthritis, and other disorders of the joints, muscles and ligaments
2018559100	55	91	Social / rehabilitation care	Specialist Rehabilitation Service	345	Specialist Rehabilitation Service	Specialist rehabilitation SERVICE which meets the NHS Specialised Services Rehabilitation Services' criteria and is registered as a Level 2a service. For further information see the NHS Specialised Services website
2018933100	93	31	Allied health services	Speech And Language Therapy	652	Speech And Language Therapy	The assessment, treatment and help to prevent speech, language and swallowing difficulties
2018556100	55	61	Social / rehabilitation care	Spinal Injuries	323	Spinal Injuries	To be used by recognised specialist units and associated outreach SERVICES only, Excludes Spinal Surgery Service - see TREATMENT FUNCTION CODE 108
2018212700	21	27	Surgical specialties	Spinal Surgery Service	108	Spinal Surgery Service	Surgery concentrating on specialised and complex treatment of the back and spine. The SERVICE has a significantly different composition and profile from the SERVICE provided in TREATMENT FUNCTION CODE - 110 Trauma & Orthopaedic. Excludes Spinal Injuries - see TREATMENT FUNCTION CODE 323
2018371100	37	11	Medical subspecialties	Sport And Exercise Medicine	325	Sport And Exercise Medicine	The diagnosis and management of medical problems caused by physical activity, the prevention of related injury and disease and the role of exercise in disease treatment
2018353100	35	31	Medical subspecialties	Stroke Medicine	328	Stroke Medicine	For stroke services excluding Transient Ischaemic Attack - see TREATMENT FUNCTION CODE 329
2018217500	21	75	Surgical specialties	Thoracic Surgery	173	Thoracic Surgery	Surgical treatment of diseases affecting organs inside the thorax (the chest). Generally treatment of conditions of the lungs, chest wall, and diaphragm
2018392100	39	21	Medical subspecialties	Transient Ischaemic Attack	329	Transient Ischaemic Attack	A multidisciplinary SERVICE for rapid diagnosis and treatment of PATIENTS presenting with suspected Transient Ischaemic Attack and mini-strokes to minimise the chance of a full stroke occurring and maximise the chances of independent living after a stroke
2018255100	25	51	Surgical subspecialties	Transplantation Surgery	102	Transplantation Surgery	Includes pre- and post-operative care for major organ transplants except heart and lung (see Cardiothoracic Transplantation). Excludes corneal grafts
2018212100	21	21	Surgical specialties	Trauma & Orthopaedics	110	Trauma & Orthopaedics	Surgery to treat injuries, congenital and acquired disorders of the bones, joints, and their associated soft tissues, including ligaments, nerves and muscles. Excludes Spinal Surgery Service - see TREATMENT FUNCTION CODE 108
2018373900	37	39	Medical subspecialties	Tropical Medicine	352	Tropical Medicine	SERVICES to diagnose and treat diseases that are found most often in tropical or sub-tropical regions
2018211500	21	15	Surgical specialties	Upper Gastrointestinal Surgery	106	Upper Gastrointestinal Surgery	Surgical treatment of disorders of the upper parts of the gastrointestinal tract
2018213500	21	35	Surgical specialties	Urology	101	Urology	Surgical treatment of disorders of the urinary system and male reproductive system

2018213100	21	31	Surgical specialties	Vascular Surgery	107	Vascular Surgery	Surgical treatment of diseases of the vascular system
2018454100	45	41	Obstetrics / gynaecology	Well Babies	424	Well Babies	Use when NEONATAL LEVEL OF CARE = 0 - Normal Care: Care given by the mother/substitute with medical and neonatal nursing advice if needed. See Well Baby

ECDS_UniqueID	Sort1	Sort2	ECDS_Group	ECDS_Description	SNOMED_Code	SNOMED_Description	Notes
2018111111	11	11	Treatment complete	Treatment complete	182992009	Treatment completed (situation)	
2018211111	21	11	Streamed at assessment	Streamed to primary care service / GP	1077021000000100	Streamed from emergency department to general practitioner following initial assessment (situation)	
2018212111	21	21	Streamed at assessment	Streamed to Urgent Care Centre	1077031000000103	Streamed from emergency department to urgent care service following initial assessment (situation)	
2018213111	21	31	Streamed at assessment	Streamed to Emergency Department	1077781000000101	Streamed to emergency department following initial assessment (situation)	
2018214111	21	41	Streamed at assessment	Streamed to Ambulatory Emergency Care service	1077081000000104	Streamed from emergency department to ambulatory emergency care service following initial assessment (situation)	
2018215111	21	51	Streamed at assessment	Streamed to falls service	1077091000000102	Streamed from emergency department to falls service following initial assessment (situation)	
2018215511	21	55	Streamed at assessment	Streamed to frailty service	1077101000000105	Streamed from emergency department to frailty service following initial assessment (situation)	
2018216111	21	61	Streamed at assessment	Streamed to mental health service	1077041000000107	Streamed from emergency department to mental health service following initial assessment (situation)	
2018311111	31	11	Streamed at assessment	Streamed to pharmacy service	1077071000000101	Streamed from emergency department to pharmacy service following initial assessment (situation)	
2018313111	31	31	Streamed at assessment	Streamed to dental service	1077051000000105	Streamed from emergency department to dental service following initial assessment (situation)	
2018315111	31	51	Streamed at assessment	Streamed to ophthalmology service	1077061000000108	Streamed from emergency department to ophthalmology service following initial assessment (situation)	
2018511111	51	11	Left before treatment complete	Left before initial assessment	1066301000000103	Left care setting before initial assessment (finding)	
2018512111	51	21	Left before treatment complete	Left after assessment with intent to attend other healthcare provider	1066311000000101	Left care setting after initial assessment (finding)	
2018514111	51	41	Left before treatment complete	Left after assessment but before treatment complete (destination unknown)	1066321000000107	Left care setting before treatment completed (finding)	
2018811111	81	11	Died	Dead on arrival	63238001	Dead on arrival at hospital (finding)	
2018812111	81	21	Died	Died in the Emergency Care facility	75004002	Emergency room admission, died in emergency room (procedure)	

ECDS_UniqueID	Sort1	Sort2	ECDS_Group	ECDS_Description	SNOMED_Code	SNOMED Description	Notes
2018111100	11	11	No safeguarding issue	No safeguarding issues identified	861931000000100	No safeguarding issues identified (finding)	
2018221100	22	11	Concern	Frequent attender of emergency department	826931000000104	Frequent attender of accident and emergency department (finding)	
2018221500	22	15	Concern	Delay in seeking medical advice	449889006	Delay in seeking medical advice (finding)	
2018222100	22	21	Concern	Child is cause for safeguarding concern	836881000000105	Child is cause for safeguarding concern (finding)	
2018223100	22	31	Concern	Adult safeguarding concern	766561000000109	Adult safeguarding concern (finding)	
2018224100	22	41	Concern	Family is cause for concern	300731000000106	Family is cause for concern (finding)	
2018225100	22	51	Concern	Carer behaviour is cause for safeguarding concern	1076171000000100	Carer behaviour is cause for safeguarding concern (situation)	
2018226100	22	61	Concern	Unborn child is cause for safeguarding concern	878111000000109	Unborn child is cause for safeguarding concern (finding)	
2018311100	31	11	At risk - general	At risk for deliberate self harm	401206008	At risk for deliberate self harm (finding)	
2018312100	31	21	At risk - general	At risk of physical abuse	416936003	At risk of physical abuse (finding)	
2018312300	31	23	At risk - general	At risk for other-directed violence	129707006	At risk for other-directed violence (finding)	
2018313100	31	31	At risk - general	Child at risk	160877008	Child at risk (finding)	
2018313300	31	33	At risk - general	Vulnerable adult	417430008	Vulnerable adult (finding)	
2018315100	31	51	At risk - general	At risk of financial abuse	761571000000106	At risk of financial abuse (finding)	
2018315500	31	55	At risk - general	At risk of discriminatory abuse	417427001	At risk of discriminatory abuse (finding)	
2018316100	31	61	At risk - general	At risk of institutional abuse	838481000000106	At risk of institutional abuse (finding)	
2018317100	31	71	At risk - general	At risk of human trafficking	1045861000000100	At risk of human trafficking (finding)	
2018317700	31	77	At risk - general	At risk of radicalisation	1076841000000100	At risk of radicalisation (finding)	
2018318100	31	81	At risk - general	Has child subject of child protection plan	864491000000105	Has child subject of child protection plan (situation)	
2018318300	31	83	At risk - general	Family member subject of child protection plan	375041000000100	Family member subject of child protection plan (situation)	
2018318700	31	87	At risk - general	Domestic abuse victim in household	881081000000100	Domestic abuse victim in household (finding)	
2018351100	35	11	At risk - psychological / sexual	At risk of domestic violence	707087005	At risk of domestic violence (finding)	
2018353100	35	31	At risk - psychological / sexual	At risk of sexual abuse	417361000	At risk of sexual abuse (finding)	
2018353500	35	35	At risk - psychological / sexual	At risk of sexual exploitation	919461000000108	At risk of sexual exploitation (finding)	
2018356100	35	61	At risk - psychological / sexual	At risk of female genital mutilation	713201008	At risk of female genital mutilation (finding)	
2018356500	35	65	At risk - psychological / sexual	At risk of honour based violence	1066201000000100	At risk of honour based violence (finding)	
2018356900	35	69	At risk - psychological / sexual	At risk of forced marriage	1054321000000100	At risk of forced marriage (finding)	
2018357100	35	71	At risk - psychological / sexual	At risk of emotional abuse	1065691000000100	At risk of emotional abuse (finding)	
2018357500	35	75	At risk - psychological / sexual	At risk of psychological abuse	1045831000000100	At risk of psychological abuse (finding)	
2018511100	51	11	Drug / alcohol / neglect	Suspected alcohol abuse	415685003	Suspected alcohol abuse (situation)	
2018511500	51	15	Drug / alcohol / neglect	Family history of alcohol misuse	293161000000103	Family history of alcohol misuse (situation)	
2018512100	51	21	Drug / alcohol / neglect	Suspected drug abuse	162591001	Suspected drug abuse (situation)	
2018512500	51	25	Drug / alcohol / neglect	Family history of substance misuse	287351000000105	Family history of substance misuse (situation)	
2018514100	51	41	Drug / alcohol / neglect	Suspected victim of child neglect	702953007	Suspected victim of child neglect (situation)	
2018515100	51	51	Drug / alcohol / neglect	Self-neglect	248054003	Self-neglect (finding)	
2018551100	55	11	Psychological / sexual	Suspected victim of emotional abuse	697951004	Suspected victim of emotional abuse (situation)	
2018552100	55	21	Psychological / sexual	Suspected victim of sexual abuse	702579009	Suspected victim of sexual abuse (situation)	
2018552200	55	22	Psychological / sexual	Suspected victim of child sexual abuse	700254002	Suspected victim of child sexual abuse (situation)	
2018552500	55	25	Psychological / sexual	Suspected victim of sexual grooming	700253008	Suspected victim of sexual grooming (situation)	
2018555100	55	51	Psychological / sexual	Alleged victim of sexual assault	297591000000108	Alleged victim of sexual assault (situation)	
2018661100	66	11	General / physical	Suspected non-accidental injury to child	700255001	Suspected non-accidental injury to child (situation)	
2018661500	66	15	General / physical	Suspected victim of child abuse	162596006	Suspected victim of child abuse (situation)	
2018663100	66	31	General / physical	Suspected domestic abuse	697950003	Suspected domestic abuse (situation)	
2018665100	66	51	General / physical	Suspected victim of physical abuse	697949003	Suspected victim of physical abuse (situation)	
2018665500	66	55	General / physical	Suspected victim of bullying	1065911000000100	Suspected victim of bullying (situation)	
2018669100	66	91	General / physical	Disclosure of being subjected to abuse	1065901000000100	Alleged being subjected to abuse (situation)	

ECDS_UniqueID	Sort1	Sort2	ECDS_Group	ECDS_Description	SNOMED_Code	SNOMED_Description	Notes
2018111111	11	11	Discharged	Home	306689006	Discharge to home (procedure)	
2018112111	11	21	Discharged	Residential care facility without 24 hour nursing care (e.g. residential home)	306691003	Discharge to residential home (procedure)	
2018113111	11	31	Discharged	Residential care facility with 24 hour nursing care (e.g. nursing home)	306694006	Discharge to nursing home (procedure)	
2018114111	11	41	Discharged	Police	306705005	Discharge to police custody (procedure)	
2018114511	11	45	Discharged	Custodial services e.g. prison / detention centre	50861005	Patient discharge, to legal custody (procedure)	
2018311111	31	11	Ambulatory / short stay	Short stay (less than 24hr) ward outside the ED but managed by ED	1066331000000109	Emergency department discharge to emergency department short stay ward (procedure)	
2018312111	31	21	Ambulatory / short stay	Ambulatory Emergency Care service	1066341000000100	Emergency department discharge to ambulatory emergency care service (procedure)	
2018313111	31	31	Ambulatory / short stay	Hospital in the home service	1066351000000102	Discharge to hospital at home service (procedure)	
2018511111	51	11	Admitted	Ward – physical ward bed outside ED	306706006	Discharge to ward (procedure)	
2018551111	55	11	Admitted	High Dependency Unit (level 2)	1066361000000104	Emergency department discharge to high dependency unit (procedure)	
2018553111	55	31	Admitted	Coronary Care Unit (level 2)	1066371000000106	Emergency department discharge to coronary care unit (procedure)	
2018555111	55	51	Admitted	Special Care Baby Unit (level 2)	1066381000000108	Emergency department discharge to special care baby unit (procedure)	
2018611111	61	11	Admitted	Intensive Care Unit (level 3)	1066391000000105	Emergency department discharge to intensive care unit (procedure)	
2018614111	61	41	Admitted	Neonatal Intensive Care Unit (level 3)	1066401000000108	Emergency department discharge to neonatal intensive care unit (procedure)	
2018911111	91	11	Transfer	Transfer to another hospital	19712007	Patient transfer, to another health care facility (procedure)	
2018951111	95	11	Died	Mortuary	305398007	Admission to the mortuary (procedure)	

ECDS_UniqueID	Sort1	Sort2	ECDS_Group	ECDS_Description	SNOMED_Code	SNOMED_Description	Notes
2018111100	11	11	Community	General Practitioner	989501000000106	Discharge from Accident and Emergency service with advice for follow up treatment by general practitioner (procedure)	
2018112100	11	21	Community	Physiotherapy	306170007	Referral to physiotherapy service (procedure)	
2018113100	11	31	Community	Dentist	306735003	Referral to general dental surgery service (procedure)	
2018114100	11	41	Community	Community psychiatric support services	183584001	Referral to community psychiatric nurse (procedure)	
2018115100	11	51	Community	Other community service	710915002	Referral to community service (procedure)	
2018211100	21	11	Hospital	Fracture clinic	301791000000104	Referral to fracture clinic (procedure)	
2018212100	21	21	Hospital	Ambulatory Care service	898791000000105	Referral for ambulatory care (procedure)	
2018213100	21	31	Hospital	Outpatients (not fracture clinic)	1066111000000103	Referral to outpatients department (procedure)	
2018214100	21	41	Hospital	Review in ED (scheduled)	1077181000000100	Follow-up review in emergency department (finding)	
2018216100	21	61	Hospital	Medical specialist (private)	266747000	Referral to private doctor (procedure)	
2018911100	91	11	No referral	No referral	3780001	Routine patient disposition, no follow-up planned (procedure)	

ECDS_UniqueID	Sort 1	ECDS_Group	ECDS_Description	ECDS_Code	SNOMED_Description	Notes
n/a	n/a	n/a	Copy of discharge letter provided to patient	787281000000102	Provision of copy of discharge letter to patient (procedure)	

DATA GROUP: RESEARCH AND OUTBREAK NOTIFICATION

FUNCTION: To carry details of any Research and/or Disease Outbreak Notifications.
Group Status: O
Group Repeats: 0..1

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	DATA ITEM REPEATS	FORMAT	SNOMED CT / DM&D /ODS	JUSTIFICATION	ECDS CODE SET	LINK TO CURRENT CDS Type 010 INFORMATION ONLY	VALIDATION RULES		DATA ITEM PROVENANCE	NOTES
										POPULATION VALIDATION F - Format is validated V - Validated against an explicit list of permitted values as defined in the NHS Data Dictionary	POST SCHEMA VALIDATION		
RESEARCH AND OUTBREAK NOTIFICATION	CLINICAL TRIAL IDENTIFIER	A unique identifier assigned to a CLINICAL TRIAL.	O	0..1	max an20	DM&D	Nearly all research in Emergency Care in the UK is government funded, and therefore data collection and aggregation is an important direct cost for any research. At present, the customisation of any software to aggregate the results of patient recruitment is a significant barrier and cost to such research. Inability to do research harms the NHS' ability to better understand emergency care and commission the right care that meets patient needs. Promoting research, audit and benchmarking across the NHS requires embedded IT support as a key enabler. The ability to capture and flow relevant data cost-effectively enables multi-centre trials that will save the NHS many thousands of pounds in building custom IT solutions to track patient recruitment. Facilitating multi-centre trials is particularly important because they increase the reliability of the research – the results are much more likely to be robust and applicable across a wide range of hospitals, and therefore the research itself is much more cost-effective.	n/a	n/a	F	n/a	NEW' A&E data item	CLINICAL TRIAL IDENTIFIER is the same as attribute CLINICAL TRIAL IDENTIFIER. Used in the CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set: • The CLINICAL TRIAL IDENTIFIER must be recognised and registered with an ORGANISATION which is a Primary Registry in the World Health Organisation International Clinical Trials Registry Platform. • CLINICAL TRIAL IDENTIFIER is collected for a specified purpose at national level only and will not be available from the Secondary Uses Service for use by unauthorised ORGANISATIONS or individuals.
RESEARCH AND OUTBREAK NOTIFICATION	DISEASE OUTBREAK NOTIFICATION	DISEASE OUTBREAK NOTIFICATION is used in the CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set to support collection of nationally-notifiable data relating to outbreaks of disease which are identified in Emergency Care Departments. Where a SNOMED CT CODE is available, the DISEASE OUTBREAK NOTIFICATION field should contain this. If a SNOMED CT CODE is NOT available, then it is permissible to submit free-text detail of the disease.	O	0..1	max an20	DM&D	By including this field, the data set will address key National Institute of Health Research (NIHR) priorities for efficient research design, and will enable research into and rapid response to major infectious disease health threats.	n/a	n/a	F	n/a	NEW' A&E data item	DISEASE OUTBREAK NOTIFICATION is collected for a specified purpose at national level only and will not be available from the Secondary Uses Service for use by unauthorised ORGANISATIONS or individuals.

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	SCHEMA DATA ITEM STATUS (M/R/O)	CQUIN DATA ITEM REQUIRED (Y/N)	DATA ITEM REPEATS	FORMAT	SNOMED CT / DM&D /ODS	JUSTIFICATION	ECDS CODE SET	LINK TO CURRENT CDS Type 010 INFORMATION ONLY	VALIDATION RULES		DATA ITEM PROVENANCE	NOTES
											POPULATION VALIDATION F - Format is validated V - Validated against an explicit list of permitted values as defined in the NHS Data Dictionary	POST SCHEMA VALIDATION		
PATIENT PATHWAY - PATIENT PATHWAY IDENTITY **DATA GROUP STATUS: M** **DATA GROUP REPEATS: 1..1** **NOTES: Submit either 'UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)' or 'PATIENT PATHWAY IDENTIFIER'**														
PATIENT PATHWAY - PATIENT PATHWAY IDENTITY	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	The unique booking reference number assigned by the Choose and Book system when a PATIENT accepts an APPOINTMENT DATE OFFERED of an APPOINTMENT OFFER where the offer was made via the Choose and Book system. When a PATIENT accepts an APPOINTMENT DATE OFFERED, the unique booking reference number issued and used during the booking process is considered to be 'converted' i.e. an APPOINTMENT has been created and recorded; and the PATIENT has been placed on an Out-Patient Waiting List even if subsequently the PATIENT does not attend or cancels the APPOINTMENT. UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) should only be recorded where the type of booking system is the Choose and Book system.	M	N	1..1	n12	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/u/un/unique_booking_reference_number_(converted)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	Either submit UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) **OR** PATIENT PATHWAY IDENTIFIER
PATIENT PATHWAY - PATIENT PATHWAY IDENTITY	PATIENT PATHWAY IDENTIFIER	An identifier, which together with the ORGANISATION CODE / ORGANISATION IDENTIFIER of the issuer, uniquely identifies a PATIENT PATHWAY. This is a specific type of the attribute ACTIVITY IDENTIFIER. Where a pathway is initiated by a SERVICE REQUEST using the Choose and Book system, the PATIENT PATHWAY will be uniquely identified by the Unique Booking Reference Number (UBRN) of the first referral and the ORGANISATION CODE of Choose and Book which is X09. Where the pathway is initiated by some other method, the PATIENT PATHWAY IDENTIFIER will be allocated by the Organisation receiving the SERVICE REQUEST which together with that Organisation's ORGANISATION CODE / ORGANISATION IDENTIFIER will uniquely identify the PATIENT PATHWAY.	M	N	1..1	an20	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/p/pat/patient_pathway_identifier_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	Either submit UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) OR PATIENT PATHWAY IDENTIFIER
PATIENT PATHWAY - PATIENT PATHWAY IDENTITY	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER) is the ORGANISATION IDENTIFIER of the Organisation issuing the PATIENT PATHWAY IDENTIFIER.	M	N	1..1	min an3 max an5	ODS	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/attributes/o/org/organisation_code_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT PATHWAY - REFERRAL TO TREATMENT PERIOD CHARACTERISTICS **DATA GROUP STATUS: M** **DATA GROUP REPEATS: 1..1**														
PATIENT PATHWAY - REFERRAL TO TREATMENT PERIOD CHARACTERISTICS	REFERRAL TO TREATMENT PERIOD STATUS	The status of an ACTIVITY (or anticipated ACTIVITY) for the REFERRAL TO TREATMENT PERIOD decided by the lead CARE PROFESSIONAL.	M	N	1..1	an2	DM&D	As per CDS 6.2 Type 010	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/r/ref/referral_to_treatment_period_status_de.asp?shownav=0	V	n/a	Originates from A&E CDS Type 010	
PATIENT PATHWAY - REFERRAL TO TREATMENT PERIOD CHARACTERISTICS	WAITING TIME MEASUREMENT TYPE	The type of waiting time measurement methodology which may be applied during a PATIENT PATHWAY. The methodology applied may be for one part of a PATIENT PATHWAY, such as the measurement of a REFERRAL TO TREATMENT PERIOD, or other parts of the PATIENT PATHWAY according to Department of Health policy.	M	N	1..1	an2	DM&D	As per CDS 6.2 Type 010	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/w/waiting_time_measurement_type_de.asp?shownav=0	V	n/a	Originates from A&E CDS Type 010	
PATIENT PATHWAY - REFERRAL TO TREATMENT PERIOD CHARACTERISTICS	REFERRAL TO TREATMENT PERIOD START DATE	The start date of a REFERRAL TO TREATMENT PERIOD.	O	N	0..1	an10 CCYY-MM-DD	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/r/ref/referral_to_treatment_period_start_date_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT PATHWAY - REFERRAL TO TREATMENT PERIOD CHARACTERISTICS	REFERRAL TO TREATMENT PERIOD END DATE	The end date of a REFERRAL TO TREATMENT PERIOD.	O	N	0..1	an10 CCYY-MM-DD	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/r/ref/referral_to_treatment_period_end_date_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT PATHWAY - WITHHELD IDENTITY STRUCTURE **DATA GROUP STATUS:** **DATA GROUP REPEATS: 1..1** **NOTES: Must be used where the Commissioning Data Set record has been anonymised**														
PATIENT IDENTITY - WITHHELD IDENTITY STRUCTURE	NHS NUMBER STATUS INDICATOR CODE	The trace status of the NHS number.	M	N	1..1	an2	DM&D	As per CDS 6.2 Type 010	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/n/nhs/nhs_number_status_indicator_code_de.asp?shownav=0	V	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - WITHHELD IDENTITY STRUCTURE	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) is the ORGANISATION IDENTIFIER derived from the PATIENT's POSTCODE OF USUAL ADDRESS, where they reside within the boundary of a: •Clinical Commissioning Group •Care Trust •Local Health Board (Wales) •Scottish Health Board •Northern Ireland Local Commissioning Group •Primary Healthcare Directorate (Isle of Man) •Local Authority.	R	N	0..1	min an3 max an5	ODS	Updated to new Organisation code guidelines	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/o/org/organisation_code_(residence_responsibility)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - WITHHELD IDENTITY STRUCTURE	WITHHELD IDENTITY REASON	WITHHELD IDENTITY REASON allows suppliers of data set records to indicate to recipients of the record (for example, the Commissioner of the activity) that the record has been purposely anonymised for a valid reason.	R	N	0..1	an2	DM&D	As per CDS 6.2 Type 010	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/w/we/withheld_identity_reason_de.asp?shownav=0	V	n/a	Originates from A&E CDS Type 010	
PATIENT PATHWAY - VERIFIED IDENTITY STRUCTURE **DATA GROUP STATUS:** **DATA GROUP REPEATS: 1..1** **NOTES: Must be used where the NHS NUMBER STATUS INDICATOR CODE National Code = 01 (Number present and verified)**														
PATIENT IDENTITY - LOCAL PATIENT IDENTIFIER STRUCTURE	LOCAL PATIENT IDENTIFIER (EXTENDED)	A number used to identify a PATIENT uniquely within a Health Care Provider. It may be different from the PATIENT's case note number and may be assigned automatically by the computer system.	M	N	1..1	max an20	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/l/li/local_patient_identifier_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - LOCAL PATIENT IDENTIFIER STRUCTURE	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) is the ORGANISATION IDENTIFIER of the Organisation that assigned the LOCAL PATIENT IDENTIFIER.	M	N	1..1	min an3 max an5	ODS	Updated to new Organisation code guidelines	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/o/org/organisation_code_(local_patient_identifier)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - VERIFIED IDENTITY STRUCTURE	NHS NUMBER	The NHS NUMBER, the primary identifier of a PERSON, is a unique identifier for a PATIENT within the NHS in England and Wales.	M	N	1..1	n10	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/n/nhs/nhs_number_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - VERIFIED IDENTITY STRUCTURE	NHS NUMBER STATUS INDICATOR CODE	The trace status of the NHS number.	M	N	1..1	an2	DM&D	As per CDS 6.2 Type 010	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/n/nhs/nhs_number_status_indicator_code_de.asp?shownav=0	V	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - VERIFIED IDENTITY STRUCTURE	POSTCODE OF USUAL ADDRESS	The code assigned by Royal Mail to identify postal delivery areas across the United Kingdom.	M	N	1..1	max an8	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/p/po/postcode_of_usual_address_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - VERIFIED IDENTITY STRUCTURE	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	An ORGANISATION CODE is a code which identifies an Organisation uniquely.	R	N	0..1	min an3 max an5	ODS	Updated to new Organisation code guidelines	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/o/org/organisation_code_(residence_responsibility)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - VERIFIED IDENTITY STRUCTURE	PERSON BIRTH DATE	The date on which a PERSON was born or is officially deemed to have been born.	R	N	0..1	an10 CCYY-MM-DD	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/p/pers/person_birth_date_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT PATHWAY - UNVERIFIED IDENTITY STRUCTURE **DATA GROUP STATUS:** **DATA GROUP REPEATS: 1..1** **NOTES: Submit either 'UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)' or 'PATIENT PATHWAY IDENTIFIER'**														
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	LOCAL PATIENT IDENTIFIER (EXTENDED)	A number used to identify a PATIENT uniquely within a Health Care Provider. It may be different from the PATIENT's casenote number and may be assigned automatically by the computer system. Where care for NHS patients is sub-commissioned in the independent sector or overseas, the NHS commissioner PAS Number should be used. If no NHS PAS Number has been assigned the independent sector or overseas PAS Number should be used.	M	N	1..1	max an20	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/l/li/local_patient_identifier_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	An ORGANISATION CODE is a code which identifies an Organisation uniquely.	M	N	1..1	min an3 max an5	ODS	Updated to new Organisation code guidelines	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/o/org/organisation_code_(local_patient_identifier)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	NHS NUMBER	The NHS NUMBER, the primary identifier of a PERSON, is a unique identifier for a PATIENT within the NHS in England and Wales.	R	N	0..1	n10	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/n/nhs/nhs_number_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	NHS NUMBER STATUS INDICATOR CODE	The trace status of the NHS number	M	N	1..1	an2	DM&D	As per CDS 6.2 Type 010	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/n/nhs/nhs_number_status_indicator_code_de.asp?shownav=0	V	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	PATIENT NAME - PERSON NAME STRUCTURED OR PATIENT NAME - PERSON NAME UNSTRUCTURED	PATIENT NAME is the PERSON NAME where the PERSON NAME CLASSIFICATION is 'Preferred Name' of the PATIENT.	O	N	0..1	max an70	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/p/pat/patient_name_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	PATIENT USUAL ADDRESS - ADDRESS STRUCTURED (Label format Postal Address) OR PATIENT USUAL ADDRESS - ADDRESS UNSTRUCTURED (Character string)	PATIENT USUAL ADDRESS is the usual ADDRESS nominated by the PATIENT, where the ADDRESS ASSOCIATION TYPE is 'Main Permanent Residence' or 'Other Permanent Residence'.	R	N	0..1	max an175 (5 lines each an35)	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/p/pat/patient_usual_address_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	POSTCODE OF USUAL ADDRESS	The code assigned by Royal Mail to identify postal delivery areas across the United Kingdom.	R	N	0..1	max an8	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/p/po/postcode_of_usual_address_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) is the ORGANISATION IDENTIFIER derived from the PATIENT's POSTCODE OF USUAL ADDRESS, where they reside within the boundary of a: •Clinical Commissioning Group •Care Trust •Local Health Board (Wales) •Scottish Health Board •Northern Ireland Local Commissioning Group •Primary Healthcare Directorate (Isle of Man) •Local Authority.	R	N	0..1	min an3 max an5	ODS	Updated to new Organisation code guidelines	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/o/org/organisation_code_(residence_responsibility)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	PERSON BIRTH DATE	The date on which a PERSON was born or is officially deemed to have been born.	R	N	0..1	an10 CCYY-MM-DD	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/p/pers/person_birth_date_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
PATIENT CHARACTERISTICS (EMERGENCY CARE)	PERSON STATED GENDER CODE	The gender of a PERSON. PERSON STATED GENDER CODE is self declared or inferred by observation for those unable to declare their PERSON STATED GENDER.	R	N	0..1	an1	DM&D	As per CDS 6.2 Type 010. Updated to align to most recent information standard to describe gender, changed from Person Gender Code.	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/p/pers/person_gender_code_current_de.asp?shownav=0	V	n/a	Originates from A&E CDS Type 010	
PATIENT CHARACTERISTICS (EMERGENCY CARE)	ETHNIC CATEGORY	The ethnicity of a PERSON, as specified by the PERSON.	R	N	0..1	max an2	DM&D	As per CDS 6.2 Type 010	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/e/ep/ethnic_category_de.asp?shownav=0	V	n/a	Originates from A&E CDS Type 010	
PATIENT CHARACTERISTICS (EMERGENCY CARE)	ACCOMMODATION STATUS (SNOMED CT)	ACCOMMODATION STATUS (SNOMED CT) is the SNOMED CT concept ID which is used to identify the details of the ACCOMODATION of the PERSON.	R	N	0..1	min n6 max n18	SNOMED CT	This item is necessary to identify rates of ED treatment, admission and discharge of specific populations of patients. This will substantially aid planning and delivery of care for specific population groups at both a	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	
PATIENT CHARACTERISTICS (EMERGENCY CARE)	PREFERRED SPOKEN LANGUAGE (SNOMED CT)	PREFERRED SPOKEN LANGUAGE (SNOMED CT) is the SNOMED CT concept ID which is used to capture the preferred spoken LANGUAGE of the PERSON.	R	N	0..1	min n6 max n18	SNOMED CT	Necessary to understand how best to provide for patient needs, identify language barriers that may prevent optimal healthcare and enable planning for how these may be ameliorated. This data is necessary to ensure that translation resources match patient need.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	
PATIENT CHARACTERISTICS (EMERGENCY CARE)	ACCESSIBLE INFORMATION PROFESSIONAL REQUIRED CODE (SNOMED CT)	ACCESSIBLE INFORMATION PROFESSIONAL REQUIRED CODE (SNOMED CT) is the SNOMED CT concept ID which is used to identify that the PAITENT requires support from a communication professional.	R	N	0..1	min n6 max n18	SNOMED CT	Necessary to understand how best to provide for patient needs, identify language barriers that may prevent optimal healthcare and enable	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for	NEW' A&E data item	
PATIENT CHARACTERISTICS (EMERGENCY CARE)	INTERPRETER LANGUAGE (SNOMED CT)	INTERPRETER LANGUAGE (SNOMED CT) is the SNOMED CT concept ID which is used to capture the preferred spoken LANGUAGE of the communication professional.	R	N	0..1	min n6 max n18	SNOMED CT	Necessary to understand how best to provide for patient needs, identify language barriers that may prevent optimal healthcare and enable	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for	NEW' A&E data item	This data item must be collected if Accessible Information Professional Required Code is 'Interpreter needed'.
PATIENT CHARACTERISTICS (EMERGENCY CARE)	OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE	The charging category relating to an OVERSEAS VISITOR STATUS.	R	N	0..1	an1	DM&D	As per CDS 6.2 Type 010. Code set amended to align to new DH guidance on reclaiming overseas visitors contributions to NHS care.	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/o/ov/overseas_visitor_status_classification_at_cds_activity_date_de.asp?shownav=0	V	n/a	Originates from A&E CDS Type 010	
MENTAL HEALTH ACT LEGAL STATUS	START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	The MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START DATE records the start date of the Mental Health Act Legal Status Classification Assignment Period.	M	N	1..1	an10 CCYY-MM-DD	DM&D	To support a better understanding of the use of the Mental Health Act in acute trusts, specifically Emergency Departments	n/a	n/a	F	n/a	NEW' A&E data item	

MENTAL HEALTH ACT LEGAL STATUS	START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	The MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START TIME records the start time of the Mental Health Act Legal Status Classification Assignment Period.	M	N	1..1	an8 HH:MM:SS	DM&D	To support a better understanding of the use of the Mental Health Act in acute trusts, specifically Emergency Departments.	n/a	n/a	F	n/a	NEW' A&E data item	
MENTAL HEALTH ACT LEGAL STATUS	EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	The DATE when a MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION for a PATIENT expires.	R	N	0..1	an10 CCYY-MM-DD	DM&D	To support a better understanding of the use of the Mental Health Act in acute trusts, specifically Emergency Departments.	n/a	n/a	F	n/a	NEW' A&E data item	
MENTAL HEALTH ACT LEGAL STATUS	EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	The TIME when a MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION for a PATIENT expires.	R	N	0..1	an8 HH:MM:SS	DM&D	To support a better understanding of the use of the Mental Health Act in acute trusts, specifically Emergency Departments.	n/a	n/a	F	n/a	NEW' A&E data item	
MENTAL HEALTH ACT LEGAL STATUS	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE	A code which identifies the MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION. Note that the National Code 'Informal' is used for those PATIENTS who are neither formally detained nor receiving supervised aftercare.	M	N	1..1	an2	DM&D	To support a better understanding of the use of the Mental Health Act in acute trusts, specifically Emergency Departments.	Link to code set	n/a	V	n/a	NEW' A&E data item	
GP REGISTRATION	GENERAL MEDICAL PRACTITIONER (SPECIFIED)	GENERAL MEDICAL PRACTITIONER (SPECIFIED) is the GENERAL MEDICAL PRACTITIONER PPD CODE of the GENERAL MEDICAL PRACTITIONER specified by the PATIENT.	O	N	0..1	an8	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/g/general_medical_practitioner_(specified)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
GP REGISTRATION	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	An ORGANISATION SITE CODE is a code which identifies an Organisation Site uniquely.	R	N	0..1	an6	ODS	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/g/general_medical_practice_code_(patient_registration)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
EMERGENCY CARE ATTENDANCE LOCATION	ORGANISATION SITE IDENTIFIER (OF TREATMENT)	An ORGANISATION SITE CODE is a code which identifies an Organisation Site uniquely.	M	N	1..1	min an5 max an9	Updated to new Organisation code guidelines	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/s/site/site_code_(of_treatment)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
EMERGENCY CARE ATTENDANCE LOCATION	EMERGENCY CARE DEPARTMENT TYPE	The type of Emergency Care Department	M	N	1..1	an2	As per CDS 6.2 Type 010. Updated to include new code for Ambulatory Emergency Care Unit in anticipation of this data set being used to support the collection of AEC data in the future.	As per CDS 6.2 Type 010	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/a_and_e_department_type_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	Urgent Care Centres should be recorded as a Type 3 Department.
AMBULANCE DETAILS	AMBULANCE INCIDENT NUMBER	An identifier for each PATIENT TRANSPORT JOURNEY.	R	N	0..1	max an20	DM&D	As per CDS 6.2 Type 010 Amended from 'Optional' to 'Required' at request of DH. Making these data items required will allow linking of ambulance and emergency department data, thus providing information about a patient from the moment an ambulance is called until they leave hospital. This will provide learning opportunities that can benefit ambulance services, emergency departments and patients.	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/ag/ambulance_incident_number_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	This information should be recorded when EMERGENCY CARE ARRIVAL MODE is recorded as patient arrives by Emergency road ambulance, Emergency road ambulance with medical escort, Non-emergency road ambulance, Helicopter, or Fixed wing / medical repatriation by air.
AMBULANCE DETAILS	ORGANISATION CODE (CONVEYING AMBULANCE TRUST)	An ORGANISATION CODE is a code which identifies an Organisation uniquely.	R	N	0..1	min an3 max an5	ODS	Updated to new Organisation code guidelines. Amended from 'Optional' to 'Required' at request of DH. Making these data items required will allow linking of ambulance and emergency department data, thus providing information about a patient from the moment an ambulance is called until they leave hospital. This will provide learning opportunities that can benefit ambulance services, emergency departments and patients.	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/o/org/organisation_code_(conveying_ambulance_trust)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	This information should be recorded when EMERGENCY CARE ARRIVAL MODE is recorded as patient arrives by Emergency road ambulance, Emergency road ambulance with medical escort, Non-emergency road ambulance, Helicopter, or Fixed wing / medical repatriation by air.
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ATTENDANCE IDENTIFIER	A unique number or set of characters that is applicable to only one ACTIVITY for a PATIENT within an Organisation.	M	N	1..1	max an12	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/a_and_e_attendance_number_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ARRIVAL MODE (SNOMED CT)	EMERGENCY CARE ARRIVAL MODE (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the transport mode by which the PATIENT arrived at the Emergency Care Department.	R	N	0..1	min n6 max n18	SNOMED CT	As per CDS 6.2 Type 010. Code set updated to include greater granularity in descriptors than used currently (brought in by emergency ambulance and other). Arrival mode helps commissioners to match the records of ambulance patients to Emergency Care and inpatient activity and is part of the information set that allows the patient journey to be across different providers in the healthcare system. Arrival mode is often used as a proxy for patient acuity in analysis and planning as patients brought to the Emergency Care facility by ambulance are more likely to be admitted than	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/accident_and_emergency_arrival_mode_code_de.asp?shownav=0	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	Originates from A&E CDS Type 010	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ATTENDANCE CATEGORY	The category of Emergency Care Attendance.	R	N	0..1	an1	DM&D	As per CDS 6.2 Type 010 Necessary to understand the reason and nature for the visit to the healthcare provider. This data item provides an indication of whether a PATIENT is making first or follow-up attendance at a particular Accident and Emergency Department.	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/accident_and_emergency_attendance_category_code_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT)	The source of referral of each Accident and Emergency Episode. Source from which patient was referred/ advised to attend the ED. Not mode of transport	R	Y	0..1	min n6 max n18	SNOMED CT	Code set updated to include greater granularity in descriptors than currently used. This data item is necessary to understand why patients attend Emergency Care. This informs commissioning both locally and centrally and for long-term workforce planning so that the NHS can ensure that the correct blend of staff are recruited and trained.	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/s/so/source_of_referral_for_a_and_e_de.asp?shownav=0	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	Originates from A&E CDS Type 010	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE)	ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE) is the ORGANISATION IDENTIFIER of the Organisation Site from which a PATIENT arrived at an Emergency Care department.	R	N	0..1	min an5 max an9	ODS	This data necessary to link records for the (rare, but high acuity) patients who are transferred between institutions. As acute care networks and retrieval/ transfer arrangements become more common, recording this information will be increasingly important for commissioners of services to understand patient pathways, and where in the pathway value is added. This information is also important in payment mechanisms as incentives will need to be in place to ensure that the correct patients are transferred e.g. referring providers are not penalised because they transfer 'high value' patients. The regional organisation of healthcare into networks has increased the need for patients to be transferred to Emergency Centres with Specialist Services for optimum care of conditions that require highly specialised acute care delivered in regional centres e.g. Stroke, Cardiac, and Trauma	n/a	n/a	F	n/a	NEW' A&E data item	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ARRIVAL DATE	An Emergency Care Arrival Date may be either: • the Arrival Date At Accident and Emergency Department or • the Ambulatory Emergency Care Arrival Date. An Arrival Date At Accident and Emergency Department is the date the PATIENT self presented at the Accident and Emergency Department or arrived in an Ambulance at the Accident and Emergency Department.	M	N	1..1	an10 CCYY-MM-DD	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/ap/arrival_date_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ARRIVAL TIME	The Emergency Care Arrival Time may be either: • the Arrival Time At Accident and Emergency Department or • the Ambulatory Emergency Care Arrival Time. An Arrival Time At Accident and Emergency Department is the date the PATIENT self presented at the Accident and Emergency Department or arrived in an Ambulance at the Accident and Emergency Department.	M	N	1..1	an8 HH:MM:SS	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/ap/arrival_time_at_accident_and_emergency_department_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	AGE AT CDS ACTIVITY DATE	AGE AT CDS ACTIVITY DATE is derived as the number of completed years between the PERSON BIRTH DATE of the PATIENT and the CDS ACTIVITY DATE.	M	N	1..1	max n3	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/ag/age_at_cds_activity_date_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE INITIAL ASSESSMENT DATE	The Emergency Care Initial Assessment Date may be either: • the Accident and Emergency Initial Assessment Date or • the Ambulatory Emergency Care Initial Assessment Date. An Accident and Emergency Initial Assessment Date is the date that the PATIENT is first assessed in the Accident and Emergency Department.	R	N	0..1	an10 CCYY-MM-DD	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/accident_and_emergency_initial_assessment_date_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE INITIAL ASSESSMENT TIME	The Emergency Care Initial Assessment Time may be either: • the Accident and Emergency Initial Assessment Time or • the Ambulatory Emergency Care Initial Assessment Time. An Accident and Emergency Initial Assessment Time is the time, recorded using the 24 hour clock, that the PATIENT is first assessed in the Accident and Emergency Department for first attendances and unplanned follow-up attendances.	R	N	0..1	an8 HH:MM:SS	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/a_and_e_initial_assessment_time_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ACUITY (SNOMED CT)	EMERGENCY CARE ACUITY (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE. EMERGENCY CARE ACUITY (SNOMED CT) is the SNOMED CT® concept ID which is used to indicate the acuity of the PATIENT's condition on the Emergency Care Initial Assessment Date and Emergency Care Initial Assessment Time. The EMERGENCY CARE ACUITY (SNOMED CT) may be determined by a formal triage process, or by the physical allocation of the PATIENT to a	R	Y	0..1	min n6 max n18	SNOMED CT	Emergency Care Acuity is a measure of the urgency and severity of the condition with which the patient has presented to the emergency care facility as defined by the first clinician who assesses the patient. 'Clinician' in this context could be any	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	This data item will required providers to map current triage scores or allocation of a patients intended treatment area to a five point acuity score. Please refer to ECDS User Guidance

ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT)	EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE. EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT) is the SNOMED CT® concept ID which is used to indicate the nature of the PATIENT's chief complaint as assessed by the CARE PROFESSIONAL first assessing the PATIENT.	R	Y	0..1	min n6 max n18	SNOMED CT	There is a need for Emergency Care to standardise input measurement to record accurately the type of patients attending across a range of Emergency Care services, which will help inform commissioners – both central and local - as to the likely nature and complexity of patient loads. As the NHS moves to value-based commissioning, it is fundamentally important to be able to measure	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	Chief complaint code sets should be implemented with flags as highlighted. When a chief complaint has an injury flag this will require the injury data items to be completed.
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE DATE SEEN FOR TREATMENT	The Emergency Care Date Seen For Treatment may be: • the Accident and Emergency Date Seen For Treatment or • the Ambulatory Emergency Care Date Seen For Treatment. Accident and Emergency Date Seen For Treatment is the date, that the PATIENT is seen by a clinical decision maker (someone who can define the management plan and discharge the PATIENT) to diagnose the problem and arrange or start definite treatment as necessary."	R	N	0..1	an10 CCYY-MM-DD	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/accident_and_emergency_date_seen_for_treatment_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE TIME SEEN FOR TREATMENT	The Emergency Care Time Seen For Treatment may be either: • the Accident and Emergency Time Seen For Treatment or • the Ambulatory Emergency Care Time Seen For Treatment An Accident and Emergency Time Seen For Treatment is the time, recorded using the 24 hour clock, that the PATIENT is seen by a clinical decision maker (someone who can define the management plan and discharge the PATIENT) to diagnose the problem and arrange or start definite treatment as necessary."	R	N	0..1	an8 HH:MM:SS	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/a_and_e_time_seen_for_treatment_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
INJURY CHARACTERISTICS	INJURY DATE	The date that the injury occurred.	M	N	1..1	an10 CCYY-MM-DD	DM&D	This data item is necessary to identify delay between injury occurrence and presentation. Delay from injury is important to know in two situations: • 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.	n/a	n/a	F	n/a	NEW' A&E data item	Injury data items should be captured when a Chief Complaint is recorded which has an injury flag.
INJURY CHARACTERISTICS	INJURY TIME	The time that the injury occurred.	M	N	1..1	an8 HH:MM:SS	DM&D	This data item is necessary to identify delay between injury occurrence and presentation. Delay from injury is important to know in two situations: • 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.	n/a	n/a	F	n/a	NEW' A&E data item	Injury data items should be captured when a Chief Complaint is recorded which has an injury flag.
INJURY CHARACTERISTICS	EMERGENCY CARE PLACE OF INJURY (SNOMED CT)	The type of location at which the person was present when the injury occurred.	R	N	0..1	min n6 max n18	SNOMED CT	To be able to understand the patterns of injury, and more importantly how to prevent them, it is necessary to be able to collect basic information regarding the type of place where the injury occurred. This information allows the data to be aggregated in a meaningful way so	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	Injury data items should be captured when a Chief Complaint is recorded which has an injury flag.
INJURY CHARACTERISTICS	EMERGENCY CARE PLACE OF INJURY (LATITUDE)	EMERGENCY CARE PLACE OF INJURY (LATITUDE) is the latitude of the EMERGENCY CARE PLACE OF INJURY (SNOMED CT), expressed in decimal degrees.	O	N	0..1	max n3.n6	DM&D	Exact longitude and latitude is the preferred method of coding injury place if extracted from an electronic system e.g. ambulance electronic patient record system or a kiosk system with an inbuilt map.	n/a	n/a	F	n/a	NEW' A&E data item	
INJURY CHARACTERISTICS	EMERGENCY CARE PLACE OF INJURY (LONGITUDE)	EMERGENCY CARE PLACE OF INJURY (LONGITUDE) is the longitude of the EMERGENCY CARE PLACE OF INJURY (SNOMED CT), expressed in decimal degrees.	O	N	0..1	max n3.n6	DM&D	Exact longitude and latitude is the preferred method of coding injury place if extracted from an electronic system e.g. ambulance electronic patient record system or a kiosk system with an inbuilt map.	n/a	n/a	F	n/a	NEW' A&E data item	
INJURY CHARACTERISTICS	EMERGENCY CARE INJURY INTENT (SNOMED CT)	The most likely human intent in the occurrence of the injury or poisoning as assessed by clinician.	R	N	0..1	min n6 max n18	SNOMED CT	Preventing preventable injury is of great benefit to individuals and society, and identifying the number and severity of assaults has been very difficult. Understanding injury intent underpins all injury prevention work, whether at a local or national level. An example	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	Injury data items should be captured when a Chief Complaint is recorded which has an injury flag.
INJURY CHARACTERISTICS	EMERGENCY CARE INJURY ACTIVITY STATUS (SNOMED CT)	The status of activity being undertaken by the person at the moment the injury occurred.	R	N	0..1	min n6 max n18	SNOMED CT	Injury surveillance has resulted in major reductions in injury from road traffic collisions and workplace incidents. However the biggest rise in injury in the last ten years are injuries occurring in the home and during leisure and sport.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	Injury data items should be captured when a Chief Complaint is recorded which has an injury flag.
INJURY CHARACTERISTICS	EMERGENCY CARE INJURY ACTIVITY TYPE (SNOMED CT)	The type of activity being undertaken by the person at the moment the injury occurred.	R	N	0..1	min n6 max n18	SNOMED CT	Injury surveillance has resulted in major reductions in injury from road traffic collisions and workplace incidents. However the biggest rise in injury in the last ten years are injuries occurring in the home and during leisure and sport. The ageing population has meant that the pattern and severity of injuries occurring at home has become a significant health burden to the NHS. Better data will inform prevention of these injuries, and more granular activity data is essential for this process to understand the cause. 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.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	Injury data items should be captured when a Chief Complaint is recorded which has an injury flag.
INJURY CHARACTERISTICS	EMERGENCY CARE INJURY MECHANISM (SNOMED CT)	How the injury was caused.	R	N	0..1	min n6 max n18	SNOMED CT	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.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	Injury data items should be captured when a Chief Complaint is recorded which has an injury flag.
INJURY CHARACTERISTICS	EMERGENCY CARE INJURY ALCOHOL OR DRUG INVOLVEMENT (SNOMED CT)	A record of any drugs or alcohol used by the patient, which are thought likely to have contributed to the need to attend the ED.	R	N	0..*	min n6 max n18	SNOMED CT	Drugs and alcohol are frequently implicated in the cause of injury and the ECDS proposes a structured way to capture this data.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	Injury data items should be captured when a Chief Complaint is recorded which has an injury flag.
PATIENT CLINICAL HISTORY	COMORBIDITY (SNOMED CT)	A record of whether a person has any of the NHS list of medical co-morbidities.	R	N	0..*	min n6 max n18	SNOMED CT	Co-morbidities are a key determinant in patient care e.g. whether it is safe to treat a patient in the community or whether a patient should be admitted to hospital e.g. for pneumonia, cellulitis. An accurate list of co-morbidities and current medications are therefore essential pieces of knowledge in the effort to minimise inpatient admissions and risk to patients – ensuring the right treatment in the right place. Flowing this data nationally allows a better understanding of the factors that predict complexity of emergency care which in turn allows accurate commissioning of services to meet the needs of patients in the best and most effective way e.g. if there are many attendances for patients with diabetes-related complaints, would a community nurse be an effective intervention to prevent these? Equally, if a patient presents with what appears to be a relatively minor condition e.g. a foot infection, the	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	It is anticipated that data item will be populated automatically from the patient's local electronic health record or in from a local or national care record system such as SCR. Data entry will **not** be performed by ED staff.
SERVICE AGREEMENT DETAILS	COMMISSIONING SERIAL NUMBER	A number used to uniquely identify a NHS SERVICE AGREEMENT by an Organisation acting as commissioner of patient care services.	R	N	0..1	max an6	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/c/co/commissioning_serial_number_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
SERVICE AGREEMENT DETAILS	NHS SERVICE AGREEMENT LINE NUMBER	A number (alphanumeric) to provide a unique identifier for a line within a NHS SERVICE AGREEMENT.	O	N	0..1	max an10	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/n/nhs/nhs_service_agreement_line_number_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
SERVICE AGREEMENT DETAILS	PROVIDER REFERENCE NUMBER	PROVIDER REFERENCE NUMBER is a number convention agreed locally between a provider and Commissioner for use within a Commissioning Data Set message.	O	N	0..1	max an17	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/p/prod/provider_reference_number_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
SERVICE AGREEMENT DETAILS	COMMISSIONER REFERENCE NUMBER	A number (alphanumeric) allocated by the commissioner to a REFERRAL REQUEST.	O	N	0..1	max an17	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/c/co/commissioner_reference_number_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
SERVICE AGREEMENT DETAILS	ORGANISATION IDENTIFIER (CODE OF PROVIDER)	ORGANISATION IDENTIFIER (CODE OF PROVIDER) is the ORGANISATION IDENTIFIER of the Organisation acting as a Health Care Provider.	M	N	1..1	min an3 max an5	ODS	Updated to new Organisation code guidelines	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/o/org/organisation_code_(code_of_provider)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
SERVICE AGREEMENT DETAILS	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) is the ORGANISATION IDENTIFIER of the Organisation commissioning health care.	M	N	1..1	min an3 max an5	ODS	Updated to new Organisation code guidelines	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/o/org/organisation_code_(code_of_commissioner)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	

CARE PROFESSIONALS (EMERGENCY CARE)	PROFESSIONAL REGISTRATION ISSUER CODE	A code which identifies the PROFESSIONAL REGISTRATION BODY.	M	N	1..1	an2	DM&D	As per CDS 6.2 Type 010	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/p/prod/professional_registration_issuer_code_de.asp?shownav=0	V	n/a	Originates from A&E CDS Type 010	
CARE PROFESSIONALS (EMERGENCY CARE)	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER	The registration identifier allocated by an Organisation.	M	Y	1..1	max an32	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/p/prod/professional_registration_entry_identifier_(main_operating_care_professional)_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
CARE PROFESSIONALS (EMERGENCY CARE)	CARE PROFESSIONAL TIER (EMERGENCY CARE)	The tier of CARE PROFESSIONAL treating the PATIENT during an Emergency Care Attendance. The CARE PROFESSIONAL TIERS FOR EMERGENCY CARE are defined in the Royal College of Emergency Medicine Guidelines for Medical and Practitioner Staffing in Emergency Departments. See the Royal College of Emergency Medicine website at Medical and Practitioner Workforce Guidance.	M	Y	1..1	an2	DM&D	Recording the clinician(s) responsible for patient care is necessary for • Operational planning and clinical governance- ensuring that the right grade of clinician is responsible for the right acuity and complexity of patient load • Workforce planning – ensuring that the right number of clinical staff are trained to satisfy the service need • Training metrics – ensuring that trainees are exposed to a suitable case mix of patients to achieve an appropriate level of expertise in their field. • Performance data. Time to see clinician is used as a performance/ quality metric in many healthcare systems. This 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	Link to code set	n/a	V	n/a	NEW' A&E data item	
CARE PROFESSIONALS (EMERGENCY CARE)	CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR (EMERGENCY CARE)	An indication of whether a CARE PROFESSIONAL is responsible for discharge of the PATIENT from an Emergency Care Attendance.	M	Y	1..1	an1	DM&D	Recording the clinician(s) responsible for patient care is necessary for • Operational planning and clinical governance- ensuring that the right grade of clinician is responsible for the right acuity and complexity of patient load • Workforce planning – ensuring that the right number of clinical staff are trained to satisfy the service need • Training metrics – ensuring that trainees are exposed to a suitable case mix of patients to achieve an appropriate level of expertise in their field. • Performance data. Time to see clinician is used as a performance/ quality metric in many healthcare systems. This 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	Link to code set	n/a	V	n/a	NEW' A&E data item	
EMERGENCY CARE DIAGNOSIS (SNOMED CT)	EMERGENCY CARE DIAGNOSIS (SNOMED CT)	Diagnoses of the patient, in order of their relevance to the emergency presentation.	M	Y	1..1	min n6 max n18	SNOMED CT	As per CDS 6.2 Type 010. A key element of the ECDS is a system to record diagnosis by pairing a diagnosis code from a SNOMED-CT subset (the ECDS Diagnostic Data Set) with a two way qualifier. The quality of diagnosis data currently collected in emergency care (CDS type 010 v6.2) is very poor. In developing the ECDS Diagnostic Data Set (DDS) a few key design principles were used: - Exhaustive : the DDS items should cover all conditions commonly seen, but not very rare conditions – i.e. if a candidate condition had not been seen during the >50 physician years of experience of the senior EM physicians constructing the original list. - Exclusive: for any given clinical picture, there should be one and only one best answer.	Link to code set	n/a	F	a. For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for record X, field Y is not in the acceptable range". In addition, any normal business logic for IG reasons shall be followed. b. If one of the items corresponds to the "extremely sensitive" list of items then the record MUST be anonymised. c. The "extremely sensitive" list of SNOMED values must be added to SUS so that it can cross-check, and then follow existing IG rules appropriately (flagging / warning to the user for feedback). • NB: Providers shouldn't send this information, so this is a back-stop in case they do. • NB: there aren't any "extremely sensitive" items in the current list (we a ref'd), but in theory one could be introduced in future as part of maintenance, so it's best to have this function in from the outset so we don't forget. d. Supplier guidance is to prioritise the ECDS sub set in the interface. e. Supplier guidance is to send ALL investigations / treatments to SUS because the grouper can handle unlimited values. • NB: this is not a problem for SUS and HES in future will be able to bring across either everything, or prioritise and/or de-duplicate	Originates from A&E CDS Type 010	It is recommended that diagnosis is captured according to the SNOMED subset (ECDS Diagnostic Data Set) locally. These are the codes which will need to flow as part of the A&E CDS.
EMERGENCY CARE DIAGNOSIS (SNOMED CT)	CODED CLINICAL ENTRY SEQUENCE NUMBER	The sequence of the diagnosis in order of relevance to the emergency department attendance.	M	Y	1..1	max n5	DM&D		n/a	n/a	F	n/a	NEW' A&E data item	This should be captured for each diagnosis recorded.
EMERGENCY CARE DIAGNOSIS (SNOMED CT)	EMERGENCY CARE DIAGNOSIS QUALIFIER (SNOMED CT)	The qualifier allows the clinician to express the (un) certainty of each of the diagnoses.	M	Y	1..1	min n6 max n18	SNOMED CT	A qualifier enables users to express their certainty/ lack of certainty regarding a diagnosis.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	This should be captured for each diagnosis recorded.
EMERGENCY CARE INVESTIGATIONS	EMERGENCY CARE CLINICAL INVESTIGATION (SNOMED CT)	The investigations performed while the person is under the care of the Emergency Care facility.	M	N	1..1	min n6 max n18	SNOMED CT	As per CDS 6.2 Type 010. Amended to include new investigations codes. Amended to be collected in SNOMED CT.	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/accident_and_emergency_investigation_first_de.asp?shownav=0	F	a. For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for record X, field Y is not in the acceptable range". In addition, any normal business logic for IG reasons shall be followed. b. If one of the items corresponds to the "extremely sensitive" list of items then the record MUST be anonymised. c. The "extremely sensitive" list of SNOMED values must be added to SUS so that it can cross-check, and then follow existing IG rules appropriately (flagging / warning to the user for feedback). • NB: Providers shouldn't send this information, so this is a back-stop in case they do. • NB: there aren't any "extremely sensitive" items in the current list (we a ref'd), but in theory one could be introduced in future as part of maintenance, so it's best to have this function in from the outset so we don't forget. d. Supplier guidance is to prioritise the ECDS sub set in the interface. e. Supplier guidance is to send ALL investigations / treatments to SUS because the grouper can handle unlimited values. • NB: this is not a problem for SUS and HES in future will be able to bring across either everything, or prioritise and/or de-duplicate	Originates from A&E CDS Type 010	
EMERGENCY CARE INVESTIGATIONS	PROCEDURE DATE (EMERGENCY CARE CLINICAL INVESTIGATION)	The date on which investigations were performed while the person was under the care of the Emergency Care facility.	R	N	0..1	an10 CCYY-MM-DD	DM&D		n/a	n/a	F	n/a	NEW' A&E data item	This data item should be recorded when an investigation is performed.
EMERGENCY CARE INVESTIGATIONS	PROCEDURE TIME (EMERGENCY CARE CLINICAL INVESTIGATION)	The time at which investigations were performed while the person was under the care of the Emergency Care facility.	R	N	0..1	an8 HH:MM:SS	DM&D		n/a	n/a	F	n/a	NEW' A&E data item	This data item should be recorded when an investigation is performed.
EMERGENCY CARE TREATMENTS	EMERGENCY CARE PROCEDURE	The treatments performed while the person is under the care of the Emergency Care facility.	M	N	1..1	min n6 max n18	SNOMED CT	As per CDS 6.2 Type 010. Amended to include new treatment codes. Amended to be collected in SNOMED CT.	Link to code set	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/accident_and_emergency_treatment_first_de.asp?shownav=0	F	a. For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for record X, field Y is not in the acceptable range". In addition, any normal business logic for IG reasons shall be followed. b. If one of the items corresponds to the "extremely sensitive" list of items then the record MUST be anonymised. c. The "extremely sensitive" list of SNOMED values must be added to SUS so that it can cross-check, and then follow existing IG rules appropriately (flagging / warning to the user for feedback). • NB: Providers shouldn't send this information, so this is a back-	Originates from A&E CDS Type 010	
EMERGENCY CARE TREATMENTS	PROCEDURE DATE	The date on which treatments were performed while the person was under the care of the Emergency Care facility.	R	N	0..1	an10 CCYY-MM-DD	DM&D		n/a	n/a	F	n/a	NEW' A&E data item	This data item should be recorded when an treatment is performed.
EMERGENCY CARE TREATMENTS	PROCEDURE TIME	The time at which treatments were performed while the person was under the care of the Emergency Care facility.	R	N	0..1	an8 HH:MM:SS	DM&D		n/a	n/a	F	n/a	NEW' A&E data item	This data item should be recorded when an treatment is performed.
REFERRALS TO OTHER SERVICES	REFERRED TO SERVICE (SNOMED CT)	An inpatient service to which the patient was referred for admission or opinion by the treating clinician.	R	N	0..1	min n6 max n18	SNOMED CT	This process data is necessary to understand and optimise the care process within emergency care. Current IT systems set up for CDS version 010 routinely collect the time and specialty of referral of a patient. This information is essential to plan bed capacity within the hospital and is also used by commissioners to understand patient flow. Therefore	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	
REFERRALS TO OTHER SERVICES	ACTIVITY SERVICE REQUEST DATE (EMERGENCY CARE)	The DATE that a PATIENT was referred to another SERVICE during an Emergency Care Attendance.	M	N	1..1	an10 CCYY-MM-DD	DM&D	The date and time paired with the specialty 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	n/a	n/a	F	n/a	NEW' A&E data item	This data item should be recorded when a patient is referred to a service.
REFERRALS TO OTHER SERVICES	ACTIVITY SERVICE REQUEST TIME (EMERGENCY CARE)	The TIME that a PATIENT was referred to another SERVICE during an Emergency Care Attendance.	M	N	1..1	an8 HH:MM:SS	DM&D	The date and time paired with the specialty 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	n/a	n/a	F	n/a	NEW' A&E data item	This data item should be recorded when a patient is referred to a service.
REFERRALS TO OTHER SERVICES	REFERRED TO SERVICE ASSESSMENT DATE	A Referred To Service Assessment Date is the date that a CARE PROFESSIONAL from a SERVICE which a PATIENT has been referred to, assesses the PATIENT.	R	N	0..1	an10 CCYY-MM-DD	DM&D	ECDS has incorporated a date stamp for date of referral to inpatient / specialist services. When we explored this further, there was feedback from existing data collection standards e.g. trauma (TARN) and the Mental Health Services Data set, that what matters in terms of patient outcome, patient flow and patient experience is the time interval from referral to time of physical assessment by the inpatient team.	n/a	n/a	F	n/a	NEW' A&E data item	This is not the date at which the inpatient unit clinician is collecting information regarding the patient e.g. old notes, radiology or pathology requests. It should be the date the clinician is physically in the same room as the patient and clinical examination is occurring.

REFERRALS TO OTHER SERVICES	REFERRED TO SERVICE ASSESSMENT TIME	A Referred To Service Assessment Time is the time that a CARE PROFESSIONAL from a SERVICE which a PATIENT has been referred to, assesses the PATIENT.	R	N	0..1	an8 HH:MM:SS	DM&D	ECDS has incorporated a timestamp for time of referral to inpatient / specialist services. When we explored this further, there was feedback from existing data collection standards e.g. trauma (TARN) and the Mental Health Services Data set, that what matters in terms of patient outcome, patient flow and patient experience is the time interval from referral to time of physical assessment by the inpatient team.	n/a	n/a	F	n/a	NEW' A&E data item	This is not the date at which the inpatient unit clinician is collecting information regarding the patient e.g. old notes, radiology or pathology requests. It should be the date the clinician is physically in the same room as the patient and clinical examination is occurring.
DISCHARGE FROM EMERGENCY CARE	DECIDED TO ADMIT DATE	The date a DECISION TO ADMIT was made.	R	N	0..1	an10 CCYY-MM-DD	DM&D	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.	n/a	n/a	F	n/a	NEW' A&E data item	This data item should be recorded in the ED record on the occasion whereby a decision is made to refer a patient to a service.
DISCHARGE FROM EMERGENCY CARE	DECIDED TO ADMIT TIME	The time a DECISION TO ADMIT was made.	R	N	0..1	an8 HH:MM:SS	DM&D	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	n/a	n/a	F	n/a	NEW' A&E data item	This data item should be recorded in the ED record on the occasion whereby a decision is made to refer a patient to a service.
DISCHARGE FROM EMERGENCY CARE	ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT)	ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT) is the TREATMENT FUNCTION CODE of the SERVICE to which a PATIENT is to be admitted.	R	N	0..1	an3	DM&D	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	Link to code set	n/a	F	n/a	NEW' A&E data item	
DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DISCHARGE STATUS (SNOMED CT)	The status of the PATIENT on discharge from an Emergency Care Department. Captures whether treatment took place within the ED, if the patient was streamed to another service or if the patient left before treatment was complete.	R	Y	0..1	min n6 max n18	SNOMED CT	This data item and its counterparts Emergency Care Discharge Destination and Emergency Care Discharge Follow-up are necessary to understand resource needs and transfer of responsibility between different organisations.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	
DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE ATTENDANCE CONCLUSION DATE	The Emergency Care Attendance Conclusion Date may be either: • the Accident and Emergency Attendance Conclusion Date or • the Ambulatory Emergency Care Attendance Conclusion Date. Where the PATIENT dies in the Emergency Care Department, the Emergency Care Attendance Conclusion Date is the same as the PERSON DEATH DATE. An Accident and Emergency Attendance Conclusion Date is the date that a PATIENT's Accident and Emergency Attendance concludes or when treatment in the Accident and Emergency Department is completed (whichever is the later). For those PATIENTS admitted into hospital, the ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE is recorded	R	N	0..1	an10 CCYY-MM-DD	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/accident_and_emergency_attendance_conclusion_date_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE ATTENDANCE CONCLUSION TIME	The Emergency Care Attendance Conclusion Time may be either: • the Accident and Emergency Attendance Conclusion Time or • the Ambulatory Emergency Care Attendance Conclusion Time. Where the PATIENT dies in the Emergency Care Department, the Emergency Care Attendance Conclusion Time is the same as the PERSON DEATH TIME.	R	N	0..1	an8 HH:MM:SS	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/a_and_e_attendance_conclusion_time_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DEPARTURE DATE	The Emergency Care Departure Date may be either: • the Accident and Emergency Departure Date or • the Ambulatory Emergency Care Departure Date. An Accident and Emergency Departure Date is the date that a PATIENT leaves an Accident and Emergency Department after an Accident and Emergency Attendance has concluded.	R	N	0..1	an10 CCYY-MM-DD	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/accident_and_emergency_departure_date_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DEPARTURE TIME	An Emergency Care Departure Time is an ACTIVITY DATE TIME. The Emergency Care Departure Time may be either: • the Accident and Emergency Departure Time or • the Ambulatory Emergency Care Departure Time. An Accident and Emergency Departure Time is the time recorded using a 24 hour clock that a PATIENT leaves an Accident and Emergency Department after an Accident and Emergency Attendance has concluded.	R	N	0..1	an8 HH:MM:SS	DM&D	As per CDS 6.2 Type 010	n/a	http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/a_and_e_departure_time_de.asp?shownav=0	F	n/a	Originates from A&E CDS Type 010	
DISCHARGE FROM EMERGENCY CARE	SAFEGUARDING CONCERN (SNOMED CT)	SAFEGUARDING CONCERN (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE. SAFEGUARDING CONCERN (SNOMED CT) is the SNOMED CT® concept ID which is used to identify an unresolved issue or concern regarding adult and child safeguarding that requires communication to another ORGANISATION or care agency.	R	N	0..*	min n6 max n18	SNOMED CT	Safeguarding information is routinely collected at a local level as part of normal safeguarding requirements but is collected inconsistently and there is no consistent central information regarding number and nature of referrals for safeguarding.	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	
DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT)	EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the intended destination of the PATIENT following discharge from the Emergency Care Department.	R	N	0..1	min n6 max n18	SNOMED CT	This data item and its counterparts Emergency Care Discharge Status and Emergency Care Discharge Follow-up are necessary to understand resource needs and transfer of responsibility between different organisations. 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	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	
DISCHARGE FROM EMERGENCY CARE	ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE)	ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE) is the ORGANISATION IDENTIFIER of the Organisation Site to which a PATIENT is discharged following an Emergency Care Attendance.	R	N	0..1	min an5 max an9	ODS	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.	n/a	n/a	F	n/a	NEW' A&E data item	
DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT)	EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the SERVICE to which a PATIENT was referred for continuing care following an Emergency Care Attendance.	R	N	0..1	min n6 max n18	SNOMED CT	This data item and its counterparts Emergency Care Discharge Destination and Emergency Care Discharge Follow up are necessary to understand resource needs and transfer of responsibility between different organisations. Analysis by Public Health England has	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	
DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DISCHARGE INFORMATION GIVEN (SNOMED CT)	EMERGENCY CARE DISCHARGE INFORMATION GIVEN (SNOMED CT) is the SNOMED CT® concept ID which is used to identify whether a copy of a letter to their GENERAL PRACTITIONER has been printed and given to the PATIENT on discharge from an Emergency Care Department.	R	N	0..1	min n6 max n18	SNOMED CT	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	Link to code set	n/a	F	For any data item which contains a value other than specified in relevant code set, accept the value but suppress it so it cannot leave SUS+ (it will be visible to those with SUS access and therefore available for diagnostic and troubleshooting). Log it appropriately for response to user such as "Value for records X, field Y is not in the acceptable range"	NEW' A&E data item	
RESEARCH AND OUTBREAK NOTIFICATION	CLINICAL TRIAL IDENTIFIER	A unique identifier assigned to a CLINICAL TRIAL.	O	N	0..1	max an20	DM&D	Nearly all research in Emergency Care in the UK is government funded, and therefore data collection and aggregation is an important direct cost for any research. At present, the customisation of any software to aggregate the results of patient recruitment is a significant barrier and cost to such research. Inability to do research harms the NHS' ability to better understand emergency care and commission the right care that meets patient needs. Promoting research, audit and benchmarking across the NHS requires embedded IT support as a key enabler. The ability to capture and flow relevant data cost-effectively enables multi-centre trials that will save the NHS many thousands of pounds in building custom IT solutions to track patient recruitment. Facilitating multi-centre trials is particularly important because they increase the reliability of the research – the results are much more likely to	n/a	n/a	F	n/a	NEW' A&E data item	CLINICAL TRIAL IDENTIFIER is the same as attribute CLINICAL TRIAL IDENTIFIER. Used in the CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set. • The CLINICAL TRIAL IDENTIFIER must be recognised and registered with an ORGANISATION which is a Primary Registry in the World Health Organisation International Clinical Trials Registry Platform. • CLINICAL TRIAL IDENTIFIER is collected for a specified purpose at national level only and will not be available from the Secondary Uses Service for use by unauthorised ORGANISATIONS or individuals.
RESEARCH AND OUTBREAK NOTIFICATION	DISEASE OUTBREAK NOTIFICATION	DISEASE OUTBREAK NOTIFICATION is used in the CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set to support collection of nationally-notifiable data relating to outbreaks of disease which are identified in Emergency Care Departments. Where a SNOMED CT CODE is available, the DISEASE OUTBREAK NOTIFICATION field should contain this. If a SNOMED CT CODE is NOT available, then it is permissible to submit free-text detail of the disease.	O	N	0..1	max an20	DM&D	By including this field, the data set will address key National Institute of Health Research (NIHR) priorities for efficient research design, and will enable research into and rapid response to major infectious disease health threats.	n/a	n/a	F	n/a	NEW' A&E data item	DISEASE OUTBREAK NOTIFICATION is collected for a specified purpose at national level only and will not be available from the Secondary Uses Service for use by unauthorised ORGANISATIONS or individuals.

NHS Digital

Board Meeting – Public Session

Title of paper:	**Community Services Data Set Direction**
Board meeting date:	31 May 2017
Agenda item no:	NHSD 17 02 04 bii
Paper presented by:	Prof. Martin Severs Medical Director and Caldicott Guardian
Paper prepared by:	Gouri Shanker Chandel, Senior Project Manager, Community Services Data Set Project
Paper approved by: (Sponsor Director)	Prof. David Hughes, Director of Information & Analytics
Purpose of the paper:	Full Directions request from Department of Health and NHS England to enable the flow of data from Providers
Additional Documents and or Supporting Information:	Annexe A – The Direction – final draft v0.2 from DH/NHSE Annexe B – Statutory Direction Giving Checklist – v1.4 Annexe C – Requirements Specification v1.0 Annexe D – CSDS Dataset v1.0 (TOS for SCCI)
Please specify the key risks and issues:	There is no risk directly associated with the acceptance of the Directions.
Patient/public interest:	There are no significant patient or public interest issues, there will be a reduction in burden as local collection will no longer be required.
Supplementary papers:	Annexe E – Responses to EMT suggestions
Actions required by the Board:	The paper is being submitted for the acceptance of the Full Directions to enable data collection to be undertaken as part of the development of the Community Services Health Dataset.

Official

Community Services Data Set Direction

Published 19 May 2017

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Executive Summary

Further to the approval of Directions for the Community Services Data Set Pilot that came into force on 20 March 2017 this paper is a request for the agreement to the attached Full Directions to enable the collection of data from all providers of Community Services to support the implementation of a new national Community Services Data Set (CSDS).

Background

The flow of a national community services data set has been prioritised by NIB and has a ministerial focus. Agreement has been reached with NHS England to amend the existing 'Children and Young Persons Health Services dataset' (CYPHS) to enable the collection of data for the whole community by removing the age restriction presently enforced when collecting data.

An application for the issue of an Information Standards Notice was approved by the Standardisation Committee for Care Information (SCCI) on 29 March 2017 and was issued on 21 April 2017 (Appendix A)

Directions have been raised by NHS England on behalf of Department of Health in support of the 'full' collection of data relating to all Community Service Providers.

Recommendation

The Directions have been put in place to ensure we have a clear legal basis for collection of the data from providers, on the advice of Information Governance.

Providers will be asked to flow the same data to NHS Digital as they currently do for the CYPHS data set, but include all patients (not just those aged 0-18 yrs.). In practice, we believe that a number of providers already produce an extract from their systems which includes all patients, and then strip out any patients over 18 when creating their submission file for the CYPHS data set. The providers will be asked to include all patients in their submission

It is proposed that NHS Digital Board approve the attached Directions to enable the collection of data to be undertaken under the new national Community Services Data Set (CSDS).

Implications

Strategy Implications

The project is aligned with the strategic objective of centralising major data collections to reduce local collection requirements and develop agreed information standards. It also supports both the NIB Paperless 2020 Agenda, being an explicit objective of Domain H, Programme 26, and the NHS England 5 Year Forward Plan.

Financial Implications

The funding for Phase 1 of the programme has been agreed through a new Work Commission and Investment Justification which this forms part of. The funding for Phase 2, which involves increasing the scope of the collection to include a greater depth of community data, is subject to a separate investment justification being made in May 2017. The project is

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one of the prioritised projects under the NIB Programme and will be supported under Domain H's Data Content Programme.

Stakeholder Implications

There is clear focus and drive at the senior stakeholder level for a national flow of community services data, with an expected timeline for delivery of Phase 1 in autumn 2017. There are no major stakeholder implications at present, as the existing CYPHS dataset will continue to operate until the Community Health Services Data Set is operational. The CSDS will effectively be a new dataset providing centralised community information and be welcomed by stakeholders.

Phase 2 of the programme will look at increasing the scope of the existing data set to include a greater depth of community data and support strategies/initiatives including P2020, the NHS Improvement Scorecard, evidence-based commissioning, patient-centred outcomes and the creation of community tariffs/payment mechanisms.

An Advisory Group will be set up to ensure we have comprehensive input into the development of future requirements.

Handling

There are no handling issues directly associated with accepting the Directions.

Risks and Issues

The request for the acceptance at this early stage is to ensure we reduce the overall risk on the development of the Community Services Data Set as it moves from pilot to full implementation and provides the legal basis for NHS Digital to collect the data from agreed launch date in autumn 2017. There are no risks directly associated with the acceptance of the Directions.

Corporate Governance and Compliance

As part of the consultation process, this Direction was reviewed at EMT on 11 May 2017 and all Directions should be referred to the NHS Digital Board for consideration and acceptance.

The legal basis for the collection is described in the Direction.

Management Responsibility

Jackie Shears, Programme Director – Data Content and New Data Collections is responsible for the delivery of the CSDS. The CSDS project has its own project board with an NHS England SRO, Suzanne Rastrick, and reports to the Domain H Board via the Data Content Programme Board.

Professor David Hughes, Executive Director of Information and Analytics. This Portfolio will deal with the Directions on a day to day basis.

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Actions Required of the Board

The paper is being submitted for the acceptance of the Directions to enable data collection to be undertaken as part of the development of the national level Community Services Data Set. Following acceptance by the NHS Digital Board data will be collected on a regular basis from all publically funded community service providers, commencing from autumn 2017.

Note: EMT feedback and supplementary information are provided in a separate document, Annexe E.

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DIRECTIONS

NATIONAL HEALTH SERVICES, ENGLAND

The Health and Social Care Information Centre (Establishment of Information Systems for National Health Services: Community Services Data Set) Directions 2017

The Secretary of State for Health gives the following Directions to the Health and Social Care Information Centre in exercise of the powers conferred by sections *254(1), (2)(a), and (6)* of the Health and Social Care Act 2012.

In accordance with section 254(5) of the Health and Social Care Act 2012, the Secretary of State has consulted the Health and Social Care Information Centre before giving these Directions.

Citation, commencement and interpretation

1. These Directions may be cited as The Health and Social Care Information Centre (Establishment of Information Systems for National Health Services: Community Services Data Set) Directions 2017 and shall come into force on 01 November 2017.

2. In these Directions–

"The 2012 Act"	means the Health and Social Care Act 2012[1];
"Information Standard"	means a document containing standards in relation to the processing of information as provided for in section 250(2) of the 2012 Act. References to the number and title of an Information Standard are to the number and title given to a particular Information Standard within the Information Standards Notice;
"HSCIC"	means the Health and Social Care Information Centre[2];
"Relevant	means an organisation type that is listed under "applies to"

[1] 2012 c7

[2] The Health and Social Care Information Centre is a body corporate established under section 252(1) of the Health and Social Care Act 2012

Organisation"	in the Specification;
"SCCI1069"	is the unique reference number for the Community Services Data Set Information Standard;
"Specification"	means the Community Services Data Set v1.0 Requirements Specification that has been published by the Secretary of State on 20 April 2017 and annexed to these Directions at Annex A or any subsequent amended version of the same document published by the Secretary of State;
"Technical Output Specification"	means the Community Services Data Set (CSDS) v1.0 Technical Output Specification version 1.0.4 dated 28/02/2017 and annexed to these Directions at Annex B or any subsequent amended version of the same document published by the Secretary of State.

Establishing and Operating the Community Services Data Set Information System

3. – (1) Pursuant to its powers under sections 254(1) and 254(6) of the 2012 Act, the Secretary of State directs the HSCIC to establish and operate a system for the collection of the information described in sub-paragraph (2) from the Relevant Organisations, such system to be known as "the Community Services Data Set Information System".

(2) The information referred to in sub-paragraph (1) is the information described in the Technical Output Specification.

(3) The Secretary of State directs HSCIC to carry out the activities described in sub-paragraph (1) in accordance with the Specification and generally in such a way as to enable and facilitate compliance with the Specification.

S254(3) - Requirement for these Directions

4. In accordance with section 254(2)(a) of the 2012 Act, the Secretary of State confirms that it is necessary or expedient for him to have the information that will be obtained through the HSCIC complying with these Directions in relation to the Secretary of State's functions in connection with the provision of health services. In particular the information obtained through compliance with these Directions will facilitate or enable the achievement of the purposes of Information Standard SCCI1069 that are described in the Specification.

DRAFT

Accounts

5. The HSCIC must keep proper accounts, and proper records in relation to the accounts, in connection with the Community Services Data Set Information System.

Signed by authority of the Secretary of State for Health

[INSERT DATE]

Annex A – Community Services Data Set v1.0 Requirements Specification

(This document has been removed. Please see the Shared Documents Folder)

Annex B – Community Services Data Set (CSDS) v1.0 Technical Output Specification version 1.0.4

(This document has been removed. Please see the Shared Documents Folder)

DRAFT

Statutory Direction Giving Checklist

The HSCIC can only act within the boundaries as set out by the 2012 Health and Social Care Act. As such, in order to commission the HSCIC to collect data, or provide advice or guidance on IT or system delivery functions, it is often necessary to give direction in the form of Statutory Instrument. Completion of this checklist will establish whether a Statutory Direction is require. Please note:

- It is important to respond to each question in the checklist
- Where the information requested is dependent on a decision that had yet to be made, please state that this issue will be decided in due course
- Please use 'plain English'

Completion of the checklist will enable any potential problems or legal dead-ends to be identified. DH and NHS E each have a separate process which must be followed in order to issue a direction and separate documentation detailing these is available.

Required Information	Legal Basis / Power under 2012 Act	Response (*to be completed by Policy Team*)
➢ **Summary:** ***The Health and Social Care Information Centre (Establishment of Information Systems for National Health Services: Community Services Data Set) Directions 2017***		
1. What work would you like the HSCIC to perform?	s.254	Establish and operate a system for the collection of the Community Services Data Set (CSDS). This is the full implementation of the pilot data collected under the *The Health and Social Care Information Centre (Establishment of Information Systems for NHS Services: Children and Young People's Health Services) Directions 2015.* This extends the Children and Young Peoples' Health Services (CYPHS) dataset, to remove the age restriction. The collection will include data from NHS and local authority providers. Once established this collection will supersede the CYPHS collection, and this direction will be repealed. There is no repeal in these directions to allow flexibility should the CSDS collection be delayed.
2. What purpose will this serve?	s.254	The Community Services Data Set (CSDS) is a patient level, output based, secondary uses data set which will deliver robust, comprehensive, nationally consistent and comparable person-centred information for people who are in contact with publicly-funded Community Services.
➢ **Prerequisites**		
3. [DH DIRECTIONS ONLY]Does it relate to a function of the Sec of State in relation to the provision of health services or adult social care in England?	s.254	Provision of Health Services – to inform provision of Community Services to all ages. Services are delivered by the NHS and some children's services by local authorities.

4. [DH DIRECTIONS ONLY] If not, would the direction be in the interests of the health service in England or recipients or providers of adult social care in England?	s.254	
5. [NHS ENGLAND DIRECTIONS ONLY] What are the NHS England functions in respect of which it is necessary or expedient for NHS England to have the data?	s.254(3)	
6. How has HSCIC been consulted?	s.254(5)	HSCIC is has developed the standard upon which the collection is based. This has been published on the recommendation of SCCI
7. Is it possible that the proposal could be deemed to be potentially controversial?[1] If so, why?	s.254	No
➢ **Collection / Analysis**		
8. Will the HSCIC collect information? If so, then to the best of your knowledge and in as much detail as possible, what data is to be collected?	s.254(1), s.253 & s.254	Yes. The specification documents are embedded in the draft directions.
9. Which persons is the information to be collected from?	s.254(1), s.259 & s.253	The Specification lists the organisations from which the data are to be collected.
10. When is the collection due to commence?	s.260 & s.262	November 2017.
11. Will the collection be person level or aggregate data[2]?	s.254(1), s.253 & s.256	Person level.
12. Will consent be sought? If not, if objections are registered, will they be respected?	s.259	Consent will not be sought. There is no direction to respect objections beyond those issued by the Secretary of State.
13. What will HSCIC do with the information? For example, will it be put together with other information?	s.253, s.254(1) & s.254(6)	None under these directions.
14. What analysis is to be undertaken by	s.253,	None directed.

[1] Please see explanatory note A.
[2] Please see explanatory note B.

the HSCIC?	s.254(1) & s.254(6)	
15. Are there documents which describe what HSCIC is to do?	s.254	The Specification and Technical Output Specification are embedded in the directions.
16. Are there data processing / information standards to be met?	s.254	The Specification and Technical Output Specification are part of standard SCCI1069 that has been published under s.250.
17. Will the HSCIC have to make significant changes to their IT infrastructure? If so, what is the latest estimate of the cost?	Reg. 32 of SI 2013/259, s.254(6) & s.253	
➢ **Publication**		
18. What information is to be published[3] (if any)? Please note the HSCIC must publish unless certain specific confidentiality, data protection or information standard concerns are applicable.	s.260(1), s.260(2) & s.260 (3)	None directed.
19. What information is not to be published (if any)?	s.260(1), s.260(2) & s.260 (3)	None directed.
20. What is the form, manner and timing of publication (if any)?	s.260	None directed.
21. What advice has been given to HSCIC by the CAG in relation to publication that HSCIC must have regard to?[4]	s.260	N/A
➢ **Dissemination**		
22. What information is to be disseminated[5] (if any)?	s.262	None directed
23. Who will the information be disseminated to? What is their legal basis to receive it? (please contact the information and Transparency	s.261(1), s.261(4), s.261(5) & s.262	N/A

[3] Please see explanatory note C.
[4] DN - effective from October 2015
[5] Please see explanatory note C.

team at the Department of Health who can secure legal advice)		
24. What form, manner and timing must the information take? Will the information disseminated be personal or aggregate?	s.262	N/A
25. What advice has been given to HSCIC by the CAG in relation to dissemination that HSCIC must have regard to?[6]	s.262	N/A

[6] DN - effective from October 2015

Explanatory notes

A. Is the proposal controversial? (Q7)

- If you think that the collection might attract a high level of public, political or media interest, please explain why. Examples might include:
  - Collections involving commercial bodies
  - Dissemination of any person level data
  - Collections involving anything other than explicit consent
  - Collections where the collection of the data could bring harm or distress to the patient, either indirectly or if collected incorrectly
  - Collection of data of vulnerable groups of people
  - Collection of data of politically sensitive groups of people, for example asylum seekers or benefits claimants

B. Person level data vs. aggregate data

- Person level data, or 'personally identifiable' data, is any which can be used to identify the individual concerned. This can extend beyond direct personal identifiers such as a person's name into other factors which could together be used to work out the identity of an individual, such as sexual preference, family size, long-standing conditions and many more.
- If you have any doubts about whether your data will be personally identifiable, please explain the proposal in as much detail as possible.

C. Publication vs. dissemination

- Publication refers to the preparation and issue of information for public consumption.
- Dissemination refers to the sharing of information within and between organisations and individuals, but not a public release.

NHS Digital

Community Services Data Set v 1.0

Requirements Specification

Published 20 April 2017

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This information standard (SCCI1069) has been approved for publication by the Department of Health under section 250 of the Health and Social Care Act 2012.

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

This information standard comprises the following documents:

- Requirements Specification
- Change Specification
- Implementation Guidance.

An Information Standards Notice (SCCI1069 Amd 57/2016) has been issued as a notification of use and implementation timescales. Please read this alongside the documents for the standard.

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

Date of publication: 20 April 2017

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Glossary of Terms

Term / Abbreviation	What it stands for
Aggregate data set	A set of data items (i.e. a data set) that captures data in aggregate form. Each record within the data set pertains to a specific form of grouping.
AHP	Allied Health Professionals work across a wide range of locations and sectors within acute, primary and community care. They are made up of the following staff groups: • Art, Drama, Music Therapists • Chiropodists/Podiatrists • Occupational Therapists • Orthoptists • Physiotherapists • Prosthetists and Orthotists • Radiographers Diagnostic and Therapeutic • Speech and Language Therapists • Dietitians
Anonymisation	A method applied to patient identifiable data items to protect the identity of individuals. Under anonymisation, the relevant data items are either randomly encrypted and no keys retained, or completely removed. Anonymised data cannot be linked with other data sets for the same individual, nor can it be reversed to expose the identity of an individual. Anonymisation is different from Pseudonymisation.
AQP	Any Qualified Provider - a means of commissioning certain NHS services in England. Clinical Commissioning Groups (CCGs) will determine the services to be commissioned as AQP; the intention is to increase patient choice. All providers must meet the qualification criteria set for a particular service and once qualified their service will appear on the NHS e-Referral Service for patients to select. The AQP scheme means that, for some conditions, patients will be able to choose from a range of approved providers, such as hospitals or high street service providers.
BAAS	The Burden Assessment and Advice Service (BAAS) process makes sure that information demands on the NHS are minimised, fit with current national health policies and are carried out in the most efficient way without duplication. It covers the Department of Health and its Arm's Length Bodies (ALBs).
Care Pathway	Care pathways describe the route that a patient will take from their first contact with a healthcare provider to the completion of their treatment.
Central Data Repository	A repository of data relating specifically to the CSDS. Could also be known as a Central Data Warehouse.
CIDS	The Community Information Data Set is an information standard, approved by the governing standards body, which defines a patient-level data set. CIDS is an 'output data set'; therefore it sets out to describe "what should be extracted" from local IT systems. CIDS is not an input standard or 'clinical data set'; therefore, CIDS does not define "what should be captured or collected" from local IT systems. CIDS is approved for local collection only and is being retired on introduction of the CSDS, eliminating the need for a separate local data flow.
Clinical Governance	Clinical governance is defined by the Department of Health as describing "the structures, processes and culture needed to ensure that healthcare organisations - and all individuals within them - can assure the quality of the care they provide and are continuously seeking to improve it".

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Collection Date	The date when services within the scope of this standard should start data collection in their electronic systems.
Commissioned Currencies	The payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs. The two fundamental features being nationally determined currencies and tariffs. Currencies are the unit of healthcare for which a payment is made, and can take a number of forms covering different time periods from an outpatient attendance or a stay in hospital, to a year of care for a long term condition. Tariffs are the set prices paid for each currency.
Conformance Date	The date when services and IT systems must conform to standards and meet the specification as set out in the mandate and guidance. This can be read as when the first submission window closes for the CSDS and care providers must therefore be fully conformant.
CSDS	The Community Services Data Set is an information standard, approved by the governing standards body, which defines a patient-level data set for all patients in receipt of publicly-funded Community Services. CSDS is an 'output data set'; therefore it sets out to describe "what should be extracted" from local IT systems and periodically be submitted to the central data repository. CSDS is not an input standard or 'clinical data set'; therefore, this data set does not define "what should be captured or collected" from local IT systems.
CYPHS Data Set	The Children and Young People's Health Services Data Set is an information standard, approved by the governing standards body, which defines a patient-level data set for all patients, aged 0-18 inclusive, in receipt of NHS-funded Community Services. The CYPHS data set is an 'output data set'; therefore it sets out to describe "what should be extracted" from local IT systems and periodically be submitted to the central data repository. The CYPHS data set is not an input standard or 'clinical data set'; therefore, this data set does not define "what should be captured or collected" from local IT systems. The CSDS replaces the CYPHS data set.
Data Controller	A person who (either alone or jointly or in common with other persons) determines the purposes for which and the manner in which any personal data are, or are to be, processed. A data controller must be a "person" recognised in law, that is to say: • individuals; • organisations; and • other corporate and unincorporated bodies of persons. Data controllers will usually be organisations, but can be individuals, for example self-employed consultants. Even if an individual is given responsibility for data protection in an organisation, they will be acting on behalf of the organisation, which will be the data controller.
Data Group	A collection of data items that describe a distinct event or episode. This can also be referred to as a table of data.
Data Item	A single component of a data group that holds one piece of information relating to an event or episode.
Data Set	The full collection of data groups. See 'Technical Output Specification'.
Data Submission File	One file related to a data set that data providers submit to the central data repository. A data submission consists of an Extensible Markup Language (XML) file containing the data for a single reporting period in the format defined by NHS Digital. When submitting two reporting periods in a single file, this would be the primary submission for month one and the refresh submission for month two.
Derived	A data item populated at the central data repository as part of post-deadline processing. The derived data item is based on the manipulation of the 'source' data items using mathematical, logical or other types of transformation process, or by using source data to derive further data from

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	national look-up tables.
HSCIC	Health and Social Care Information Centre - A non-departmental body created by statute, also known as NHS Digital.
Information Standard	An Information Standard as specified within the Health and Social Care Act 2012 is 'a document containing standards in relation to the processing and use of information'. An Information Standard specifies rules for the processing, management and sharing of information and specifies what process is needed, the 'quality' required in the form of conformance criteria and how it can be implemented.
ISN	Information Standards Notices (ISNs) are issued by the Standardisation Committee for Care Information (SCCI) to give notice of changes to information requirements and information standards used by the NHS and Social Care Services.
Last Good File	The most recent collection of valid records submitted by a data provider for a reporting period.
N3	The NHS national broadband network linking hospitals, medical centres and General Medical Practices in England and Scotland. To be replaced by the Health and Social Care Network (HSCN). https://digital.nhs.uk/health-social-care-network
NHS Digital	A data, information and technology resource for the health and care system which plays a fundamental role in driving better care, better services and better outcomes for patients in England. Previously (and still legally) known as the HSCIC.
Null	A data item with no value (i.e. blank) which therefore has no meaning. This is different from a value of 0, since 0 is an actual value.
ODS	Organisation Data Service (ODS) codes facilitate a patient's treatment by providing unique identification codes for organisational entities of interest to the NHS, for example NHS Trusts or CCGs, organisation sites such as hospitals, or GP Practices. The codes are distributed to the wider NHS and uploaded on to IT systems, thus providing a set of organisational data and organisation types, names, addresses etc that are consistent across the board.
Output Data Set	A set of standardised data items defining "what should be extracted" from local clinical IT systems. NHS trusts have the flexibility of adopting any local data collection process and system they see fit, so long as the system can extract data as per the Technical Output Specification (TOS). An output data set is not usually used for direct patient care and is only for secondary uses purposes e.g. national reporting.
Patient Level	Relating to a single data subject (e.g. person or patient), as opposed to an aggregate data set.
Post-deadline Processing	The processing undertaken at the close of a submission window by the central data repository.
Pre-deadline Processing	The processing carried out immediately on a submitted file to validate the file as a whole, extract the records that are (or may be) for the particular reporting period, and validate those records.
Pseudonymisation	A method applied to identifiable data items to protect the identity of individuals. Under pseudonymisation, a standard encryption key is used to encode patient identifiable data items so that data linkages within and outside the data set, for the same individual, are feasible. Because the encryption key is retained by a single "Data Controller", there is also the potential to reverse the process (de-code) and expose the identity of the individual. The encryption key is only decoded for specific purposes (e.g.: migration of data into another platform or enable linkages to other data sets). Pseudonymisation is different from Anonymisation.
Reference Data Set	A data set containing data groups and data items which are outside the scope of the original Community Information Data Set (CIDS), providing a

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	comprehensive secondary uses data set for community care. The Reference Data Set has not been approved as a national data standard by the Standardisation Committee for Care Information (SCCI) or predecessor board, nor does the central data repository provide any storage capability for its data items.
Reporting Period	The period (usually a calendar month) for which a particular data upload refers.
RTT	Referral To Treatment refers to the length of waiting time for a patient's treatment, focusing on the entire patient journey from the initial receipt of a referral to the first definitive treatment.
SCCI	Standardisation Committee for Care Information - a committee with membership drawn from a range of health and social care organisations with responsibility for overseeing the development, assurance and approval of information standards, data collections and data extractions used within the health and social care system.
Screening	A public health service in which members of a defined population, who do not necessarily perceive they are at risk of, or are already affected by a disease or its complications, are asked a question or offered a test, to identify those individuals who are more likely to be helped than harmed by further tests or treatment to reduce the risk of a disease or its complications.
Secondary Uses	Re-using clinical and operational information for purposes other than direct patient care. For example, national reporting.
Submission Cycle	The data submission frequency and timescales to which Information Management Services must be able to compile electronic files and make periodical electronic submissions in accordance to the standard.
Submission Period or Submission Window	The time period (usually approximately one calendar month) during which a data provider may submit data uploads for a given reporting period.
Systemic Capability	The ability to record information (clinical, administrative or for any other purposes) in an electronic form. This applies to commercial IT solutions, bespoke IT systems or modular electronic services which have the functional capability of extracting the required data to meet the standards of a specific output specification.
TCS	Transforming Community Services was a Department of Health programme that aimed to provide essential care to people, families and communities, from health promotion to end of life care. This care is provided in many settings, at critical points in people's lives, and often to those in vulnerable situations.
TOS	Technical Output Specification – a specification that fully defines the data items within the output data set. The Technical Output Specification splits the data set into a number of data groups (tables), each containing related data items and values.

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1 Overview

This product precisely defines the patient level Community Services Data Set (CSDS) standard, 'what it is' and 'how it should be implemented'.

It is the formal definition of the standard.

1.1 Background

Standard	
Standard Number	SCCI1069
Standard Title	Community Services Data Set
Description	**Background** The Community Services Data Set (CSDS) is a patient level, output based, secondary uses data set which will deliver robust, comprehensive, nationally consistent and comparable person-centred information for people who are in contact with publicly-funded Community Services. As a secondary uses data set it intends to re-use clinical and operational data for purposes other than direct patient care. It defines the data items, definitions and associated value sets to be extracted or derived from local systems. The CSDS is an update to the Children and Young People's Health Services (CYPHS) data set standard (ref: SCCI1069) so that the scope includes data for people of all ages in receipt of publicly-funded Community Services. The CYPHS data set collected data for all patients aged 0 up until their nineteenth birthday. In addition, the Community Information Data Set (CIDS) standard (ref: SCCI1510), which is for local data collection and extraction only, is being retired as part of this release, eliminating the need for a separate local data flow. **In Scope** The data collected in the CSDS covers all publicly funded Community Services provided by Health Care Providers in England. This includes (but is not limited to) Community Health Trusts, acute organisations, Independent Sector Healthcare Providers and Local Authorities that provide Community Services. For the purpose of this scope, all services defined in 'Service or Team Type Referred To' within the CSDS Technical Output Specification that are delivered by Healthcare Professionals within the scope of providing Community Services are required to provide data to the CSDS. This includes any services that have transitioned into new organisational forms as a result of the Transforming Community Services (TCS) programme. Community Services that are funded and/or provided by the NHS or Local Authorities, for example provided by the NHS but commissioned by Local Authorities, are required to include their clinical activity in the CSDS. New care models are set to change the way in which primary, community and acute secondary services are organised. This makes it hard to define Community Services as organisational structures may include all three, as well as elements of social care. However, some examples of Community Service activity within the scope of the CSDS are outlined below: • Health Promotion drop in sessions.

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	• Home visits by District Nursing or Allied Health Professionals. • Residential care home visits. • Health Visiting activities. • Community Dentistry. • Community Paediatrician sessions in a clinic. These activities may take place in locations including health centres, Sure Start centres, day care facilities, schools or community centres, mobile facilities, hospitals, or the patient's own home (including care homes). Following the recent transition of commissioning arrangements, the commissioning of public health services is the responsibility of the Local Authority. The following recently transitioned community services commissioned by Local Authorities are within the scope of the CSDS: • Health Visiting Service. • School Nursing Service. • Public Health and Lifestyle Service. • Family Support Service. For further guidance on commissioning responsibilities for Local Authorities, see https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216708/dh_131904.pdf. For the commissioning of such services for children, see https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children. Please refer to the CSDS Technical Output Specification for a complete list of the Community Services currently covered within the scope of CSDS. The list is also available in Appendix A. **Out of Scope** The data set scope excludes all care settings listed below, but may be readdressed in line with any changes in service model provision: • Core Ambulance and Emergency Care Services. • Services covered solely by primary care contracts (General Medical Services (GMS), Personal Medical Services (PMS), Alternative Provider Medical Services (APMS) and Specialist Medical Provider Services (SPMS)). • Other Primary Care Services that are not considered Community Services including General Dental Services, General Ophthalmology Services and Pharmacy Services. • Social Care and specialist community services where separate data flows exist, e.g. community mental health. • Admitted Patient Care (including Community Hospitals, General Acute or Mental Health). This data will be in the scope of other data sets, such as the Commissioning Data Sets (CDS). • Maternity Services - depending on local processes, information on Newborn Hearing Screening and Blood Spot Card Investigation Results can be captured by Maternity or Child Health Services (Health Visitors). The remit of this information standard covers results captured within Child Health (as opposed to Maternity) Services. • Outpatient Care which was previously provided under General Acute or Mental Health contracts. This data will be in the scope of other data sets, such as the Commissioning Data Sets (CDS). • Non-health service funded activity, e.g. Speech and Language Therapy activity

	which is funded directly by schools. • Activity reported through the National Drug Treatment Monitoring System (NDTMS) Data Set, Sexual and Reproductive Health Activity Data Set (SRHAD) or Genitourinary Medicine Clinic Activity Dataset (GUMCAD). • Activity funded through Acute Payment Currencies (formally Payment by Results or PbR), i.e. included in Health Resource Groups (HRGs). • Prison or secure facility-based health services (however, community-based services visiting a prison or secure facility to deliver healthcare are in scope). **Impact on Existing Data Flows** The following activity will continue to flow via the existing Commissioning Data Sets (CDS): • Outpatient activity under the responsibility of Consultants or Nurses (and, optionally, Allied Health Professionals), including such activity taking place as part of a Consultant-Led Referral To Treatment (RTT) Pathway. • Interface service activity which starts a Consultant Led RTT pathway (e.g. musculoskeletal services). • Admitted Patient Care (APC) activity taking place within a Community Hospital. In certain circumstances there may be a requirement to flow activity within multiple data sets, e.g. Interface Service activity which starts a Consultant Led RTT pathway should also flow in the Commissioning Data Set (CDS). The CSDS does not change the existing mandated CDS flows for Admitted Patient Care, Outpatients or A&E. It does not alter the RTT flows covered by ISB 0092 Amd 7/2013 ‘Allied Health Professional (AHP) Referral To Treatment (RTT)’. http://content.digital.nhs.uk/isce/publication/isb0092 In addition, the Community Information Data Set (CIDS) standard (ref: SCCI1510), which is for local data collection and extraction only, is being retired as part of this release, eliminating the need for a separate local data flow.

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<table>
<tr><td>Applies to</td><td><u>Organisation Types</u>
The standard includes all organisational forms providing publicly funded Community Services, including those resulting from Transforming Community Services (TCS), and may include the following organisation types (both Foundation Trust and Non-Foundation Trusts):
• Acute Trusts.
• Mental Health Trusts.
• Community Healthcare Trusts.
• Care Trusts.
• Social Enterprises.
• Integrated Care Organisations.
• Any Qualified Providers (AQPs).
• Local Authorities.
• Independent Sector Providers (including Third Sector).

The standard also applies to IT systems used by Community Services.

<u>Departments</u>
The standard must be read and used by all Heads of Community Services, and related clinical and support services that have an active involvement in delivering the community care pathway or the support thereof.

<u>Professionals</u>
The standard applies to all community care professions working in or supporting Community Services, such as:
• Nursing, Health Visitors and Midwifery staff; for example Specialist Nurses.
• Allied Health Professionals; for example Physiotherapists and Dietitians.
• Other Care Professionals; for example, Counsellors or Play Therapists.

<u>IT Systems</u>
The standard predominantly, but not exclusively, relates to Community Systems, Patient Administration Systems (PAS) and Electronic Patient Records (EPR).</td></tr>
<tr><td colspan="2">Release</td></tr>
<tr><td>Release Number</td><td>Amd 57/2016</td></tr>
<tr><td>Release Title</td><td>Version 1.0</td></tr>
<tr><td>Description</td><td>Changes to the existing CYPHS standard are:
• Removal of age limit restricting the data set to patients aged 0 up until their nineteenth birthday, so that the CSDS can collect data for people of all ages in receipt of publicly-funded Community Services.
• Minor changes to data item and group-level descriptions as a result of the removal of the age limit.
• Renaming of the standard to ‘Community Services Data Set’, and consequential updates to the message (schema) headers and other supporting documents.
In addition, the CIDS standard is being retired, to eliminate the need for a</td></tr>
</table>

	separate local data flow.
Implementation Completion Date	From 1st October 2017, providers of publicly-funded Community Services ***MUST*** be able to collect information locally, and their systems ***MUST*** be fully conformant with this standard. From 1st November 2017, providers of publicly-funded Community Services ***MUST*** begin submitting CSDS submissions in accordance with this standard. Providers of publicly-funded Community Services may also volunteer to participate in pilot trials ahead of the Implementation Completion Date to test the process ahead of full data collection, upon discussion and agreement with NHS Digital. Pilot data ***MAY*** be provided from 1st June 2017 onwards.
Full Conformance Date	1st December 2017

1.2 Supporting Documents

This document should be read in conjunction with the following:

Ref #	Title
1	CSDS Technical Output Specification
2	CSDS Data Model
3	CSDS System Conformance Checklist
4	CSDS Implementation Guidance
5	CSDS Change Specification
6	CSDS User Guidance
7	CSDS Technical Guidance
8	CSDS XML Schema (login required)

Please see section 2.2 of the *Implementation Guidance* for a full list, descriptions and locations of each related document.

1.3 Related Standards

Ref #	Reference	Title
1	ISB 1513 Amd 45/2012	Maternity Services Data Set
2	SCCI1510 *(N.B. retired as part of this release)*	Community Information Data Set
3	ISB 1072 Amd 30/2012	Child and Adolescent Mental Health Services Data Set
4	ISB 0149-02	NHS Number for Secondary Care
5	ISB 0149-01	NHS Number for General Practice
6	ISB 1555	Birth Notifications
7	ISB 0092 Amd 16/2010	Commissioning Data Sets (CDS) version 6.2

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8	SCCI0034	SNOMED CT
9	SCCI1609	Child Protection Information Sharing (CP-IS)
10	SCCI0090	Organisation Data Service (ODS): Health and Social Care Organisation Reference Data
11	SCCI1605	Accessible Information
12	SCCI0021	International Classification of Diseases

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2 Health and Care Organisations

2.1 Requirements

Requirement [1]	
The following section describes the care provider requirements of this standard.	
Timeframe	
(1.1)	From 1st October 2017, providers of Community Services as defined in this Information Standard ***MUST*** be able to collect the information as defined in the Technical Output Specification for local use.
(1.2)	From 1st November 2017, providers of Community Services as defined in this Information Standard ***MUST*** begin submitting the monthly CSDS submissions as per the instructions in the CSDS Technical Guidance. The providers ***MUST*** allow time to review and implement corrections to their submission files within the designated window.
Scoping	
(2.1)	With immediate effect, providers of Community Services ***MUST*** review the 'In scope' and 'Out of scope' sections of this Specification to establish whether the standard applies to the services they offer.
(2.2)	Providers ***SHOULD*** review all related documentation to fully understand the background, objectives and scope of this information standard.
Feasibility Assessment	
(3.1)	With immediate effect, providers of Community Services ***MUST*** review the CSDS Technical Output Specification (TOS) and CSDS User Guidance to understand the scope and definition of each data item.
(3.2)	As an Output Data Set, the CSDS is intended to only define "what should be extracted" from local IT systems, not "what should be captured". A clinical data set will need data items beyond what the CSDS specifies; consequently, providers of Community Services ***SHOULD NOT*** use this data set to support their clinical and operational data capture. The whole ethos around the CSDS is to only re-use clinical data and not specify standards for capturing clinical data.
(3.3)	Providers of Community Services ***SHOULD*** familiarise themselves with the CSDS XML schema and conversion tool[2] to understand how data items are grouped for the Data Submission File.
(3.4)	Providers of Community Services ***SHOULD*** carry out a 'data mapping exercise' to understand how well their existing electronic systems align to the CSDS TOS and take appropriate action to ensure that the standard is fully met. The self-assessment 'System Conformance Checklist' tool is available on the NHS Digital website to support this mapping exercise. The mapping exercise is likely to need the involvement of experienced CSDS leads, the organisation's Information Management Service and the appropriate IT system suppliers.
(3.5)	Providers of Community Services ***MUST*** make submissions only for those data items defined in the TOS and no additional data items should be included.
Information Governance	
(4.1)	The CSDS Implementation Guidance explains the Information Governance issues surrounding the data set. Caldicott Guardians and the Heads of Community Services

[1] The key words MUST, SHOULD and MAY are defined in RFC-2119.

[2] An XML conversion tool package for the CSDS has been developed by NHS Digital. This enables providers to load or copy their data into the provided table structure. Once complete, a routine can be run that will export the submission into the required XML format ready for submission to the central data repository. Use of the conversion tool is optional. Further information can be found in the CSDS Technical Guidance.

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	MUST review the Information Governance Guidelines within the CSDS Implementation Guidance to understand: - How data submission, storage and reporting processes handle identifiable and sensitive data items. - How consent issues should be best managed.
(4.2)	Providers of Community Services ***MUST*** make available information and guidance to patients stating that their clinical care data may be re-used for the purpose of data analysis and reporting.
(4.3)	With immediate effect, providers of Community Services ***SHOULD*** read the 'NHS Confidentiality Code of Practice', 'Caldicott Report' and subsequent 'Information: To share or not to share?' Information Governance Review (second Caldicott review) for guidance and technical support related to data and information sharing at both operational and secondary use levels.
(4.4)	Providers of Community Services ***SHOULD*** also consult and adhere to the good practice advice and guidance set out in the NHS Digital's 'A Guide to Confidentiality in Health and Social Care'.
(4.5)	To prevent breaches of confidentiality, it ***MUST*** be the sole responsibility of the Providers of Community Services' Caldicott Guardian to ensure the subject information is withheld where appropriate.
(4.6)	Any immediate concerns ***SHOULD*** be addressed to the standard's developers at NHS Digital, or the Health Research Authority (HRA) Confidentiality Advisory Group (CAG) if the concerns relate to data dissemination.
(4.7)	Providers of Community Services ***SHOULD*** ensure that local data repositories comply to appropriate data security controls.
Clinical Governance	
(5.1)	As an Information Standard that approves a national patient-level CSDS: - Governing and audit bodies ***MAY*** use the data set to monitor whether providers of Community Services are making year on year improvements. - Providers of Community Services ***MAY*** use the data set to compare and contrast performance to drive service improvements. It is therefore clear that the data set can be used for clinical governance purposes.
Clinical Risks	
(6.1)	Providers of Community Services ***SHOULD*** always seek to understand the context of published national reports and be aware that the information presented depends greatly upon the quality of information submitted.
(6.2)	Ongoing efforts ***SHOULD*** be made to ensure that data quality is of the highest standard before forming judgements about reports and introducing changes.
(6.3)	Where there is a system change in order to meet this standard (e.g. the procurement of a new clinical system from a different supplier), providers of Community Services ***SHOULD*** ensure that supplier organisations are compliant with the clinical safety standards SCCI0129 and SCCI0160.
Central Data Submission	
(7.1)	Providers of Community Services ***MUST*** create a monthly data submission as set out in the CSDS Technical Guidance. Therefore, Providers of Community Services ***MUST*** be able to: - Collate and extract data from local IT systems as per the CSDS TOS. - Structure the data and create a data submission file as per the CSDS Technical Guidance. - Apply the basic validation rules and ensure that the submission file conforms to these. - Ensure the data submission file only contains data for a single month and relates to one provider organisation.

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- Submit the data submission file as per the data submission protocol highlighted in the Technical Guidance.

(7.2) Providers of Community Services ***MUST*** submit data monthly to the central data repository, based on a schedule that will be published on the NHS Digital website in advance of the Conformance Date.

(7.3) The schedule outlines the timeframe (Submission Window) within which data relating to a monthly period (Reporting Period) ***MUST*** be submitted.

(7.4) Providers of Community Services ***MUST*** check error reports, correct errors and make re-submissions at the earliest opportunity. Further details on error correction and re-submissions are explained within the Technical Guidance.

Constructing a Data Submission File

The CSDS Technical Guidance document provides information on how to create a monthly submission file. Providers of Community Services ***MUST*** review this document; however, noted below are key requirements of the technical submission architecture.

(8.1) A submission ***MUST***:
- Only contain data for a single provider organisation.
- Only contain data relating to activities occurring in a single month.
- Meet the conditions and validation rules explained in the CSDS TOS.

(8.2) Each Data Submission File ***MUST*** consist of a:
- Header group.
- Two or more data groups, including CYP001 and CYP002 entries for every record.

(8.3) Each group consists of one or more data items. The groupings of data items for each table ***MUST*** be as per the layout specified in the CSDS TOS.

(8.4) Providers of Community Services ***MUST*** include in their submission all data groups they can generate from local electronic systems.

(8.5) The first data submission ***MUST*** include all data relating to referrals that were open on 1st October 2017 and all subsequent new referrals.

(8.6) The Information Standard does not stipulate how data should be collected in local electronic systems, so the groups ***MAY*** generate data from one or more data sources. It ***MAY*** be that providers of Community Services adopt a local data repository to aggregate data from all relevant sources and use this to generate the Data Submission File. A conversion tool has also been provided which ***MAY*** be used to collate data from multiple systems and produce a submission file in the correct XML format.

Validation Rules

(9.1) With immediate effect, providers of Community Services ***MUST*** review the CSDS TOS to understand the data validation rules that will be applied to each data group on arrival at the central data repository to all incoming Data Submission Files. Any validation rules not adhered to will result in appropriate groups or the entire submission being rejected.

(9.2) Where error reports are generated due to non-conformance against validation rules, providers of Community Services ***MUST*** take immediate action and resubmit the corrected file within the submission window. Details of the rejection and error messages contained within the reports are provided within the CSDS TOS.

Data Quality Feedback

(10.1) With immediate effect, providers of Community Services ***MUST*** review the CSDS TOS to understand the data quality rules that will be applied to each data group on arrival at the central data repository.

(10.2) Providers of Community Services ***SHOULD*** review reports generated by NHS Digital highlighting issues with data quality to allow them to take further action before the submission window closes.

(10.3) Providers of Community Services ***SHOULD*** make every effort to resolve inherent systemic errors and address recurring data quality issues, as once the submission window closes for a particular reporting period there will not be a further opportunity to resubmit the data.

Monthly Submission

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(11.1)	A submission ***MUST*** be made via the central data repository on a monthly basis and as per instructions laid out in the CSDS Technical Guidance.
Issues and Maintenance	
(12.1)	To support the implementation of this information standard, providers of Community Services ***SHOULD*** highlight any persistent issues and feed these back to the standard's developers. Feedback will be used by the developers to improve the implementation and data collection processes for future consideration towards a data set change or, indeed, further implementation phases. Feedback can be sent via enquiries@nhsdigital.nhs.uk.
Requirements of Key Personnel Involved in the Delivery of this Data Set	
(13.1)	**Heads of Community Services** are responsible for capturing the information as part of the on-going care of patients. They ***MUST***: - Familiarise themselves with the CSDS TOS to understand what data items are mandated by this Information Standard. - Assist their organisation's IT or Information Management service in completing the CSDS System Conformance Checklist to assess what proportion of the CSDS TOS data items are available from the their organisation's local IT systems. - Ensure they understand and implement the Information Governance approach adopted for this data set, which can be found in the Information Governance section of the Implementation Guidance. - Explain to operational and clinical staff the importance of capturing data for the CSDS.
(13.2)	**Clinical staff *MUST***: - Capture the CSDS TOS data items in an accurate and timely manner. - Understand the deployed IG approach, especially in relation to the handling of sensitive data.
(13.3)	**Informatics staff** are responsible for producing extracts that conform to the XML schema and TOS. They ***MUST***: - Familiarise themselves with the CSDS TOS and XML schema to understand what data items are mandated by this Information Standard. - Configure electronic patient record systems to allow compliance with the standard. - Submit the data to the central data repository within the prescribed reporting periods and deadlines. - Review and work with clinicians to resolve data quality issues identified in the output reports. - Ensure they understand and implement the Information Governance approach adopted for this data set, which can be found in the Information Governance section of the Implementation Guidance. Informatics staff ***MAY*** also be responsible for the collation of information from a range of disparate systems into the CSDS. This will include ensuring completeness and data quality of the information within the data set.
Working Practices	
Cascading the Information Standard requirements to operational staff	
(14.1)	With immediate effect, all clinicians and operational staff involved in community care need to be made aware of this Information Standard. Providers of Community Services' Chief Executives ***MUST*** be held accountable to comply with the dates instructed by the mandate. The mandate and an appropriate Project Brief ***SHOULD***, therefore, be cascaded to the commissioned Community Services for the attention of the Community Service leads and other relevant staff.
(14.2)	Instructions ***MUST*** also be communicated to the organisation's information leads to initiate collaborative work with Informatics Services and Community Services as early as possible.
System upgrades	

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(15.1) This Standard looks to re-use clinical and operational data for national analysis and reporting. Providers of Community Services ***SHOULD*** conduct a mapping exercise to determine how well local systems map to the CSDS TOS (using the CSDS System Conformance Checklist).

(15.2) For data items that align to the data set TOS, providers of Community Services ***MUST*** collate the data locally on a monthly basis.

(15.3) Where the mapping exercise identifies gaps, providers of Community Services ***SHOULD*** plan to undertake development efforts with their IT system suppliers to upgrade existing IT systems.

(15.4) Providers of Community Services ***SHOULD*** consider the provision of adequate resources to make plans for any transcription requirements of paper records to electronic forms which ultimately meet the entire mandated data standard for central returns.

How CSDS providers should look to capture data

(16.1) This Standard defines the data items that that should be extracted from local electronic systems. Providers of Community Services ***SHOULD*** continue to develop their electronic systems to support the clinical data capture which best supports their working practices and business plans.

(16.2) However, when planning to improve systems and services, consideration ***MUST*** be made to this Information Standard during the development and implementation stages.

The TOS and User Guidance provide further information on the data items which need to be captured.

How to achieve timely data capture and file submission

(17.1) The data set has been deliberately split into a number of data groups. The data groups are intended to support the business processes of Community Service providers. Providers of Community Services ***MUST*** make every effort to record clinical information in real time or as a minimum, transcribe information to an electronic form at the earliest opportunity to support clinical interventions and decisions. This procedure will also support seamless data extraction from electronic systems for the required monthly central return.

How to manage data submissions if data is captured across several systems

(18.1) Due to the number of services considered Community Services, each of which ***MAY*** use its own dedicated IT system, the CSDS spans several services and systems (e.g. Health Visiting and Child Health). The Information Standard makes it very clear that a submission file can only include data pertaining to one organisation and for reporting periods that are open. Therefore, providers of Community Services ***MAY*** wish to consider developing a local data repository to generate the monthly submission files.

Demonstrating readiness

(19.1) During September 2017 a state of readiness questionnaire will be circulated to assess conformance with this standard. This ***MUST*** be completed by providers of Community Services and returned to NHS Digital within the specified deadline.

2.2 Conformance Criteria

This section describes the tests that can be measured to indicate that the information standard is being used correctly by a provider organisation (conformance criteria). Conformance of provider organisations is also assessed through analysis of the submitted data, once it is received by NHS Digital. In each case, the requirement(s) being measured by each criterion is shown in italics.

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Conformance Criteria
(1.1) All relevant data from the CSDS TOS, i.e. mandatory items and required items that should be reported where they apply, are collected locally from 1st October 2017. This will be measured by assessing the data received by providers from the submissions commencing.
(1.2, 7.1, 7.2, 7.3, 8.1, 8.2, 8.3, 8.4 ,8.5 and 11.1) Submissions to the CSDS, constructed in accordance with the CSDS Technical Guidance and TOS, are made from 1st November 2017 and on a monthly basis thereafter. This will be measured by assessing the data received by providers from the submissions commencing.
(2.1, 3.1 and 3.5) The CSDS Information Standards Notice, Requirements Specification (this document), and other supporting documents have been reviewed within one month of the publication date of this Information Standard, in order to establish which services are covered by the scope, how the data items within the data set are defined, and what data items should be included in submissions. This will be measured using the state of readiness questionnaire (see 19.1).
(4.1, 4.2 and 4.5) Prior to the start of local data collection on 1st October 2017, the Information Governance considerations around the CSDS have been reviewed by Caldicott Guardians and the Heads of Community Services, and relevant information communicated to patients about the collection and submission of their data. This will be measured using the state of readiness questionnaire (see 19.1).
(9.1 and 10.1) By 1st November 2017 the CSDS TOS has been reviewed and the relevant data validation and data quality rules are understood. Any such issues are identified and acted upon after each submission. This will be measured by assessing the data received by providers from the submissions commencing and assessing any improvements in data quality.
(9.2) From 1st November 2017, all error reports generated due to non-conformance with validation rules are reviewed in a timely manner, allowing for re-submission of a corrected file within the submission window. This will be measured by assessing the data received by providers from the submissions commencing and assessing any improvements in data quality between primary and refresh submissions.
(13.1, 13.2 and 13.3) Key personnel involved in the delivery of the CSDS understand their obligations in relation to local data capture, the submission of CSDS data, and the required information governance approach, prior to local data collection commencing on 1st October 2017. This will be measured using the state of readiness questionnaire (see 19.1).
(19.1) The CSDS state of readiness questionnaire is completed and returned to NHS Digital by the communicated deadline (likely to be 29th September 2017). This will be measured by the submission of the completed state of readiness questionnaire.

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3 IT Systems

3.1 Requirements

Requirement [3]
The following section describes the care provider requirements to ensure that their IT systems conform to this standard.
Timeframe
(1.1) From 1st October 2017 systems used by Community Services ***MUST*** be able to capture and/or derive the data items defined within this standard. This includes mapping of local codes to national codes, and the ability to extract this information as envisaged within this standard, e.g. without interim workarounds. Suppliers ***MAY*** assess this against the System Conformance Checklist which can be found on the NHS Digital website. (1.2) Changes made to systems ***MUST*** result in minimal increase on burden for providers in capturing and extracting the information defined in the CSDS TOS, and any additional burden ***MUST*** be proportionate. (1.3) When considering potential developments, minimising the burden on providers and supporting good data quality ***MUST*** be prioritised.
Scoping
(2.1) IT Systems Suppliers ***SHOULD*** review all related documentation to fully understand the background, objectives and scope of this information standard.
Feasibility Assessment
(3.1) With immediate effect, IT Systems Suppliers ***SHOULD*** review the CSDS Technical Output Specification (TOS) and CSDS User Guidance to understand the scope and definition of each data item. (3.2) As an Output Data Set, the CSDS is intended to only define “what should be extracted” from local IT systems, not “what should be captured”. A clinical data set will need data items beyond what the CSDS specifies. (3.3) While IT Systems Suppliers ***SHOULD*** use this data set to support their system development, they ***SHOULD NOT*** use the data set exclusively and ***SHOULD*** also consider the full requirements of the care setting where it is used. The whole ethos around the CSDS is to only re-use clinical data, not specify standards for capturing clinical data. (3.4) IT Systems Suppliers ***SHOULD*** familiarise themselves with the CSDS XML schema and conversion tool to understand how data items are grouped for the Data Submission File. (3.5) IT Systems Suppliers ***SHOULD*** provide tools to enable a ‘data mapping exercise’ to be carried out and where possible complete the mappings to the national codes on behalf of the CSDS providers. A self-assessment ‘System Conformance Checklist’ is a tool available on the NHS Digital website to support this mapping exercise.
Information Governance
The CSDS Implementation Guidance explains the Information Governance issues surrounding the data set. (4.1) IT Systems ***MUST*** provide a mechanism to allow providers to identify records where patients have objected to the use of their data for secondary purposes or where there is a legal requirement to restrict the flow of identifiable information for a patient.

[3] The key words MUST, SHOULD and MAY are defined in RFC-2119.

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Clinical Risks	
(5.1)	IT System suppliers ***SHOULD*** always ensure that any changes resulting from the implementation of the CSDS are compliant with the safety standards SCCI0129 and SCCI0160.
Constructing a data submission file	
(6.1)	The CSDS Technical Guidance document provides information on how to create a monthly submission file. IT Systems Suppliers ***SHOULD*** review this document and the steps outlined in Section 2.1 (Health and Care Organisations - Requirements) above.
Validation rules	
(7.1)	IT Systems Suppliers ***SHOULD*** review the CSDS Technical Guidance and TOS to understand the data validation rules that will be applied at the central data repository to all incoming Data Submission Files. Any validation rules not adhered to will result in appropriate groups or the entire Data Submission File being rejected, depending on the particular validation rule.
Data quality feedback	
(8.1)	With immediate effect, IT Systems Suppliers ***SHOULD*** review the CSDS TOS to understand the data quality rules that will be applied to each data group on arrival at the central data repository.
(8.2)	From 1st November 2017, all systems used by Community Services ***MUST*** have the ability to produce data quality reports to support providers in producing their submission files in line with the CSDS TOS.
Demonstrating readiness	
(9.1)	During September 2017 a state of readiness questionnaire will be circulated to assess conformance with this standard. This ***SHOULD*** be completed by all suppliers of systems used by Community Services and returned to NHS Digital within the specified deadline.

3.2 Conformance Criteria

This section describes the tests that can be measured to indicate that the information standard is being used correctly within IT systems. In each case, the requirement(s) being measured by each criterion is shown in italics.

Conformance Criteria
(1.1) All relevant data from the CSDS TOS, i.e. mandatory items and required items that should be recorded where they apply, can be captured by systems used by Community Services from 1st October 2017. Functionality to map local codes/values to national codes/values is included, and the system is able to extract this information as envisaged within this standard. This will be measured using the state of readiness questionnaire (see 9.1) and, later, through provider submissions.
(1.2) and (1.3) Systems used by Community Services are able to extract data for the CSDS, with minimal additional burden for providers, from 1st October 2017. The format is compatible with the XML schema without a reliance on interim workarounds. This will be measured using the state of readiness questionnaire (see 9.1).
(1.3) and (8.2) Systems used by Community Services are able to produce data quality reports to support providers in producing their submission files in line with the CSDS TOS, from 1st November 2017. This will be measured using the state of readiness questionnaire (see 9.1) and, later, through assessing the data quality of provider's submissions.
(4.1) Systems used by Community Services have the required functionality, from 1st November 2017, to allow providers to identify records where patients have objected to the use of their data for secondary

purposes or where there is a legal requirement to restrict the flow of identifiable information for a patient. This will be measured using the state of readiness questionnaire (see 9.1).
(9.1) The CSDS state of readiness questionnaire is completed and returned to NHS Digital by the communicated deadline (likely to be 29th September 2017). This will be measured by the submission of the completed state of readiness questionnaire.

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Appendix A: List of Community Services within scope of this Information Standard

- Appliances Service
- Arts Therapy Service
- Cancer Service
- Cardiac Service
- Children's Community Nursing Service
- Clinical Psychology Service
- Community Dental Service
- Community Paediatrics Service
- Continence Service
- Counselling Service
- Dermatology Service
- Diabetes Service
- Diagnostic Service
- District Nursing Service
- Ear Nose and Throat Service
- End of Life Care Service
- Family Support Service
- Gastrointestinal Service
- Haematology Service
- Health Visiting Service
- Hearing Service
- Integrated Multi-Disciplinary Team
- Intermediate Care Service
- Long Term Conditions Case Management Service
- Musculoskeletal Service
- Neurology Service
- Nutrition and Dietetics Service
- Occupational Therapy Service
- Orthoptist Service
- Pain Management Service
- Phlebotomy Service
- Physiotherapy Service

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- Podiatry Service
- Public Health and Lifestyle Service
- Rehabilitation Service
- Respiratory Service
- Respite Care Service
- Rheumatology Service
- School Nursing Service
- Speech and Language Therapy Service
- Tissue Viability Service
- Treatment Room Nursing Service
- Vulnerable Children's Service
- Vulnerable Adult's Service

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Purpose of this document

The CSDS v1.0 Technical Output Specification (TOS) is intended to provide a comprehensive technical view of the provider submission (32 data set tables) and processed Bureau Service Portal (BSP) Extracts.

The 32 data set tables include data item level detail necessary to construct an output data set suitable for submission. The data set tables also include additional information explaining which records should be included in a submission (inclusion rules).

Background

The CSDS Information Standard is the specification of a patient-level data-extraction (output) standard intended for community service providers in England.
This Information Standard has been accepted by the Standardisation Committee for Care Information (SCCI) and has been assigned standard number SCCI1069. This mandates the patient-level CSDS as a national data standard.

The ISN does not directly place any requirement on system suppliers to accommodate the CSDS within their systems. The contractual agreement between data providers and system suppliers will dictate whether system suppliers have to abide by the ISN.

The formal Information Standard can be found at:
http://content.digital.nhs.uk/isce/publication/scci1069

Further information and supporting documents can be found at:
http://digital.nhs.uk/csds

Related Documents

A comprehensive set of documentation has been developed by the project team. Please see the Implementation Guidance, Section 2.2, for an overview of the documentation available and where they can be found.

This document should be read in conjunction with the following documents:
- CSDS Requirements Specification
- CSDS Change Request
- CSDS Implementation Guidance
- CSDS User Guidance
- CSDS Technical Guidance
- NHS Data Model and Dictionary

Please note that a version of the Technical Output Specification (this document) including details of validation rules (rejections/warnings) and derivations generated from the submitted data is also available.

Document Version History

Version	Date Issued	Brief Summary of Change

Community Services Data Set (CSDS) v1.0

Technical Output Specification

Data item / Group changes

Change ID	XML Element Name	Group	Data Item Name	Item Type	Item Amend Type	Previous	New	Change Reason(s)	Date Changed	Version Number	JIRA Ticket No (Internal Use)
1	C404010	CYP404AssTechToSupportDisTyp	ASSISTIVE TECHNOLOGY FINDING (SNOMED CT)	Data Item Format	Amendment	min an6 max an18	min n6 max n18	SNOMED codes can only contain numeric values	03/01/2017	1.0.1	N/A
2	C609910	CYP609CodedAssessmentReferral	CODED ASSESSMENT TOOL TYPE (SNOMED CT)	Data Item Format	Amendment	min an6 max an18	min n6 max n18	SNOMED codes can only contain numeric values	03/01/2017	1.0.1	N/A
3	C612910	CYP612 Coded Scored Assessment (Contact)	CODED ASSESSMENT TOOL TYPE (SNOMED CT)	Data Item Format	Amendment	min an6 max an18	min n6 max n18	SNOMED codes can only contain numeric values	03/01/2017	1.0.1	N/A
4	C613910	CYP613 Anonymous Self Assessment	CODED ASSESSMENT TOOL TYPE (SNOMED CT)	Data Item Format	Amendment	min an6 max an18	min n6 max n18	SNOMED codes can only contain numeric values	03/01/2017	1.0.1	N/A
5	C403010	CYP403 CPP	CHILD PROTECTION PLAN REASON CODE	Data Item Description	Amendment	The reason the Child or Young Person (Children and Young People's Health Service) is subject to an active Child Protection Plan.	The reason the Child or Young Person is subject to an active Child Protection Plan.	Remove ambiguity in current description - data item should still be collection in CSDS	03/01/2017	1.0.1	N/A
6	C606010	CYP606 Provisional Diagnosis	PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY)	Data Item Description	Amendment	This is the provisional DIAGNOSIS of the child or young person, from a specific classification or clinical terminology, for the main condition treated or investigated during the relevant episode of healthcare.	This is the provisional DIAGNOSIS of the person, from a specific classification or clinical terminology, for the main condition treated or investigated during the relevant episode of healthcare.	This data item applies to both adults and children. Due to the change in scope to include adults within the CSDS, as opposed to just children in the CYPHS data set, provisional diagnoses for adults may also be included in this field.	06/01/2017	1.0.2	N/A
7	C001110	CYP001 MPI	PERSON RELATIONSHIP (MAIN CARER)	Data Item Description	Amendment	The relationship between the child/young person and the person/s who undertake/s the main caring role for them.	The relationship between the child/young person and the person who undertakes the main caring role for them.	Remove ambiguity in original description - No impact on Data Dictionary	12/01/2017	1.0.3	N/A
8	C102030	CYP102 Service Type Referred To	REFERRAL REJECTION DATE	Validation	Amendment	CYP10219 - Record rejected - Referral Rejection Date is after the File Creation Date Time. Service Request Identifier=<C102902> Local Patient Identifier (Extended)=<C101901> Referral Rejection Date=<C102030>	CYP10219 - Record rejected - Referral Rejection Date is after the Date and Time Data Set Created. Service Request Identifier=<C102902> Local Patient Identifier (Extended)=<C101901> Referral Rejection Date=<C102030>	To ensure consistency with other validations	12/01/2017	1.0.3	CYPHS-441
9	C102030	CYP102 Service Type Referred To	REFERRAL REJECTION DATE	Validation	Amendment	CYP10221 - Record rejected - Referral Rejection Date is after the Discharge Date. Service Request Identifier=<C102902> Local Patient Identifier (Extended)=<C101901> Referral Rejection Date=<C102030>	CYP10221 - Record rejected - Referral Rejection Date is after the Service Discharge Date. Service Request Identifier=<C102902> Local Patient Identifier (Extended)=<C101901> Referral Rejection Date=<C102030>	To ensure consistency with other validations	12/01/2017	1.0.3	CYPHS-441
10	C102020	CYP102 Service Type Referred To	REFERRAL CLOSURE DATE	Validation	Amendment	CYP10225 - Record rejected - Referral Closure Date is before the start of the reporting period. Service Request Identifier=<C102902> Local Patient Identifier (Extended)=<C101901>	CYP10225 - Record rejected - Referral Closure Date is before the Reporting Period Start Date. Service Request Identifier=<C102902> Local Patient Identifier (Extended)=<C101901>	To ensure consistency with other validations	12/01/2017	1.0.3	CYPHS-441
11	C102020	CYP102 Service Type Referred To	REFERRAL CLOSURE DATE	Validation	Amendment	CYP10209 - Record rejected - Referral Closure Date is after the File Creation Date Time. Service Request Identifier=<C102902> Local Patient Identifier (Extended)=<C101901>	CYP10209 - Record rejected - Referral Closure Date is after the Date and Time Data Set Created. Service Request Identifier=<C102902> Local Patient Identifier (Extended)=<C101901>	To ensure consistency with other validations	12/01/2017	1.0.3	CYPHS-441
12	C102020	CYP102 Service Type Referred To	REFERRAL CLOSURE DATE	Validation	Amendment	CYP10213 - Record rejected - Referral Closure Date is after the Discharge Date. Service Request Identifier=<C102902> Local Patient Identifier (Extended)=<C101901>	CYP10213 - Record rejected - Referral Closure Date is after the Service Discharge Date. Service Request Identifier=<C102902> Local Patient Identifier (Extended)=<C101901>	To ensure consistency with other validations	12/01/2017	1.0.3	CYPHS-441
13	N/A	CYP201 Care Contact	N/A	Validation	Amendment	CYP20142 - Group rejected - More than one CYP201 provided for this Care Contact Identifier=<C201903>	CYP20142 - Group rejected - More than one CYP201 provided for this Care Contact Identifier. Care Contact Identifier=<C201903> Service Request Identifier=<C201902>	To ensure consistency with other validations	12/01/2017	1.0.3	CYPHS-596
14	CYPREJ007	File-level Rejects	N/A	File-level Reject	Amendment	**Validation Failure Message** CYPREJ007 **-** Failed Date of Birth Check. File contains invalid dates of birth. **Help Text** Invalid dates of birth corrupt the allocation of the MCDS pseudo person ID and cannot be accepted. Date of Birth, if provided, must not be after the end of the latest reporting period selected. The derived age at start of the earliest reporting period selected must not be 19 years old or greater.	**Validation Failure Message** CYPREJ007 **-** Failed Date of Birth Check. File contains invalid dates of birth. **Help Text** Invalid dates of birth corrupt the allocation of the MCDS pseudo person ID and cannot be accepted. Date of Birth, if provided, must not be after the end of the latest reporting period selected.	Remove restriction on adults	31/01/2017	1.0.4	N/A
15	CYPREJ000	File-level Rejects	N/A	File-level Reject	Amendment	**Validation Failure Message** CYPREJ000 - Failed Submission File Format Check. The file is not a valid XML file. **Help Text** The file you have uploaded has failed format checks, and so your submission has been rejected. This could be because of any of the following reasons: -The file is not an XML file. -The XML file you have uploaded has been checked against the XML schema for this data set and has been found to not be well-formed. -The Bureau Service Portal failed to successfully upload the submission file from the data provider. -A technical issue arose when trying to upload data from the submitted XML file into the database. Please review the XML file to check it complies with the structure defined by the current XML schema and resubmit the file.	**Validation Failure Message** CYPREJ000 - Failed Submission File Format Check. The file is not a valid XML file. **Help Text** The file you have uploaded has failed format checks, and so your submission has been rejected. This could be because of any of the following reasons: -The file is not an XML file. -The XML file you have uploaded has been checked against the XML schema for this data set and has been found to not be well-formed. -The Bureau Service Portal failed to successfully upload the submission file from the data provider. -A technical issue arose when trying to upload data from the submitted XML file into the database. -The file contains XML reserved characters. Please review the XML file to check it complies with the structure defined by the current XML schema and resubmit the file.	Provide further information about XML reserved characters.	31/01/2017	1.0.4	N/A

16	CYPREJ000	File-level Rejects	N/A	File-level Reject	Amendment	**Validation Failure Message** CYPREJ000 - Failed Submission File Format Check. The file is not a valid XML file. **Notes** [previously blank]	**Validation Failure Message** CYPREJ000 - Failed Submission File Format Check. The file is not a valid XML file. **Notes** The presence of XML reserved characters in any free text fields within a submission file could cause this error message, the XML reserved characters being: > < & % Any reserved characters can be replaced with the appropriate entity reference if these characters genuinely need to be present.	Provide further information about XML reserved characters.	31/01/2017	1.0.4	N/A
17	C611030	CYP611 Observation	PERSON LENGTH IN CENTIMETRES	National Code Definitions	Addition		Added '99.9 - Length unknown' to National Code Definitions	To align with National Code Definitions in Data Dictionary.	08/02/2017	1.0.4	N/A
18	C003020	CYP003 Accommodation Type	ACCOMMODATION STATUS RECORDED DATE	Data Item Name	Amendment	ACCOMMODATION STATUS DATE	ACCOMMODATION STATUS RECORDED DATE	To align correctly with Data Dictionary.	09/02/2017	1.0.4	N/A
19	C003020	CYP003 Accommodation Type	ACCOMMODATION STATUS RECORDED DATE	Validation	Amendment	CYP00307 - Record rejected - Accommodation Status Date has incorrect date format. Local Patient Identifier (Extended)=<C003901>	CYP00307 - Record rejected - Accommodation Status Recorded Date has incorrect date format. Local Patient Identifier (Extended)=<C003901>	To correct data item name following alignment with Data Dictionary.	09/02/2017	1.0.4	N/A
20	C003020	CYP003 Accommodation Type	ACCOMMODATION STATUS RECORDED DATE	Validation	Amendment	If Accommodation Status Date is after the end of the reporting period, the record will be rejected. CYP00308 - Record rejected - Accommodation Status Date is after the end date of the reporting period. Local Patient Identifier (Extended)=<C003901> Accommodation Status Date=<C003020>	If Accommodation Status Recorded Date is after the end of the reporting period, the record will be rejected. CYP00308 - Record rejected - Accommodation Status Recorded Date is after the end date of the reporting period. Local Patient Identifier (Extended)=<C003901> Accommodation Status Recorded Date=<C003020>	To correct data item name following alignment with Data Dictionary.	09/02/2017	1.0.4	N/A
21	C003020	CYP003 Accommodation Type	ACCOMMODATION STATUS RECORDED DATE	Validation	Amendment	If Accommodation Status Date is before Person Birth Date, the record will be rejected. CYP00310 - Record rejected - Accommodation Status Date is before Person Birth Date. Local Patient Identifier (Extended)=<C003901> Accommodation Status Date=<C003020> Person Birth Date=<C001060>	If Accommodation Status Recorded Date is before Person Birth Date, the record will be rejected. CYP00310 - Record rejected - Accommodation Status Recorded Date is before Person Birth Date. Local Patient Identifier (Extended)=<C003901> Accommodation Status Recorded Date=<C003020> Person Birth Date=<C001060>	To correct data item name following alignment with Data Dictionary.	09/02/2017	1.0.4	N/A
22	C003020	CYP003 Accommodation Type	ACCOMMODATION STATUS RECORDED DATE	Validation	Amendment	If Person Birth Date is blank AND Accommodation Status Date is before 1 January 1901, the record will be rejected. CYP00311 - Record rejected - Person Birth Date is blank AND Accommodation Status Date is before 1 January 1901. Local Patient Identifier (Extended)=<C003901> Person Birth Date=<C001060>Accommodation Status Date=<C003020>	If Person Birth Date is blank AND Accommodation Status Recorded Date is before 1 January 1901, the record will be rejected. CYP00311 - Record rejected - Person Birth Date is blank AND Accommodation Status Recorded Date is before 1 January 1901. Local Patient Identifier (Extended)=<C003901> Person Birth Date=<C001060>Accommodation Status Recorded Date=<C003020>	To correct data item name following alignment with Data Dictionary.	09/02/2017	1.0.4	N/A
23	C101050	CYP101 Service or Team Referral	REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE)	National Code Definitions	Amendment	M04 - General Medical Practitioner with Special Interests	M04 - General Medical Practitioner with A Special Interest	To align with National Code Definitions in Data Dictionary.	09/02/2017	1.0.4	N/A
24	C101050	CYP101 Service or Team Referral	REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE)	National Code Definitions	Amendment	Nursing, Health Visitors and Midwifery	Nursing, Health Visiting and Midwifery	To align with National Code Definitions in Data Dictionary.	09/02/2017	1.0.4	N/A
25	C001110	CYP001 MPI	PERSON RELATIONSHIP (MAIN CARER)	Validation	Addition		If the person was 19 years of age or over at the start of the reporting period and the Person Relationship (Main Carer) is populated the record will be rejected. CYP00182 - Record rejected - Person was 19 years of age or over at the start of the reporting period, but Person Relationship (Main Carer) is populated. Local Patient Identifier (Extended)=<C001901> Person Relationship (Main Carer) =<C001110> Person Birth Date =<C001060> Reporting Period Start Date = <C000040>	To prevent this data item flowing for adults as the current national code definition list does not account sufficiently for the relationships of people who have care responsibility of an adult.	17/02/2017	1.0.4	N/A
26	C001110	CYP001 MPI	PERSON RELATIONSHIP (MAIN CARER)	Validation	Addition		If the Person Birth Date is blank and Person Relationship (Main Carer) is populated the record will be rejected. CYP00183 - Record rejected - Person Birth Date is blank and Person Relationship (Main Carer) is populated. Local Patient Identifier (Extended)=<C001901> Person Relationship (Main Carer) =<C001110>	To prevent this data item flowing for adults (or individuals whose age cannot be determined) as the current national code definition list does not account sufficiently for the relationships of people who have care responsibility of an adult.	17/02/2017	1.0.4	N/A
27	N/A	N/A	N/A	Spreadsheet tab	Remove	Release History	Release History tab combined with Data Set Details tab	Remove duplicate information	17/02/2017	1.0.4	N/A
28	N/A	N/A	N/A	Spreadsheet tab	Remove	Change Control (Internal)	Change Control (Internal) tab combined with Change control (v1.0) tab	Remove duplicate information	17/02/2017	1.0.4	N/A
29	C001120	CYP001 MPI	HEALTH VISITOR FIRST ANTENATAL VISIT DATE	Validation	Addition		If Health Visitor First Antenatal Visit Date is after the Person Birth Date, the record will be rejected. CYP00184 - Record rejected - Health Visitor First Antenatal Visit Date is after the Person Birth Date. Local Patient Identifier (Extended)=<C001901> Health Visitor First Antenatal Visit Date=<C001120> Person Birth Date=<C001060>	To prevent incorrect records from flowing into the dataset. The first antenatal visit date must have taken place before the person was born.	17/02/2017	1.0.4	N/A
30	C001120	CYP001 MPI	HEALTH VISITOR FIRST ANTENATAL VISIT DATE	Validation	Addition		If Person Birth Date is blank AND Health Visitor First Antenatal Visit Date is populated, the record will be rejected. CYP00185 - Record rejected - Person Birth Date is blank AND Health Visitor First Antenatal Visit Date is populated. Local Patient Identifier (Extended)=<C001901> Health Visitor First Antenatal Visit Date=<C001120>	To prevent incorrect records from flowing into the dataset. The first antenatal visit date must have taken place before the person was born. If the person birth date is not know then this cannot be verified.	17/02/2017	1.0.4	N/A

31	C001120	CYP001 MPI	HEALTH VISITOR FIRST ANTENATAL VISIT DATE	Validation	Remove	If Health Visitor First Antenatal Visit Date is after the Person Birth Date, a warning will be generated. CYP00165 - Warning - Health Visitor First Antenatal Visit Date is after the Person Birth Date. Local Patient Identifier (Extended)=<C001901> Health Visitor First Antenatal Visit Date=<C001120> Person Birth Date=<C001060>		Superseded by CYP00184	17/02/2017	1.0.4	N/A
32	C001120	CYP001 MPI	HEALTH VISITOR FIRST ANTENATAL VISIT DATE	Validation	Remove	If PersonBirthDate is blank AND Health Visitor First Antenatal Visit Date is before 1 January 1901, the record will be rejected. CYP00177 - Record rejected - Person Birth Date is blank AND Health Visitor First Antenatal Visit Date is before 1 January 1901. Local Patient Identifier (Extended)=<C001901> Health Visitor First Antenatal Visit Date=<C001120>		Superseded by CYP00185	17/02/2017	1.0.4	N/A
33	C001130	CYP001 MPI	LOOKED AFTER CHILD INDICATOR	Validation	Addition		If Person was 19 years of age or over at the start of the reporting period and Looked After Child Indicator is populated, the record will be rejected. CYP00186 - Record rejected - Person was 19 years of age or over at the start of the reporting period, but Looked After Child Indicator is populated. Local Patient Identifier (Extended)=<C001901> Looked After Child Indicator =<C001130> Person Birth Date =<C001060> Reporting Period Start Date = <C000040>	To prevent this data item flowing for adults.	17/02/2017	1.0.4	N/A
34	C001130	CYP001 MPI	LOOKED AFTER CHILD INDICATOR	Validation	Addition		If Person Birth Date is blank and Looked After Child Indicator is populated, the record will be rejected. CYP00187 - Record rejected - Person Birth Date is blank and Looked After Child Indicator is populated. Local Patient Identifier (Extended)=<C001901> Looked After Child Indicator =<C001130>	To prevent this data item flowing for adults (or individuals whose age cannot be determined).	17/02/2017	1.0.4	N/A
35	C001140	CYP001 MPI	SAFEGUARDING VULNERABILITY FACTORS INDICATOR	Validation	Addition		If Person was 19 years of age or over at the start of the reporting period and Safeguarding Vulnerability Factors Indicator is populated, the record will be rejected. CYP00188 - Record rejected - Person was 19 years of age or over at the start of the reporting period, but Safeguarding Vulnerability Factors Indicator is populated. Local Patient Identifier (Extended)=<C001901> Safeguarding Vulnerability Factors Indicator=<C001140> Person Birth Date =<C001060> Reporting Period Start Date = <C000040>	To prevent this data item flowing for adults.	20/02/2017	1.0.4	N/A
36	C001140	CYP001 MPI	SAFEGUARDING VULNERABILITY FACTORS INDICATOR	Validation	Addition		If Person Birth Date is blank and Safeguarding Vulnerability Factors Indicator is populated, the record will be rejected. CYP00189 - Record rejected - Person Birth Date is blank and Safeguarding Vulnerability Factors Indicator is populated. Local Patient Identifier (Extended)=<C001901> Safeguarding Vulnerability Factors Indicator=<C001140>	To prevent this data item flowing for adults (or individuals whose age cannot be determined).	20/02/2017	1.0.4	N/A
37	C001170	CYP001 MPI	PREFERRED DEATH LOCATION DISCUSSED INDICATOR	Validation	Addition		If Person was 19 years of age or over at the start of the reporting period and Preferred Death Location Discussed Indicator is populated, the record will be rejected. CYP00192 - Record rejected - Person was 19 years of age or over at the start of the reporting period, but Preferred Death Location Discussed Indicator is populated. Local Patient Identifier (Extended)=<C001901> Preferred Death Location Discussed Indicator=<C001170> Person Birth Date =<C001060> Reporting Period Start Date = <C000040>	To prevent this data item flowing for adults.	20/02/2017	1.0.4	N/A
38	C001170	CYP001 MPI	PREFERRED DEATH LOCATION DISCUSSED INDICATOR	Validation	Addition		If Person Birth Date is blank and Preferred Death Location Discussed Indicator is populated, the record will be rejected. CYP00193 - Record rejected - Person Birth Date is blank and Preferred Death Location Discussed Indicator is populated. Local Patient Identifier (Extended)=<C001901> Preferred Death Location Discussed Indicator=<C001170>	To prevent this data item flowing for adults (or individuals whose age cannot be determined).	20/02/2017	1.0.4	N/A
39	C001180	CYP001 MPI	PERSON AT RISK OF UNEXPECTED DEATH INDICATOR	Validation	Addition		If Person was 19 years of age or over at the start of the reporting period and Person At Risk Of Unexpected Death Indicator is populated, the record will be rejected. CYP00194 - Record rejected - Person was 19 years of age or over at the start of the reporting period, but Person At Risk Of Unexpected Death Indicator is populated. Local Patient Identifier (Extended)=<C001901> Person At Risk Of Unexpected Death Indicator=<C001180> Person Birth Date =<C001060> Reporting Period Start Date = <C000040>	To prevent this data item flowing for adults.	20/02/2017	1.0.4	N/A
40	C001180	CYP001 MPI	PERSON AT RISK OF UNEXPECTED DEATH INDICATOR	Validation	Addition		If Person Birth Date is blank and Person At Risk Of Unexpected Death Indicator is populated, the record will be rejected. CYP00195 - Record rejected - Person Birth Date is blank and Person At Risk Of Unexpected Death Indicator is populated. Local Patient Identifier (Extended)=<C001901> Person At Risk Of Unexpected Death Indicator=<C001180>	To prevent this data item flowing for adults (or individuals whose age cannot be determined).	20/02/2017	1.0.4	N/A

41	N/A	CYP401 Special Educational Need Identified	N/A	Validation	Addition		This group will be rejected if patient identified by this Local Patient Identifier (Extended) in the CYP001 table is 19 years or older at the start of the reporting period. CYP40109 - Group rejected - The patient identified by this Local Patient Identifier (Extended) in the CYP001 table is 19 years or older at the start of the reporting period. Local Patient Identifier (Extended) = <C401901> Person Birth Date =<C001060> Reporting Period Start Date = <C000040>	To prevent this table flowing for adults.	22/02/2017	1.0.4	N/A
42	N/A	CYP401 Special Educational Need Identified	N/A	Validation	Addition		This group will be rejected if the CYP001 group transmitted for this Local Patient Identifier (Extended) has a blank Person Birth Date. CYP40110 - Group rejected - The CYP001 group transmitted for this Local Patient Identifier (Extended) has a blank Person Birth Date. Local Patient Identifier (Extended) = <C401901>	To prevent this table flowing for adults (or individuals whose age cannot be determined).	22/02/2017	1.0.4	N/A
43	N/A	CYP402 Safeguarding Vulnerability Factor	N/A	Validation	Addition		This group will be rejected if the patient identified by this Local Patient Identifier (Extended) in the CYP001 table is 19 years or older at the start of the reporting period. CYP40209 - Group rejected - The patient identified by this Local Patient Identifier (Extended) in the CYP001 table is 19 years or older at the start of the reporting period. Local Patient Identifier (Extended) = <C402901> Person Birth Date =<C001060> Reporting Period Start Date = <C000040>	To prevent this table flowing for adults.	22/02/2017	1.0.4	N/A
44	N/A	CYP402 Safeguarding Vulnerability Factor	N/A	Validation	Addition		This group will be rejected if the CYP001 group transmitted for this Local Patient Identifier (Extended) has a blank Person Birth Date. CYP40210 - Group rejected - The CYP001 group transmitted for this Local Patient Identifier (Extended) has a blank Person Birth Date. Local Patient Identifier (Extended) = <C402901>	To prevent this table flowing for adults (or individuals whose age cannot be determined).	22/02/2017	1.0.4	N/A
45	N/A	CYP403 Child Protection Plan	N/A	Validation	Addition		This group will be rejected if the patient identified by this Local Patient Identifier (Extended) in the CYP001 table is 19 years or older at the start of the reporting period. CYP40318 - Group rejected - The patient identified by this Local Patient Identifier (Extended) in the CYP001 table is 19 years or older at the start of the reporting period. Local Patient Identifier (Extended) = <C403901> Person Birth Date =<C001060> Reporting Period Start Date = <C000040>	To prevent this table flowing for adults.	22/02/2017	1.0.4	N/A
46	N/A	CYP403 Child Protection Plan	N/A	Validation	Addition		This group will be rejected if the CYP001 group transmitted for this Local Patient Identifier (Extended) has a blank Person Birth Date. CYP40319 - Group rejected - The CYP001 group transmitted for this Local Patient Identifier (Extended) has a blank Person Birth Date. Local Patient Identifier (Extended) = <C403901>	To prevent this table flowing for adults (or individuals whose age cannot be determined).	22/02/2017	1.0.4	N/A
47	N/A	CYP502 Immunisation	N/A	Validation	Addition		This group will be rejected if the patient identified by this Local Patient Identifier (Extended) in the CYP001 table is 19 years or older at the start of the reporting period. CYP50215 - Group rejected - The patient identified by this Local Patient Identifier (Extended) in the CYP001 table is 19 years or older at the start of the reporting period. Local Patient Identifier (Extended) = <C502901> Person Birth Date =<C001060> Reporting Period Start Date = <C000040>	To prevent this table flowing for adults.	22/02/2017	1.0.4	N/A
48	N/A	CYP502 Immunisation	N/A	Validation	Addition		This group will be rejected if the CYP001 group transmitted for this Local Patient Identifier (Extended) has a blank Person Birth Date. CYP50216 - Group rejected - The CYP001 group transmitted for this Local Patient Identifier (Extended) has a blank Person Birth Date. Local Patient Identifier (Extended) = <C502901>	To prevent this table flowing for adults (or individuals whose age cannot be determined).	22/02/2017	1.0.4	N/A
49	C001230	CYP001 MPI	NHS NUMBER (MOTHER)	Validation Rules	Amendment	Recvd Data Item Blank - Warning	Recvd Data Item Blank - N/A	The data item is not expected to flow for adults	22/02/2017	1.0.4	N/A
50	C001240	CYP001 MPI	NHS NUMBER STATUS INDICATOR CODE (MOTHER)	Validation	Remove	This field should be mandatory where the NHS Number (Mother) provided is blank to ensure proper linkage. CYP00174 - Warning - NHS Number Status Indicator Code (Mother) should be mandatory where the NHS Number (Mother) provided is blank. Local Patient Identifier =<C001901>		The data item is not expected to flow for adults	22/02/2017	1.0.4	N/A
51	C001240	CYP001 MPI	NHS NUMBER STATUS INDICATOR CODE (MOTHER)	Data Item Description	Amendment	The NHS NUMBER STATUS INDICATOR of the mother	NHS NUMBER STATUS INDICATOR CODE (MOTHER) is the trace status of the NHS NUMBER (MOTHER).	To align with description in NHS Data Model and Dictionary	22/02/2017	1.0.4	N/A
52	C001230	CYP001 MPI	NHS NUMBER (MOTHER)	Validation	Remove	CYP00168 - Warning- NHS Number (Mother) is blank. Local Patient Identifier (Extended)=<C001901>		The data item is not expected to flow for adults	22/02/2017	1.0.4	N/A
53	C001230	CYP001 MPI	NHS NUMBER (MOTHER)	Validation	Addition		If Person was 19 years of age or over at the start of the reporting period and NHS Number (Mother) is populated, the record will be rejected. CYP00196 - Record rejected - Person was 19 years of age or over at the start of the reporting period, but NHS Number (Mother) is populated. Local Patient Identifier (Extended)=<C001901> NHS Number (Mother)=<C001230> Person Birth Date =<C001060> Reporting Period Start Date = <C000040>	The data item is not expected to flow for adults	22/02/2017	1.0.4	N/A

54	C001230	CYP001 MPI	NHS NUMBER (MOTHER)	Validation	Addition		If Person Birth Date is blank and NHS Number (Mother) is populated, the record will be rejected. CYP00197 - Record rejected - Person Birth Date is blank and NHS Number (Mother) is populated. Local Patient Identifier (Extended)=<C001901> NHS Number (Mother)=<C001230>	The data item is not expected to flow for adults	22/02/2017	1.0.4	N/A
55	N/A	CYP603 Newborn Hearing Screening Audiology Referral	N/A	Validation	Addition		This group will be rejected if the patient identified by this Local Patient Identifier (Extended) in the CYP001 table is 1 year or older at the start of the reporting period. CYP60321 - Group rejected - The patient identified by this Local Patient Identifier (Extended) in the CYP001 table is 1 year or older at the start of the reporting period. Local Patient Identifier (Extended) = <C603901> Person Birth Date =<C001060> Reporting Period Start Date = <C000040>	To prevent this table flowing for anyone other than newborns.	22/02/2017	1.0.4	N/A
56	N/A	CYP603 Newborn Hearing Screening Audiology Referral	N/A	Validation	Addition		This group will be rejected if the CYP001 group transmitted for this Local Patient Identifier (Extended) has a blank Person Birth Date. CYP60322 - Group rejected - The CYP001 group transmitted for this Local Patient Identifier (Extended) has a blank Person Birth Date. Local Patient Identifier (Extended) = <C603901>	To prevent this table flowing for anyone other than newborns (or individuals whose age cannot be determined).	22/02/2017	1.0.4	N/A
57	N/A	CYP604 Blood Spot Result	N/A	Validation	Addition		This group will be rejected if the patient identified by this Local Patient Identifier (Extended) in the CYP001 table is 1 year or older at the start of the reporting period. CYP60442 - Group rejected - The patient identified by this Local Patient Identifier (Extended) in the CYP001 table is 1 year or older at the start of the reporting period. Local Patient Identifier (Extended) = <C604901> Person Birth Date =<C001060> Reporting Period Start Date = <C000040>	To prevent this table flowing for anyone other than newborns.	22/02/2017	1.0.4	N/A
58	N/A	CYP604 Blood Spot Result	N/A	Validation	Addition		This group will be rejected if the CYP001 group transmitted for this Local Patient Identifier (Extended) has a blank Person Birth Date. CYP60443 - Group rejected - The CYP001 group transmitted for this Local Patient Identifier (Extended) has a blank Person Birth Date. Local Patient Identifier (Extended) = <C604901>	To prevent this table flowing for anyone other than newborns (or individuals whose age cannot be determined).	22/02/2017	1.0.4	N/A
59	N/A	CYP605 Infant Physical Examination (GP Delivered)	N/A	Validation	Addition		This group will be rejected if the CYP001 group transmitted for this Local Patient Identifier (Extended) has a blank Person Birth Date. CYP60524 - Group rejected - The CYP001 group transmitted for this Local Patient Identifier (Extended) has a blank Person Birth Date. Local Patient Identifier (Extended) = <C605901>	To prevent this table flowing for anyone other than newborns (or individuals whose age cannot be determined).	22/02/2017	1.0.4	N/A
60	N/A	CYP610 Breastfeeding Status	N/A	Validation	Addition		This group will be rejected if the patient identified by this Local Patient Identifier (Extended) in the CYP001 table is 19 years or older at the start of the reporting period. CYP61012 - Group rejected - The patient identified by this Local Patient Identifier (Extended) in the CYP001 table is 19 years or older at the start of the reporting period. Local Patient Identifier (Extended) = <C610901> Person Birth Date =<C001060> Reporting Period Start Date = <C000040>	To prevent this table flowing for adults.	22/02/2017	1.0.4	N/A
61	N/A	CYP610 Breastfeeding Status	N/A	Validation	Addition		This group will be rejected if the CYP001 group transmitted for this Local Patient Identifier (Extended) has a blank Person Birth Date. CYP61013 - Group rejected - The CYP001 group transmitted for this Local Patient Identifier (Extended) has a blank Person Birth Date. Local Patient Identifier (Extended) = <C610901>	To prevent this table flowing for adults (or individuals whose age cannot be determined).	22/02/2017	1.0.4	N/A
62	C001050	CYP001 MPI	NHS NUMBER STATUS INDICATOR CODE	Data Item Description	Amendment	The NHS NUMBER STATUS INDICATOR of the PATIENT	NHS NUMBER STATUS INDICATOR CODE is the trace status of the NHS NUMBER.	To align with description in NHS Data Model and Dictionary	28/02/2017	1.0.4	N/A
63	C001240	CYP001 MPI	NHS NUMBER STATUS INDICATOR CODE (MOTHER)	Validation	Addition		The NHS Number Status Indicator Code (Mother) should be mandatory where the NHS Number (Mother) provided is blank and Person was under 19 years of age at the start of the reporting period. CYP00198 - Warning - NHS Number Status Indicator Code (Mother) should be mandatory where the NHS Number (Mother) provided is blank and Person was under 19 years of age at the start of the reporting period. Local Patient Identifier =<C001901> Person Birth Date =<C001060> Reporting Period Start Date = <C000040>	Updated version of CYP00174 (now retired) to only trigger for children.	28/02/2017	1.0.4	N/A
64	C001D18	CYP001 MPI	LOWER SUPER OUTPUT AREA (RESIDENCE)	Derivation	Amendment	The Lower Layer Super Output Area (Residence) for the patient, derived from the submitted POSTCODE OF USUAL ADDRESS. Where a Null postcode is submitted, Lower Layer Super Output Area (Residence) will appear as Null. Note to providers: the derivation is established through linkage with the Complete Gridlink NHS Postcode File, downloaded from http://systems.digital.nhs.uk/data/ods/datadownloads/onsdata. The derivation lookup is taken from field name LSOA01 (field 26). The Complete Gridlink NHS Postcode File in use is updated at the beginning of each month.	The Lower Layer Super Output Area (Residence) for the patient, derived from the submitted POSTCODE OF USUAL ADDRESS. Where a Null postcode is submitted, Lower Layer Super Output Area (Residence) will appear as Null. Note to providers: the derivation is established through linkage with the Complete Gridlink NHS Postcode File, downloaded from http://systems.digital.nhs.uk/data/ods/datadownloads/onsdata. The derivation lookup is taken from field name LSOA11 (field 40). The Complete Gridlink NHS Postcode File in use is updated at the beginning of each month.	So that the derivation is using the 2011 census information	28/02/2017	1.0.4	N/A

Community Services I

Technical Output Spe

Explanation of Data Set Colur

	Column/Heading
SCCI	Group Name
SCCI	Group-level notes for Data Providers
SCCI	XML Schema Element Name
SCCI	Data Item Name (Data Dict Element)
SCCI	Data Item Description
SCCI	Format
SCCI	National Code
SCCI	National Code Definition
SCCI	Information Requirements (Purpose)
SCCI	Mandatory/ Required/ Optional

ɔata Set (CSDS) v1.0

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Description
The group name is highlighted in the yellow box at the top. This name (or a truncated version of it) will be used to name the corresponding element structure in the XML Schema
Provides further notes for data providers highlighting important things that will be of interest.
The exact data item name that has been used to describe the field in the XML Schema
The data item name as described in the data dictionary
A full description of the data item
Describes the valid formats that will be accepted in this field. For dates and times it specifically refers to the exact formatting. For other fields it describes the data type required and the max/min field lengths. NB. These formats are described within the XML Schema.
Provides a list of the valid codes that can be accepted in this field (if there are any). For example, a field may only allow values of "Y", "N" and "X", which equate to "Yes", "No", "Don't Know".
Describes the meaning of the code in the previous "National Code" column
Description of the reason the data item was included within the data set. Maps to specific reporting requirement entries.
Shows levels of mandation for the data item as described to ISB. **Mandatory**: These data items MUST be reported. Failure to submit these items will result in the rejection of the submission. **Required**: These data items SHOULD be reported where they apply. Failure to submit these items will not result in the rejection of the submission but may affect the derivation of national indicators or national analysis. (Please note that the purpose of the data set is not to change clinical practice.) **Optional**: These data items MAY be submitted on an optional basis at the submitters discretion. **Derived**: These items are derived during pre and/or post deadline processing for inclusion in the extracts made available for download. Please note: these are not for submission to the BSP Please note that these rules are applied at group level i.e. they only apply where a group is present.

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Explanation of Data Set Columns

The data items listed below marked as linkage items

Data Item Name	Data Item Description	Format	Mandatory/ Required/ Optional
LOCAL PATIENT IDENTIFIER (EXTENDED)	This is 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	max an20	M
SERVICE REQUEST IDENTIFIER	The unique identifier for a SERVICE REQUEST. It would normally be automatically generated by the local system upon recording a new Referral, although could be manually assigned.	max an20	M
COMMUNITY CARE CONTACT IDENTIFIER	The COMMUNITY CARE CONTACT IDENTIFIER is used to uniquely identify the CARE CONTACT within the Health Care Provider. It would normally be automatically generated by the local system upon recording a new Care Contact, although could be manually assigned.	max an20	M
CARE ACTIVITY IDENTIFIER	The unique identifier for a CARE ACTIVITY. It would normally be automatically generated by the local system upon recording a new activity, although could be manually assigned.	max an20	M
CARE PROFESSIONAL LOCAL IDENTIFIER	CARE PROFESSIONAL LOCAL IDENTIFIER is a unique local CARE PROFESSIONAL IDENTIFIER within a Health Care Provider and may be assigned automatically by the computer system.	max an20	M
CARE PROFESSIONAL TEAM LOCAL IDENTIFIER	CARE PROFESSIONAL TEAM LOCAL IDENTIFIER is a unique local CARE PROFESSIONAL TEAM IDENTIFIER within a Health Care Provider and may be assigned automatically by the computer system.	max an20	M

Note: Above data items will allow data linkage for all the following sections:

LOCAL PATIENT IDENTIFIER

CYP001 Master Patient Index and Risk Indicators
CYP002 GP Practice Registration
CYP003 Accommodation Type
CYP101 Service or Team Referral
CYP401 Special Educational Need Identified
CYP402 Safeguarding Vulnerability Factor
CYP403 Child Protection Plan
CYP404 Assistive Technology to Support Disability Type
CYP501 Coded Immunisation

CYP502 Immunisation
CYP601 Medical History (Previous Diagnosis)
CYP602 Disability Type
CYP603 Newborn Hearing Screening Audiology Referral
CYP604 Blood Spot Result
CYP605 Infant Physical Examination (GP Delivered)

SERVICE REQUEST IDENTIFIER
CYP101 Service or Team Referral
CYP102 Service or Team Type Referred To
CYP103 Other Reason for Referral
CYP104 Referral to Treatment
CYP105 Onward Referral
CYP201 Care Contact
CYP606 Provisional Diagnosis
CYP607 Primary Diagnosis
CYP608 Secondary Diagnosis
CYP609 Coded Scored Assessment (Referral)

CARE CONTACT IDENTIFIER
CYP201 Care Contact
CYP202 Care Activity

CARE ACTIVITY IDENTIFIER
CYP202 Care Activity
CYP610 Breastfeeding Status
CYP611 Observation
CYP612 Coded Scored Assessment (Contact)

CARE PROFESSIONAL LOCAL IDENTIFIER
CYP202 Care Activity
CYP301 Group Session
CYP901 Staff Details

CARE PROFESSIONAL TEAM LOCAL IDENTIFIER
CYP102 Service or Team Type Referred To
CYP201 Care Contact

NO LINKAGE
CYP000 Header
CYP613 Anonymous Self-Assessment

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Technical Output Specification

FORMATTING

Data Dictionary	Technical Output Specification	Microsoft Access	XSD	SQL	Description	Notes
	string	Memo	string	varchar(max)	A string of ASCII characters	
	string	Text	string; max length 255	varchar(255)	A string of ASCII characters upto 255 characters	
	string			varchar(1)	A string of ASCII characters of length 1	
	string	Memo		nvarchar(max)	A string of Unicode characters	Microsoft Access allows formatting
	date	Short date	date	date	A date	
		General date	datetime	datetime		
	integer	Long integer	int	int	A number from -2,147,483,648 to 2,147,483,647	
			long	bigint	A number from -2^63 to 2^63-1	
		Integer	integer	smallint	A number from -32,768 to 32,767	
		Byte	byte	tinyint	A number from 0 to 255	
		Short time	time	n/a	hh:mm	
		Long time	time	time(0)	hh:mm:ss	
an2	an2		string; length 2	char(2)	A string of ASCII characters (any combination of numbers and/or letters) of length exactly 2	Usually treated as varchar(2) in SQL. Any character can flow including special characters.
max an2	max an2		string; max length 2	varchar(2)	A string of ASCII characters (any combination of numbers and/or letters) of length 1 to 2	Any character can flow including special characters.
an3 or an5	an3 or an5		string; length 3 or 5	char(3)/char(5)	A string of ASCII characters (any combination of numbers and/or letters) of length exactly 3 or 5	Any character can flow including special characters.
min an5 max an18	min an5 max an18		string; min length 5 max length 18	varchar(5-18)	A string of ASCII characters (any combination of numbers and/or letters) of length between 5 and 18	Any character can flow including special characters.
n2.n2	n2.n2	Single		float		
n2.n2	n2.n2	Double		float		
n2.n2	n2.n2	Decimal	decimal	decimal		
			negativeInteger			
		Integer; (with criteria)	nonNegativeInteger		An integer containing only non-negative values (0,1,2,..)	
			nonPositiveInteger		An integer containing only non-positive values (..,-2,-1,0)	
			positiveInteger		An integer containing only positive values (1,2,..)	
			short		A signed 16-bit integer	
			unsignedLong		An unsigned 64-bit integer	
			unsignedInt		An unsigned 32-bit integer	
			unsignedShort		An unsigned 16-bit integer	
			unsignedByte			
			duration			
			gDay		Defines a part of a date - the day (DD)	
			gMonth		Defines a part of a date - the month (MM)	
			gMonthDay		Defines a part of a date - the month and day (MM-DD)	
			gYear		Defines a part of a date - the year (YYYY)	
			gYearMonth		Defines a part of a date - the year and month (YYYY-MM)	
			token		A string that does not contain line feeds, carriage returns, tabs, leading or trailing spaces, or multiple spaces	
			normalizedString		A string that does not contain line feeds, carriage returns, or tabs	
			float			
			double			

EXCEPTIONS

Null values					Null	Null values must be allowed to flow provided validation rules for the individual item have been applied. Otherwise, records should not flow.
Invalid dates					A date that is invalid/incorrect as there is no such date in the calendar, e.g. 47/15/2015	These records will be rejected and an error message returned.
Dates/times when clocks change to BST					The date/time should be submitted as it is recorded in local systems.	
Postcode	max an8				The data item must be submitted with exactly eight characters. The fifth character is always a space and separates the outward and inward parts of the Postcode. In addition, where there are less than four numbers and/or letters in the outward part, this must be space filled to ensure eight characters in total.	Further detail can be found here: http://www.datadictionary.nhs.uk/web_site_content/supporting_information/nhs_postcode_directory.asp?shownav=1
"Live" Organisation					A "Live" organisation is an organisation that is active on the first day of the reporting period	
"Open" Organisation					An "Open" organisation is one deemed as being active during the reporting period	

CARDINALITY/OVERARCHING VALIDATION

Mandated data items	M				Rejected if blank, Rejected if format error, Warning if national code error (where national codes are present or a look-up table exists)	The rejections relate to all the data for that patient's record within the specific table.
Required data items	R				N/A if blank, Rejected if format error, Warning if national code error (where national codes are present or a look-up table exists)	The rejections relate to all the data for that patient's record within the specific table. Certain key required data items used for CSDS Person Index Logic (e.g. NHS Number) output a warning if blank.
Optional data items	O				N/A if blank, Rejected if format error, Warning if national code error (where national codes are present or a look-up table exists)	The rejections relate to all the data for that patient's record within the specific table.

Community Services Data Set (

Technical Output Specification

CSDS Assessment Tool Reference Table

This reference table contains a list of outcome measures (individual, total and
tables:
CYP609 Coded Scored Assessment (Referral)
CYP612 Coded Scored Assessment (Contact)

The table presents the equivalent SNOMED CT Concept ID and national cod
CT Concept ID that is not in this list will be rejected at the BSP.

Coded Assessment Tool Type (SNOMED CT)
Preferred Term (SNOMED-CT)
ASQ-3 (Ages and Stages Questionnaires Third Edition) 2 month questionnaire - communication score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 2 month questionnaire - fine motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 2 month questionnaire - gross motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 2 month questionnaire - personal-social score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 2 month questionnaire - problem solving score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 4 month questionnaire - communication score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 4 month questionnaire - fine motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 4 month questionnaire - gross motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 4 month questionnaire - personal-social score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 4 month questionnaire - problem solving score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 6 month questionnaire - communication score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 6 month questionnaire - fine motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 6 month questionnaire - gross motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 6 month questionnaire - personal-social score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 6 month questionnaire - problem solving score

ASQ-3 (Ages and Stages Questionnaires Third Edition) 8 month questionnaire - communication score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 8 month questionnaire - fine motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 8 month questionnaire - gross motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 8 month questionnaire - personal-social score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 8 month questionnaire - problem solving score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 9 month questionnaire - communication score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 9 month questionnaire - fine motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 9 month questionnaire - gross motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 9 month questionnaire - personal-social score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 9 month questionnaire - problem solving score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 10 month questionnaire - communication score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 10 month questionnaire - fine motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 10 month questionnaire - gross motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 10 month questionnaire - personal-social score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 10 month questionnaire - problem solving score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 12 month questionnaire - communication score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 12 month questionnaire - fine motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 12 month questionnaire - gross motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 12 month questionnaire - personal-social score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 12 month questionnaire - problem solving score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 14 month questionnaire - communication score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 14 month questionnaire - fine motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 14 month questionnaire - gross motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 14 month questionnaire - personal-social score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 14 month questionnaire - problem solving score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 16 month questionnaire - communication score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 16 month questionnaire - fine motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 16 month questionnaire - gross motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 16 month questionnaire - personal-social score

ASQ-3 (Ages and Stages Questionnaires Third Edition) 16 month questionnaire - problem solving score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 18 month questionnaire - communication score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 18 month questionnaire - fine motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 18 month questionnaire - gross motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 18 month questionnaire - personal-social score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 18 month questionnaire - problem solving score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 20 month questionnaire - communication score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 20 month questionnaire - fine motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 20 month questionnaire - gross motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 20 month questionnaire - personal-social score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 20 month questionnaire - problem solving score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 22 month questionnaire - communication score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 22 month questionnaire - fine motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 22 month questionnaire - gross motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 22 month questionnaire - personal-social score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 22 month questionnaire - problem solving score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 24 month questionnaire - communication score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 24 month questionnaire - fine motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 24 month questionnaire - gross motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 24 month questionnaire - personal-social score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 24 month questionnaire - problem solving score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 27 month questionnaire - communication score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 27 month questionnaire - fine motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 27 month questionnaire - gross motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 27 month questionnaire - personal-social score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 27 month questionnaire - problem solving score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 30 month questionnaire - communication score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 30 month questionnaire - fine motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 30 month questionnaire - gross motor score

ASQ-3 (Ages and Stages Questionnaires Third Edition) 30 month questionnaire - personal-social score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 30 month questionnaire - problem solving score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 33 month questionnaire - communication score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 33 month questionnaire - fine motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 33 month questionnaire - gross motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 33 month questionnaire - personal-social score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 33 month questionnaire - problem solving score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 36 month questionnaire - communication score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 36 month questionnaire - fine motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 36 month questionnaire - gross motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 36 month questionnaire - personal-social score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 36 month questionnaire - problem solving score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 42 month questionnaire - communication score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 42 month questionnaire - fine motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 42 month questionnaire - gross motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 42 month questionnaire - personal-social score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 42 month questionnaire - problem solving score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 48 month questionnaire - communication score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 48 month questionnaire - fine motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 48 month questionnaire - gross motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 48 month questionnaire - personal-social score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 48 month questionnaire - problem solving score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 54 month questionnaire - communication score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 54 month questionnaire - fine motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 54 month questionnaire - gross motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 54 month questionnaire - personal-social score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 54 month questionnaire - problem solving score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 60 month questionnaire - communication score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 60 month questionnaire - fine motor score

ASQ-3 (Ages and Stages Questionnaires Third Edition) 60 month questionnaire - gross motor score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 60 month questionnaire - personal-social score
ASQ-3 (Ages and Stages Questionnaires Third Edition) 60 month questionnaire - problem solving score
Ages and Stages Questionnaires:Social-Emotional second edition 2 month questionnaire score
Ages and Stages Questionnaires:Social-Emotional second edition 6 month questionnaire score
Ages and Stages Questionnaires:Social-Emotional second edition 12 month questionnaire score
Ages and Stages Questionnaires:Social-Emotional second edition 18 month questionnaire score
Ages and Stages Questionnaires:Social-Emotional second edition 24 month questionnaire score
Ages and Stages Questionnaires:Social-Emotional second edition 30 month questionnaire score
Ages and Stages Questionnaires:Social-Emotional second edition 36 month questionnaire score
Ages and Stages Questionnaires:Social-Emotional second edition 48 month questionnaire score
Ages and Stages Questionnaires:Social-Emotional second edition 60 month questionnaire score

(CSDS) v1.0

d/or scale scores) that can be submitted as Coded /

les for each measure. Only those measures that ap

	Person Score	
Concept ID (SNOMED CT)	Value	Value Description
952611000000105	0 - 60	
952621000000104	0 - 60	
952631000000102	0 - 60	
952651000000109	0 - 60	
952641000000106	0 - 60	
952661000000107	0 - 60	
952671000000100	0 - 60	
952681000000103	0 - 60	
952701000000101	0 - 60	
952691000000101	0 - 60	
952711000000104	0 - 60	
952721000000105	0 - 60	
952731000000107	0 - 60	
952751000000100	0 - 60	
952741000000103	0 - 60	

952761000000102	0 - 60	
952771000000109	0 - 60	
952781000000106	0 - 60	
952801000000107	0 - 60	
952791000000108	0 - 60	
952811000000109	0 - 60	
952821000000103	0 - 60	
952831000000101	0 - 60	
952851000000108	0 - 60	
952841000000105	0 - 60	
952861000000106	0 - 60	
952871000000104	0 - 60	
952881000000102	0 - 60	
952901000000104	0 - 60	
952891000000100	0 - 60	
952911000000102	0 - 60	
952921000000108	0 - 60	
952931000000105	0 - 60	
952951000000103	0 - 60	
952941000000101	0 - 60	
952961000000100	0 - 60	
952971000000107	0 - 60	
952981000000109	0 - 60	
953001000000105	0 - 60	
952991000000106	0 - 60	
953011000000107	0 - 60	
953021000000101	0 - 60	
953031000000104	0 - 60	
953051000000106	0 - 60	

953041000000108	0 - 60	
953061000000109	0 - 60	
953071000000102	0 - 60	
953081000000100	0 - 60	
953101000000106	0 - 60	
953091000000103	0 - 60	
953111000000108	0 - 60	
953121000000102	0 - 60	
953131000000100	0 - 60	
953151000000107	0 - 60	
953141000000109	0 - 60	
953161000000105	0 - 60	
953171000000103	0 - 60	
953181000000101	0 - 60	
953201000000102	0 - 60	
953191000000104	0 - 60	
953211000000100	0 - 60	
953221000000106	0 - 60	
953231000000108	0 - 60	
953251000000101	0 - 60	
953241000000104	0 - 60	
953261000000103	0 - 60	
953271000000105	0 - 60	
953281000000107	0 - 60	
953301000000108	0 - 60	
953291000000109	0 - 60	
953311000000105	0 - 60	
953321000000104	0 - 60	
953331000000102	0 - 60	

953351000000109	0 - 60	
953341000000106	0 - 60	
953361000000107	0 - 60	
953371000000100	0 - 60	
953381000000103	0 - 60	
953401000000103	0 - 60	
953391000000101	0 - 60	
953411000000101	0 - 60	
953421000000107	0 - 60	
953431000000109	0 - 60	
953451000000102	0 - 60	
953441000000100	0 - 60	
953461000000104	0 - 60	
953471000000106	0 - 60	
953481000000108	0 - 60	
953501000000104	0 - 60	
953491000000105	0 - 60	
953511000000102	0 - 60	
953521000000108	0 - 60	
953531000000105	0 - 60	
953551000000103	0 - 60	
953541000000101	0 - 60	
953561000000100	0 - 60	
953571000000107	0 - 60	
953581000000109	0 - 60	
953601000000100	0 - 60	
953591000000106	0 - 60	
953611000000103	0 - 60	
953621000000109	0 - 60	

953631000000106	0 - 60	
953651000000104	0 - 60	
953641000000102	0 - 60	
1053941000000101	0 - 465	
1053951000000103	0 - 465	
1053971000000107	0 - 465	
1053991000000106	0 - 465	
1054011000000104	0 - 465	
1054021000000105	0 - 465	
1054031000000107	0 - 465	
1054041000000103	0 - 465	
1054051000000100	0 - 465	

Assessment Tool Type (SNOMED CT) within the following CSDS

pear in this list can be submitted within the CSDS. Any SNOMED

Comments
The person score is the 'total score'. There are 6 questions for each dimension, with a possible total score of 60 for each dimension.

The score is a total score for the ASQ:SE assessment, which is not split by 'dimensions'. There are 31 questions, with a possible score of 0 - 15 for each question, giving a possible total score of 465 for each questionnaire.

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Start of Repeating Group - CYP000 CSDS Header								
CYP000 CSDS Header						Group-level notes for Data Providers:		
XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C000010	DATA SET VERSION NUMBER	The version of the CSDS that this submission file is for.	max n2.max n2			Purpose	Generic for all information requirements	M
C000020	ORGANISATION CODE (CODE OF PROVIDER)	This is the ORGANISATION CODE of the ORGANISATION acting as a Health Care Provider. This is the organisation code that will be concatenated with any Local Patient Identifiers to form a unique "Local Patient Identifier" within the national database	an3, an5 or an6			Purpose	Generic for all information requirements	M
C000030	ORGANISATION CODE (CODE OF SUBMITTING ORGANISATION)	This is the ORGANISATION CODE of the ORGANISATION of the ORGANISATION acting as the physical sender of a Data Set submission. This code provides an audit trail where a different organisation is undertaking the submission on behalf of the provider organisation. It will not be carried over into the national database.	max an6			Purpose	Generic for all information requirements	M
C000040	REPORTING PERIOD START DATE	The reporting period start date to which this file refers	an10 CCYY-MM-DD			Purpose		M
C000050	REPORTING PERIOD END DATE	The reporting period end date to which this file refers	an10 CCYY-MM-DD			Purpose		M

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Start of Repeating Group - CYP000 CSDS Header

CYP000 CSDS Header

Group-level notes for Data Providers:

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C000060	**DATE AND TIME DATA SET CREATED**	Date/time this upload file was created	an19 YYYY-MM-DDThh:mm:ss			Purpose		M

Start of Repeating Group - CYP001 Master Patient Index and Risk Indicators

CYP001 Master Patient Index and Risk Indicators

Group-level notes for Data Providers:

Master Patient Index and Risk Indicators: To carry the personal details of the person and the associated mother's NHS number (where applicable).

This group may be used to identify the person for record linkage

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Data providers should note that CYP001 and CYP002 are mandatory groups that must be included whenever any other groups are transmitted that refer to this person.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C001901	**LOCAL PATIENT IDENTIFIER (EXTENDED)**	This is 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.	max an20			All to identify individual	Used to uniquely identify an individual	M
C001010	**ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)**	The organisation code of the organisation that assigned the local patient identifier.	an3 or an5			All to identify individual	Used to uniquely identify the organisation issuing the LPI	M
C001020	**ORGANISATION CODE (RESIDENCE RESPONSIBILITY)**	The organisation code derived from the patient's POSTCODE OF USUAL ADDRESS This field can routinely be left blank, however if populated it should contain the organisation code of the commissioner with which the patient is resident.	an3			All to identify individual	Used to identify the organisation of responsibility or residence. To enable the provider to identify the commissioner derived from the patient's postcode.	R
C001030	**ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)**	The ORGANISATION CODE of the Educational Establishment, including Schools	min an5 max an8			All to identify individual	Used to identify the educational establishment of a child or young person.	R

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Start of Repeating Group - CYP001 Master Patient Index and Risk Indicators

CYP001 Master Patient Index and Risk Indicators

Group-level notes for Data Providers:

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XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C001040	**NHS NUMBER**	A number used to identify a PATIENT uniquely within the NHS in England and Wales	n10			All to identify individual	Used to uniquely identify an individual	R
C001050	**NHS NUMBER STATUS INDICATOR CODE**	NHS NUMBER STATUS INDICATOR CODE is the trace status of the NHS NUMBER.	an2	01	Number present and verified	All to identify individual	Used to uniquely identify an individual	R
				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)			
C001060	**PERSON BIRTH DATE**	The date on which a PERSON was born or is officially deemed to have been born	an10 CCYY-MM-DD			All to analyse by age	Used to calculate age at events	R

Start of Repeating Group - CYP001 Master Patient Index and Risk Indicators

CYP001 Master Patient Index and Risk Indicators

Group-level notes for Data Providers:

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XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C001070	**POSTCODE OF USUAL ADDRESS**	The POSTCODE of the ADDRESS nominated by the PATIENT with ADDRESS ASSOCIATION TYPE 'Main Permanent Residence' or 'Other Permanent Residence'	max an8			1.2.1.1	Used to associate an individual with geographical areas, e.g. CCG, Electoral Ward, Sure Start area etc	R
C001080	**PERSON STATED GENDER CODE**	PERSON STATED GENDER CODE is self declared or inferred by observation for those unable to declare their PERSON STATED GENDER.	an1	1	Male	All to analyse by sex	Used to analyse data for difference by gender	R
				2	Female			
				9	Indeterminate (Unable to be classified as either male or female)			
				X	Not Known (PERSON STATED GENDER CODE not recorded)			
C001090	**ETHNIC CATEGORY**	The ethnicity of a PERSON, as specified by the PERSON.	an2		**White**	1.2.1.9	Used to monitor equality or distinctions in service usage by ethnicity	R
				A	British			
				B	Irish			
				C	Any other White background			
					Mixed			
				D	White and Black Caribbean			
				E	White and Black African			
				F	White and Asian			
				G	Any other mixed background			
					Asian or Asian British			
				H	Indian			
				J	Pakistani			
				K	Bangladeshi			
				L	Any other Asian background			
					Black or Black British			
				M	Caribbean			
				N	African			
				P	Any other Black background			

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Start of Repeating Group - CYP001 Master Patient Index and Risk Indicators

CYP001 Master Patient Index and Risk Indicators

Group-level notes for Data Providers:

Master Patient Index and Risk Indicators: To carry the personal details of the person and the associated mother's NHS number (where applicable).

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XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
					Other Ethnic Groups			
				R	Chinese			
				S	Any other ethnic group			
				Z	Not stated			
				99	Not known			
C001100	**LANGUAGE CODE (PREFERRED)**	LANGUAGE CODE (PREFERRED) is the language the PATIENT prefers to use for communication with a Health Care Provider. LANGUAGE CODE is based on the ISO 639-1 two character language codes, see the ISO 639.2 Registration Authority website (http://www.loc.gov/standards/iso639-2/php/code_list.php), plus five extensions (q1, q2, q3, q4, q5).	an2		For spoken languages, see ISO 639-1 codes at http://www.loc.gov/standards/iso639-2/php/code_list.php	3.2.1.1	Used to monitor variances in service usage/access according to preferred language	R
					Extensions			
				q1	Braille (for people who are unable to see)			
				q2	American Sign Language			
				q3	Australian Sign Language			
				q4	British Sign Language			
				q5	Makaton (devised for children and adults with a variety of communication and Learning Disabilities)			
C001110	**PERSON RELATIONSHIP (MAIN CARER)**	The relationship between the child/young person and the person who undertakes the main caring role for them.	an3	**BPX**	**Biological Parent**	1.2.1.10	Used to monitor usage by main carer.	R
				BPM	Biological Mother			
				BPF	Biological Father			
				SPX	**Step-Parent**			
				SPM	Stepmother			
				SPF	Stepfather			
				GPX	**Grandparent**			
				GPM	Grandmother			
				GPF	Grandfather			
				ORX	**Other Relative**			
				ORA	Aunt			
				ORU	Uncle			
				ORS	Sister			
				ORB	Brother			
				ORO	Other			
				APX	**Adoptive Parent**			
				APM	Adoptive Mother			
				APF	Adoptive Father			
				FPX	**Foster Parent**			
				FPM	Foster Mother			
				FPF	Foster Father			

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Start of Repeating Group - CYP001 Master Patient Index and Risk Indicators

CYP001 Master Patient Index and Risk Indicators

Group-level notes for Data Providers:

Master Patient Index and Risk Indicators: To carry the personal details of the person and the associated mother's NHS number (where applicable).

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XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
				RCX	Residential Carer			
				OTX	Other			
				NOX	None - Lives Alone			

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Start of Repeating Group - CYP001 Master Patient Index and Risk Indicators

CYP001 Master Patient Index and Risk Indicators

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XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C001120	**HEALTH VISITOR FIRST ANTENATAL VISIT DATE**	The date when a Health Visitor has the first antenatal visit with the pregnant woman.	an10 CCYY-MM-DD			Analyse by time	Analyse the time between first antenatal visit and other events	R
C001130	**LOOKED AFTER CHILD INDICATOR**	An indication of whether a PERSON is a Looked After Child.	an1	Y	Yes (Is a Looked After Child)	1.2.1.2	To monitor services and outcomes for children and young people who are or have been looked after	R
				N	No (Is not a Looked After Child)			
				X	Not Known			
C001140	**SAFEGUARDING VULNERABILITY**	To record if there are any safeguarding vulnerability factors	an1	Y	Yes (child safeguarding vulnerability factors present)	All to analyse by safeguarding	To monitor details of children with safeguarding concerns	R

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Start of Repeating Group - CYP001 Master Patient Index and Risk Indicators

CYP001 Master Patient Index and Risk Indicators

Group-level notes for Data Providers:

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Data providers should note that CYP001 and CYP002 are mandatory groups that must be included whenever any other groups are transmitted that refer to this person.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
	FACTORS INDICATOR			N	No (child safeguarding vulnerability factors not present)	vulnerability factors indicator		
C001150	**CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR**	This indicates that a disabled person needs round the clock care and/or supervision for maintenance of their safety and/or wellbeing.	an1	Y	Yes (person requires round the clock care and/or supervision)	All to analyse by constant supervision due to disability indicator	To monitor details of children which require constant supervision due to disability	R
				N	No (person does not require round the clock care and/or supervision)			
C001160	**EDUCATIONAL ASSESSMENT OUTCOME**	The outcome of an educational assessment.	an2	01	No Special Educational Needs	8.1.3.1	Used to compare outcomes and provision for children/young people with disabilities or condition	R
				05	Subject to Education, Health and Care (EHC) plan			
C001170	**PREFERRED DEATH LOCATION DISCUSSED INDICATOR**	An indication of whether the preferred location of death was discussed with a patient or proxy by a clinician, in the event that there is an expected risk of death before the age of 18 for	an1	Y	Yes (the preferred location was discussed)	All to analyse by field	To monitor volume of people where the preferred death location was discussed	R

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Start of Repeating Group - CYP001 Master Patient Index and Risk Indicators

CYP001 Master Patient Index and Risk Indicators

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XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
		expected risk of death before the age of 18 for that person.		N	No (the preferred location was not discussed)			
C001180	**PERSON AT RISK OF UNEXPECTED DEATH INDICATOR**	An indication of whether a patient is at risk of sudden, unexpected death before the age of 18, as assessed by a clinician.	an1	Y	Yes (person at risk of unexpected death)	All to analyse by field	Used to compare outcomes and provision for children/young people with a risk of unexpected death	R
				N	No (person not at risk of unexpected death)			
C001190	**DEATH LOCATION TYPE CODE (PREFERRED)**	The preferred location of death as specified by the PATIENT.	an2	**10**	**Hospital**	All to analyse by field	Used to compare outcomes depending on preferred location type and difference between preferred and actual death location	R
				20	**Private Residence**			
				21	PATIENT's own home			
				22	Other private residence (e.g. relatives home, carers home)			
				30	**Hospice**			
				40	**Care Home**			
				41	Care Home with Nursing			
				42	Care Home without Nursing			
				50	**Other**			
				99	The CARE PROFESSIONAL did not discuss the preferred LOCATION of death prior to the death of the PATIENT			

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Start of Repeating Group - CYP001 Master Patient Index and Risk Indicators

CYP001 Master Patient Index and Risk Indicators

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XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C001200	**PERSON DEATH DATE**	The date on which a person died or is officially deemed to have died, as recorded on the death certificate.	an10 CCYY-MM-DD			8.5.15.1	Used for temporal queries, e.g. individuals that died between two dates	R
C001210	**DEATH LOCATION TYPE CODE (ACTUAL)**	The actual location where the PATIENT died.	an2	**10**	**Hospital**	All to analyse by field	Used to compare outcomes depending on actual location type and difference between preferred and actual death location	R
				20	**Private Residence**			
				21	PATIENT's own home			
				22	Other private residence (e.g. relatives home, carers home)			
				30	**Hospice**			
				40	**Care Home**			
				41	Care Home with Nursing			
				42	Care Home without Nursing			
				50	**Other**			

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Start of Repeating Group - CYP001 Master Patient Index and Risk Indicators

CYP001 Master Patient Index and Risk Indicators

Group-level notes for Data Providers:

Master Patient Index and Risk Indicators: To carry the personal details of the person and the associated mother's NHS number (where applicable).

This group may be used to identify the person for record linkage

Providers must populate all known data items for the CYP001 table as they were at the end of the reporting period, even if they are unchanged since the last submission. Do not just provide data for all "changed" data items.

Data providers should note that CYP001 and CYP002 are mandatory groups that must be included whenever any other groups are transmitted that refer to this person.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C001220	**DEATH NOT AT PREFERRED LOCATION REASON**	This will indicate the reason why the person did not die at their preferred LOCATION of death.	an2	01	Family decided to move patient to hospital	All to analyse by field	For analysis on why the person did not die at the preferred place of death	R
				02	Patient was moved to hospital for clinical reasons			
				03	Patient changed their mind			
				04	Capacity not available at preferred location			
				05	Transfer delays			
				06	Social support issues			
				07	Need for access to adequate pain relief			
				98	Other			
				99	Not known			

Start of Repeating Group - CYP002 GP Practice Registration

CYP002 GP Practice Registration

Group-level notes for Data Providers:

GP Practice Registration: To carry details of the GP Practice Registration of the person.

Data providers should note that CYP002 is a mandatory group that must be included whenever any other groups are transmitted that refer to this person.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C002901	**LOCAL PATIENT IDENTIFIER (EXTENDED)**	This is 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.	max an20			All to identify individual	Used to uniquely identify an individual	M
C002010	**GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)**	The ORGANISATION CODE of the GP Practice that the PATIENT is registered with.	an6			1.3.1	Used to identify CCG and registration with a GP	M
C002020	**START DATE (GMP PATIENT REGISTRATION)**	Start Date on which the PERSON registered with a General Medical Practitioner Practice.	an10 CCYY-MM-DD			1.3.1	Used to allow temporal analysis of registration with a GP	R
C002030	**END DATE (GMP PATIENT REGISTRATION)**	The DATE on which the PERSON ceased to be registered with a General Medical Practitioner Practice.	an10 CCYY-MM-DD			1.3.1	Used to allow temporal analysis of registration with a GP	R

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Start of Repeating Group - CYP002 GP Practice Registration								
CYP002 GP Practice Registration						**Group-level notes for Data Providers:** GP Practice Registration: To carry details of the GP Practice Registration of the person. Data providers should note that CYP002 is a mandatory group that must be included whenever any other groups are transmitted that refer to this person.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
C002040	**ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)**	The ORGANISATION CODE of the ORGANISATION responsible for the GP Practice where the PATIENT is registered, irrespective of whether they reside within the boundary of the Clinical Commissioning Group. This field can routinely be left blank, however if populated it should contain the organisation code of the commissioner that is associated with the patient's current registered GP Practice.	an3			Used to analyse by commissioner	Required for identifying the Commissioner responsible for payment	R

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Start of Repeating Group - CYP003 Accommodation Type								
CYP003 Accommodation Type						**Group-level notes for Data Providers:** Accommodation Type: To carry details of the type of accommodation of the person.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
C003901	**LOCAL PATIENT IDENTIFIER (EXTENDED)**	This is 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.	max an20			All to identify individual	Used to uniquely identify an individual	M
C003010	**ACCOMMODATION STATUS CODE**	An indication of the type of accommodation that a PATIENT currently has. This should be based on the PATIENT's main or permanent residence.	an4	**MA00**	**Mainstream Housing**	1.2.1.3 1.2.1.6 1.2.1.8 1.2.1.15	Used to monitor settings for people with disabilities, one of the factors in identifying those who are vulnerable, and comparing health and social outcomes for all people	M
				MA01	Owner occupier			
				MA02	Settled mainstream housing with family/friends			
				MA03	Shared ownership scheme e.g. Social Homebuy Scheme (tenant purchase percentage of home value from landlord)			
				MA04	Tenant - Local Authority/Arms Length Management Organisation/Registered Landlord			
				MA05	Tenant - Housing Association			
				MA06	Tenant - private landlord			
				MA09	Other mainstream housing			
				HM00	**Homeless**			
				HM01	Rough sleeper			
				HM02	Squatting			
				HM03	Night shelter/emergency hostel/Direct access hostel (temporary accommodation accepting self referrals, no waiting list and relatively frequent vacancies)			
				HM04	Sofa surfing (sleeps on different friends floor each night)			
				HM05	Placed in temporary accommodation by Local Authority (including Homelessness resettlement service) e.g. Bed and Breakfast accommodation			
				HM06	Staying with friends/family as a short term guest			
				HM07	Other homeless			
				MH00	**Accommodation with mental health care support**			
				MH01	Supported accommodation (accommodation supported by staff or resident caretaker)			
				MH02	Supported lodgings (lodgings supported by staff or resident caretaker)			
				MH03	Supported group home (supported by staff or resident caretaker)			

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Start of Repeating Group - CYP003 Accommodation Type								
CYP003 Accommodation Type						**Group-level notes for Data Providers:** Accommodation Type: To carry details of the type of accommodation of the person.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
				MH04	Mental Health Registered Care Home			
				MH09	Other accommodation with mental health care and support			
				HS00	**Acute/long stay healthcare residential facility/hospital**			
				HS01	NHS acute psychiatric ward			
				HS02	Independent hospital/clinic			
				HS03	Specialist rehabilitation/recovery			
				HS04	Secure psychiatric unit			
				HS05	Other NHS facilities/hospital			
				HS09	Other acute/long stay healthcare residential facility/hospital			
				CH00	**Accommodation with other (not specialist mental health) care support**			
				CH01	Foyer - accommodation for young people aged 16-25 who are homeless or in housing need			
				CH02	Refuge			
				CH03	Non-Mental Health Registered Care Home			
				CH09	Other accommodation with care and support (not specialist mental health)			
				CJ00	**Accommodation with criminal justice support**			
				CJ01	Bail/Probation hostel			
				CJ02	Prison			
				CJ03	Young Offenders Institute			
				CJ04	Detention Centre			
				CJ09	Other accommodation with criminal justice support such as ex-offender support			
				SH00	**Sheltered Housing (accommodation with a scheme manager or warden living on the premises or nearby, contactable by an alarm system if necessary)**			
				SH01	Sheltered housing for older persons			

Start of Repeating Group - CYP003 Accommodation Type

CYP003 Accommodation Type

Group-level notes for Data Providers:

Accommodation Type: To carry details of the type of accommodation of the person.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
				SH02	Extra care sheltered housing (also known as 'very sheltered housing'. For people who are less able to manage on their own, but who do need an extra level of care. Services offered vary between schemes, but meals and some personal care are often provided.)			
				SH03	Nursing Home for older persons			
				SH09	Other sheltered housing			
				ML00	**Mobile accommodation**			
					Other			
				OC96	Not elsewhere classified			
				OC97	Not specified			
				OC98	Not applicable			
				OC99	Not known			
C003020	**ACCOMMODATION STATUS RECORDED DATE**	The PERSON PROPERTY OBSERVED DATE when the ACCOMMODATION STATUS CODE was recorded.	an10 CCYY-MM-DD			1.2.1.3 1.2.1.6 1.2.1.8 1.2.1.15	Used to monitor settings for people with disabilities, one of the factors in identifying those who are vulnerable, and comparing health and social outcomes for all people	R

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Start of Repeating Group - CYP101 Service or Team Referral								
CYP101 Service or Team Referral						**Group-level notes for Data Providers:** Service or Team Referral: To carry details of the referral that the person is subject to. All open referrals should be provided in each reporting period they remain open, even if there has been no activity during that reporting period.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
C101902	**SERVICE REQUEST IDENTIFIER**	The unique identifier for a SERVICE REQUEST. It would normally be automatically generated by the local system upon recording a new Referral, although could be manually assigned.	max an20			All to identify referral	Used to uniquely identify a referral	M
C101901	**LOCAL PATIENT IDENTIFIER (EXTENDED)**	This is 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.	max an20			All to identify individual	Used to uniquely identify an individual	M
C101912	**ORGANISATION CODE (CODE OF COMMISSIONER)**	ORGANISATION CODE (CODE OF COMMISSIONER) is the ORGANISATION CODE of the Organisation commissioning health care. The NHS England document "Who pays? Determining responsibility for payments to providers" sets out a framework for establishing responsibility for commissioning an individual's care within the NHS, (i.e. determining who pays for a PATIENT's care.) The document includes information on the following: •General Rules •Applying the rules to Clinical Commissioning Group commissioned services •Exceptions to the general rules •Examples to help clarify the boundaries of responsibility between commissioning Organisations. For further information on this document contact NHS England at "Contact us". ORGANISATION CODE (CODE OF COMMISSIONER) will be replaced with ORGANISATION IDENTIFIER (CODE OF COMMISSIONER), when it has been approved for use in national information standards.	an3 or an5			Used to analyse by commissioner	Required for identifying the Commissioner responsible for payment	M

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Start of Repeating Group - CYP101 Service or Team Referral								
CYP101 Service or Team Referral						**Group-level notes for Data Providers:** Service or Team Referral: To carry details of the referral that the person is subject to. All open referrals should be provided in each reporting period they remain open, even if there has been no activity during that reporting period.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
C101010	**REFERRAL REQUEST RECEIVED DATE**	This is the date the REFERRAL REQUEST was received by the Health Care Provider. The waiting time for a first Out-Patient Appointment should be calculated from the date when the REFERRAL REQUEST is received. For electronic REFERRAL REQUESTS the REFERRAL REQUEST RECEIVED DATE is the date the REFERRAL REQUEST is received electronically by the Health Care Provider. For Choose and Book, the referral is received when the PATIENT's Unique Booking Reference Number (UBRN) is used to book the first outpatient appointment slot (i.e. converted). Where an electronic REFERRAL REQUEST made through Choose and Book is rejected by the chosen provider, the ORIGINAL REFERRAL REQUEST RECEIVED DATE should be used when the PATIENT is subsequently re-referred to another service, so that patients are not unfairly disadvantaged when their waiting time calculations are made. In the circumstance that a PATIENT calls the national Choose and Book Appointments Line and an APPOINTMENT SLOT is not available with the chosen Health Care Provider, the national Choose and Book Appointments Line will electronically forward the REFERRAL REQUEST details to the chosen Health Care Provider so the Health Care Provider can liaise directly with the PATIENT to arrange their Out-Patient Appointment. The REFERRAL REQUEST RECEIVED DATE will be the date that the Health Care Provider receives electronic notification from the national Choose and Book Appointments Line that the PATIENT has experienced slot unavailability. (Note that this is NOT the date that the Health Care Provider opens or actions the electronic notification). For written REFERRAL REQUESTS letters must be opened and date stamped on the day of receipt. It is this date that must be entered on any PAS or similar system, not the date on which the information is fed into the system if this is later than the date of receipt. If the REFERRAL REQUEST takes the form of a phone call followed by a letter, record the date when the letter arrives. If there is no following letter, the date of the verbal request should be recorded.	an10 CCYY-MM-DD			Used for analysis between field and other events	Required for measuring Quality & Performance - Waiting Times	M
C101020	**REFERRAL REQUEST RECEIVED TIME**	This records the time the REFERRAL REQUEST was received. This item is only required for 'urgent' priority referrals into services with target waiting times measured in hours e.g. rapid response teams or urgent care. The time should be recorded using the 24 hour clock format in eGIF format i.e. hh:mm:ss.	an8 HH:MM:SS			Used for analysis between field and other events	Required for measuring Quality & Performance - Waiting Times and Response Times	R

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Start of Repeating Group - CYP101 Service or Team Referral								
CYP101 Service or Team Referral						**Group-level notes for Data Providers:** Service or Team Referral: To carry details of the referral that the person is subject to. All open referrals should be provided in each reporting period they remain open, even if there has been no activity during that reporting period.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
C101905	**NHS SERVICE AGREEMENT LINE NUMBER**	A number (alphanumeric) to provide a unique identifier for a line within a NHS SERVICE AGREEMENT. An NHS SERVICE AGREEMENT is a formal agreement between a commissioner ORGANISATION and one or more provider ORGANISATIONS for the provision of PATIENT care services.	an10			All to identify a service agreement line	Used to uniquely identify a service agreement line	O

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Start of Repeating Group - CYP101 Service or Team Referral								
CYP101 Service or Team Referral						**Group-level notes for Data Providers:** Service or Team Referral: To carry details of the referral that the person is subject to. All open referrals should be provided in each reporting period they remain open, even if there has been no activity during that reporting period.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
C101030	**SOURCE OF REFERRAL FOR COMMUNITY**	A classification which identifies the source of referral to a Community Health Service. Internal Referrals should normally be recorded as 'Community Service' and the Referring Organisation Code will be the same as the Organisation Code (Code of Provider).	an2	01	General Medical Practitioner Practice	Used for analysis of this data item	Required for reporting on Referral Source and to support validation of Referring Organisation Code	R
				02	Self Referral			
				03	Carer/Relative			
				04	Employer			
				05	Accident and Emergency Department			
				06	Acute Hospital Inpatient/Outpatient			
				07	Community Health Service (same or other Health Care Provider)			
				08	Dental Practice			
				09	National Screening Programme			
				10	Educational Establishment			
				11	Local Authority Social Services			
				12	Hospice			
				13	Care Home			
				14	Police			
				15	Courts			
				16	Probation Service			
				17	Prison Health Service			
				18	Asylum Service			
				19	Telephone or Electronic Access Service			
				20	Voluntary Sector			
				21	Independent Sector			
				22	Ambulance Service			
				23	Mental Health Service			
				99	Not Known			
C101040	**REFERRING ORGANISATION CODE**	Organisation Code of the referring organisation. This will be applicable only if the request has originated from another organisation. It will not be applicable for a self-referral.	max an6			Used for analysis of this data item	Required for reporting on Referral Source	R
C101050	**REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE)**	The staff group of a CARE PROFESSIONAL who referred the PATIENT to a Community Health Service or Mental Health Service.	an3		**Allied Health Professionals**	Used for analysis of this data item	Required for reporting on Referral Source	R
				A01	Art Therapist			
				A02	Clinical Psychologist			
				A03	Dietitian			
				A04	Drama Therapist			
				A05	Music Therapist			
				A06	Occupational Therapist			
				A07	Orthotist			
				A08	Physiotherapist			

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Start of Repeating Group - CYP101 Service or Team Referral								
CYP101 Service or Team Referral						**Group-level notes for Data Providers:** Service or Team Referral: To carry details of the referral that the person is subject to. All open referrals should be provided in each reporting period they remain open, even if there has been no activity during that reporting period.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
				A09	Podiatrist			
				A10	Prosthetist			
				A11	Psychotherapist			
				A12	Radiographer			
				A13	Speech and Language Therapist			
				A14	Orthoptist			
					Medical/Dental			
				M01	Community Dentist			
				M02	Consultant			
				M03	General Medical Practitioner			
				M04	General Medical Practitioner with A Special Interest			
					Nursing, Health Visiting and Midwifery			
				N01	Midwife			
				N02	District Nurse			
				N03	Health Visitor			
				N04	Macmillan Nurse			
				N05	School Nurse			
				N06	Specialist Nursing - Active Case Management			
				N07	Specialist Nursing - Arthritis Nursing / Liaison			
				N08	Specialist Nursing - Asthma and Respiratory			
				N09	Specialist Nursing - Breast Care Nursing /			
				N10	Specialist Nursing - Cancer Related			
				N11	Specialist Nursing - Cardiac Nursing / Liaison			
				N12	Specialist Nursing - Children's Services			
				N13	Specialist Nursing - Community Cystic Fibrosis			
				N14	Specialist Nursing - Continence Services			
				N15	Specialist Nursing - Diabetic Nursing / Liaison			
				N16	Specialist Nursing - Enteral Feeding Nursing			
				N17	Specialist Nursing - Haemophilia Nursing			
				N19	Specialist Nursing - Infectious Diseases			
				N20	Specialist Nursing - Intensive Care Nursing			
				N21	Specialist Nursing - Palliative / Respite Care			
				N22	Specialist Nursing - Parkinson and Alzheimer			
				N23	Specialist Nursing - Rehabilitation Nursing			
				N24	Specialist Nursing - Stoma Care Services			
				N25	Specialist Nursing - Tissue Viability Nursing /			
				N26	Specialist Nursing - Transplantation Patients			
				N27	Specialist Nursing - Treatment Room Nursing			

Start of Repeating Group - CYP101 Service or Team Referral

CYP101 Service or Team Referral

Group-level notes for Data Providers:

Service or Team Referral: To carry details of the referral that the person is subject to.

All open referrals should be provided in each reporting period they remain open, even if there has been no activity during that reporting period.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
				N28	Specialist Nursing - Tuberculosis Specialist			
				N29	Specialist Nursing - Other Specialist Nursing			
				N30	Specialist Nursing - Safeguarding			
				N31	Practice Nursing			
				N32	Staff Nurse			
				N33	Other Registered Nurse			
				N34	Public Health Nurse			
					Other Care Professionals			
				C01	Appliances Technician			
				C02	Audiologist			
				C03	Counsellor			
				C04	Nursery Nurse			

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Start of Repeating Group - CYP101 Service or Team Referral								
CYP101 Service or Team Referral						**Group-level notes for Data Providers:** Service or Team Referral: To carry details of the referral that the person is subject to. All open referrals should be provided in each reporting period they remain open, even if there has been no activity during that reporting period.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
				C06	Play Therapist			
				C07	Social Worker			
				C08	Voluntary Care Worker			
				C09	Screener (in a National Screening			
				C10	Health Trainer (Non Clinical)			
				C11	Health Trainer (Clinical)			
				C12	Health Care Assistant			
				C13	Health Care Support Worker			
				C99	Other Care Professional			
C101060	**PRIORITY TYPE CODE**	This is the priority of a request for services; in the case of services to be provided by a CONSULTANT, it is as assessed by or on behalf of the CONSULTANT. Priority Type 'Urgent' should be used where the request for services is defined as clinically urgent, but it does not fall under the criteria for 'Two Week Wait' (see below). Priority Type 'Two Week Wait' should be used where either: - the request for services meets the criteria for an urgent GENERAL PRACTITIONER referral for suspected cancer. These referrals should be made in accordance with the National Institute for Health and Clinical Excellence (NICE) clinical guidelines on referral for suspected cancer. For further information, see the NICE guidance. or - the PATIENT has been referred urgently for breast symptoms, but the referral does not meet the criteria for urgent GENERAL PRACTITIONER referrals for suspected cancer.	an1	1	Routine	Used for analysis of this data item reporting on time between events	Required for reporting on Referral Priority and measuring Response Times	R
				2	Urgent			
				3	Two Week Wait			
C101070	**PRIMARY REASON FOR REFERRAL (COMMUNITY CARE)**	The primary presenting condition or symptom for which the patient was referred to a Community Health Service.	an3	001	Accident/Trauma	Used for analysis of this data item	Required for measuring Quality & Performance - RTT and Response Times	R
				002	Alopecia			
				003	Antenatal Care			
				004	Bereavement			
				005	Bladder Care			
				006	Blood Pressure			
				007	Bowel Problems			
				008	Cancer			
				009	Cardiac Conditions			
				010	Catheter Problems			
				011	Cerebral Palsy			
				012	Cleft Palate			
				013	Cognitive Problems			

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Start of Repeating Group - CYP101 Service or Team Referral

CYP101 Service or Team Referral

Group-level notes for Data Providers:

Service or Team Referral: To carry details of the referral that the person is subject to.

All open referrals should be provided in each reporting period they remain open, even if there has been no activity during that reporting period.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
				014	Colostomy Care			
				015	Continence Problems			
				017	Developmental Problems			
				018	Diabetes			
				019	Diarrhoea and Vomiting			
				020	Dizziness/Balance Problems			
				021	Downs Syndrome			
				022	Deep Vein Thrombosis			
				023	Ear Infections/Problems			
				024	Eating Disorder			
				025	Emotional/Behavioural Problems			
				026	End of Life Support			
				027	Epilepsy			
				028	Equipment Provision			
				029	Eustachian Tube Dysfunction			
				030	Falls Risk			
				031	Family Support			
				032	Feeding/Swallowing Problems			
				033	Foot Care/Problems			
				034	Head Injury			
				035	Hearing Problems/Loss			
				036	Immunisation			
				037	Laryngectomy			
				038	Leg Ulcer			
				039	Looked After Children			
				040	Low Muscle Tone			
				041	Lymphoedema Management			
				042	Mobility Problems			
				043	Musculoskeletal Problems			
				044	Neurological Problems			
				045	Healthy Child Pathway			
				046	Nutrition and Dietetics			
				047	Ophthalmic Problems			
				048	Over 75 Assessment			
				049	Pain/Symptom Control			
				050	Parkinsons Disease			
				051	Personal Hygiene			
				052	Post Operative Care			

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Start of Repeating Group - CYP101 Service or Team Referral

CYP101 Service or Team Referral

Group-level notes for Data Providers:

Service or Team Referral: To carry details of the referral that the person is subject to.

All open referrals should be provided in each reporting period they remain open, even if there has been no activity during that reporting period.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
				053	Pressure Ulcer			
				054	Problems with Activities of Daily Living			
				055	Psychological Conditions			
				056	Rehabilitation			
				057	Respiratory Conditions			
				058	Safeguarding			
				059	Skin Problems			
				060	Sleep Problems			
				061	Smoking Cessation			
				062	Speech and Language Problems			
				063	Stoma Care			
				064	Structural/Functional Impairment			
				065	Substance Misuse			
				066	Trismus/Restricted Mouth Opening			
				067	Tuberculosis			
				068	Vascular Problems			
				069	Vomiting/Nausea			
				070	Wound Care			
				071	Multiple Complex Communication Difficulties			
				072	Dental Care/Problems			
				073	Haematology/Phlebotomy			
				074	Chronic Fatigue Syndrome/Myalgic Encephalopathy			
				075	Chronic Allergy/Immunological Problem			
				076	Metabolic/Endocrine Disorders			
				077	Renal Problems			
				078	Minor Surgery			
				079	Gastrostomy Management/Care			
				080	Care of the Next Infant (CONI) Pathway			
				081	Failure to Thrive			
				082	Maternal Mood Problems			
				083	Complex Social Factors			
				084	Condition(s) Requiring Respite Care			
				085	Other Congenital Conditions			
				086	Blood Disorders			
				087	Genetic Disorders			
				088	Neonatal Abstinence Syndrome			

SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI
Start of Repeating Group - CYP101 Service or Team Referral								
CYP101 Service or Team Referral						**Group-level notes for Data Providers:** Service or Team Referral: To carry details of the referral that the person is subject to. All open referrals should be provided in each reporting period they remain open, even if there has been no activity during that reporting period.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
				999	Not known			
C101080	**SERVICE DISCHARGE DATE**	Service Discharge Date is the date a PATIENT was discharged from a SERVICE. This would occur once all the services or teams (for example as part of a multidisciplinary team) have finished treating a patient under a specific referral.	an10 (CCYY-MM-DD)			Used for analysis between field and other events	Required for measuring Quality & Performance	R
C101090	**DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)**	The Discharge Letter Issued Date (Mental Health and Community Care) is the date when the Discharge Letter was issued by the provider of Mental Health Services or Community Health Services to the PATIENT.	an10 (CCYY-MM-DD)			Used for analysis between field and other events	To support community contract reporting requirements around issuance of Discharge Letters within 24 hours of discharge.	R

Start of Repeating Group - CYP102 Service or Team Type Referred To

CYP102 Service or Team Type Referred To

Group-level notes for Data Providers:

Service Type Referred To: To carry details of the service or team that a person has been referred to.

Data providers should note that CYP001 and CYP002 are mandatory groups that must be included whenever any other groups are transmitted that refer to this person.

All open referrals should be provided in each reporting period they remain open even if there has been no activity during that reporting period.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C102902	**SERVICE REQUEST IDENTIFIER**	The unique identifier for a SERVICE REQUEST. It would normally be automatically generated by the local system upon recording a new Referral, although could be manually assigned.	max an20			All to identify professional team	Used to uniquely identify a professional team	M
C102905	**CARE PROFESSIONAL TEAM LOCAL IDENTIFIER**	CARE PROFESSIONAL TEAM LOCAL IDENTIFIER is a unique local CARE PROFESSIONAL TEAM IDENTIFIER within a Health Care Provider and may be assigned automatically by the computer system.	max an20			All to identify referral	Used to uniquely identify a referral	R
C102010	**SERVICE OR TEAM TYPE REFERRED TO (COMMUNITY CARE)**	The type of community service or team that the patient has been referred into.	an2	01	Appliances Service	All to analyse by data item	Required for reporting on the basis of Service Types	M
				02	Arts Therapy Service			
				03	Cancer Service			
				04	Cardiac Service			
				05	Community Dental Service			
				06	Community Paediatrics Service			
				07	Continence Service			
				09	Counselling Service			
				10	Dermatology Service			
				11	Diabetes Service			
				12	District Nursing Service			
				13	Ear Nose and Throat Service			
				14	End of Life Care Service			
				15	Gastrointestinal Service			
				16	Health Visiting Service			
				17	Hearing Service			
				18	Intermediate Care Service			
				19	Long Term Conditions Case Management Service			
				20	Musculoskeletal Service			
				21	Neurology Service			
				22	Nutrition and Dietetics Service			
				23	Occupational Therapy Service			
				24	Orthoptist Service			
				25	Pain Management Service			
				26	Physiotherapy Service			
				27	Podiatry Service			

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
				28	Public Health and Lifestyle Service			
				29	Rehabilitation Service			
				30	Respiratory Service			
				31	Rheumatology Service			
				32	School Nursing Service			
				33	Speech and Language Therapy Service			
				34	Vulnerable Children's Service			
				35	Vulnerable Adult's Service			
				36	Respite Care Service			
				37	Clinical Psychology Service			
				38	Children's Community Nursing Service			
				39	Diagnostic Service			
				40	Treatment Room Nursing Service			
				41	Haematology Service			
				42	Phlebotomy Service			
				43	Tissue Viability Service			
				44	Family Support Service			
				45	Integrated Multi-Disciplinary Team (jointly commissioned)			
C102020	**REFERRAL CLOSURE DATE**	The date the Referral Request to a Health Care Provider's Service was closed by the Health Care Provider's Service. The overarching referral may remain open if another service or team involved in the same referral is still actively treating the patient.	an10 (CCYY-MM-DD)			All to analyse between data item and other events	To support community contract reporting requirements around issuance of Discharge Letters within 24 hours of discharge.	R
C102030	**REFERRAL REJECTION DATE**	The date the Referral Request to a Health Care Provider's Service was rejected by the Health Care Provider's Service. The overarching referral may remain open if another service or team involved in the same referral is still actively treating the patient.	an10 (CCYY-MM-DD)			All to analyse between data item and other events	To support community contract reporting requirements around issuance of Discharge Letters within 24 hours of discharge.	R
C102040	**REFERRAL CLOSURE REASON**	The reason that a Referral Request has been closed. A Referral Request can be closed as a result of a Patient being discharged from the SERVICE. Cancelled referrals such as those entered onto a system in error should not be submitted	an2	01	Admitted elsewhere (at the same or other Health Care Provider)	All to analyse by data item	To analyse on the reason for rejection of a referral.	R
				02	Treatment completed			
				03	Moved out of the area			
				04	No further treatment appropriate			
				05	Patient did not attend			

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
		within the data set.		06	Patient died			
				07	Patient requested discharge			
				08	Referred to other speciality/service (at the same or other Health Care Provider)			
				09	Patient refused to be seen			

SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI
Start of Repeating Group - CYP103 Other Reason for Referral								
CYP103 Other Reason for Referral						**Group-level notes for Data Providers:** Other Reason for Referral: To carry details of additional reasons why a person has been referred to a specific service.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
C103902	**SERVICE REQUEST IDENTIFIER**	The unique identifier for a SERVICE REQUEST. It would normally be automatically generated by the local system upon recording a new Referral, although could be manually assigned.	max an20			All to identify referral	Used to uniquely identify a referral	M
C103010	**OTHER REASON FOR REFERRAL (COMMUNITY CARE)**	The secondary presenting conditions or symptoms for which the patient was referred to a Community Health Service.	an3	001	Accident/Trauma	Used for analysis of this data item	Required for measuring Quality & Performance - RTT and Response Times	M
				002	Alopecia			
				003	Antenatal Care			
				004	Bereavement			
				005	Bladder Care			
				006	Blood Pressure			
				007	Bowel Problems			
				008	Cancer			
				009	Cardiac Conditions			
				010	Catheter Problems			
				011	Cerebral Palsy			
				012	Cleft Palate			
				013	Cognitive Problems			
				014	Colostomy Care			
				015	Continence Problems			
				017	Developmental Problems			
				018	Diabetes			
				019	Diarrhoea and Vomiting			
				020	Dizziness/Balance Problems			
				021	Downs Syndrome			
				022	Deep Vein Thrombosis			
				023	Ear Infections/Problems			
				024	Eating Disorder			
				025	Emotional/Behavioural Problems			
				026	End of Life Support			
				027	Epilepsy			
				028	Equipment Provision			
				029	Eustachian Tube Dysfunction			
				030	Falls Risk			
				031	Family Support			
				032	Feeding/Swallowing Problems			
				033	Foot Care/Problems			
				034	Head Injury			

Start of Repeating Group - CYP103 Other Reason for Referral

CYP103 Other Reason for Referral

Group-level notes for Data Providers:

Other Reason for Referral: To carry details of additional reasons why a person has been referred to a specific service.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
				035	Hearing Problems/Loss			
				036	Immunisation			
				037	Laryngectomy			
				038	Leg Ulcer			
				039	Looked After Children			
				040	Low Muscle Tone			
				041	Lymphoedema Management			
				042	Mobility Problems			
				043	Musculoskeletal Problems			
				044	Neurological Problems			
				045	Healthy Child Pathway			
				046	Nutrition and Dietetics			
				047	Ophthalmic Problems			
				048	Over 75 Assessment			
				049	Pain/Symptom Control			
				050	Parkinsons Disease			
				051	Personal Hygiene			
				052	Post Operative Care			
				053	Pressure Ulcer			
				054	Problems with Activities of Daily Living			
				055	Psychological Conditions			
				056	Rehabilitation			
				057	Respiratory Conditions			
				058	Safeguarding			
				059	Skin Problems			
				060	Sleep Problems			
				061	Smoking Cessation			
				062	Speech and Language Problems			
				063	Stoma Care			
				064	Structural/Functional Impairment			
				065	Substance Misuse			
				066	Trismus/Restricted Mouth Opening			
				067	Tuberculosis			
				068	Vascular Problems			
				069	Vomiting/Nausea			
				070	Wound Care			
				071	Multiple Complex Communication Difficulties			
				072	Dental Care/Problems			

Start of Repeating Group - CYP103 Other Reason for Referral

CYP103 Other Reason for Referral

Group-level notes for Data Providers:

Other Reason for Referral: To carry details of additional reasons why a person has been referred to a specific service.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
				073	Haematology/Phlebotomy			
				074	Chronic Fatigue Syndrome/Myalgic Encephalopathy			
				075	Chronic Allergy/Immunological Problem			
				076	Metabolic/Endocrine Disorders			
				077	Renal Problems			
				078	Minor Surgery			
				079	Gastrostomy Management/Care			
				080	Care of the Next Infant (CONI) Pathway			
				081	Failure to Thrive			
				082	Maternal Mood Problems			
				083	Complex Social Factors			
				084	Condition(s) Requiring Respite Care			
				085	Other Congenital Conditions			
				086	Blood Disorders			
				087	Genetic Disorders			
				088	Neonatal Abstinence Syndrome			
				999	Not known			

SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI
Start of Repeating Group - CYP104 Referral to Treatment								

CYP104 Referral to Treatment

Group-level notes for Data Providers:

Referral to Treatment: To carry referral to treatment (RTT) details for the person's referral.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C104902	**SERVICE REQUEST IDENTIFIER**	The unique identifier for a SERVICE REQUEST. It would normally be automatically generated by the local system upon recording a new Referral, although could be manually assigned.	max an20			All to identify referral	Used to uniquely identify a referral	M
C104010	**UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)**	The unique booking reference number assigned by the Choose and Book system when a PATIENT accepts an APPOINTMENT DATE OFFERED of an APPOINTMENT OFFER where the offer was made via the Choose and Book system. When a PATIENT accepts an APPOINTMENT DATE OFFERED, the unique booking reference number issued and used during the booking process is considered to be 'converted' i.e. an APPOINTMENT has been created and recorded; and the PATIENT has been placed on an Out-Patient Waiting List even if subsequently the PATIENT does not attend or cancels the APPOINTMENT.	n12			All to identify a booking	For RTT	R
C104020	**PATIENT PATHWAY IDENTIFIER**	An identifier, which together with the ORGANISATION CODE of the issuer, uniquely identifies a PATIENT PATHWAY.	an20			All to identify a patient pathway	for RTT	R
C104030	**ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)**	This is the ORGANISATION CODE of the ORGANISATION issuing the PATIENT PATHWAY IDENTIFIER. Where Choose and Book has been used, the ORGANISATION CODE X09 should be used.	max an5			All to identify individual	for RTT	R
C104040	**WAITING TIME MEASUREMENT TYPE**	The type of waiting time measurement methodology which may be applied during a PATIENT PATHWAY. The methodology applied may be for one part of a PATIENT PATHWAY, such as the measurement of a REFERRAL TO TREATMENT PERIOD, or other parts of the	an2	01	Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement	All to analyse this data item	To analyse the reason for rejection of a referral	R
				02	Allied Health Professional Referral To Treatment Measurement			
				09	Other Referral To Treatment Measurement Type			

SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI
Start of Repeating Group - CYP104 Referral to Treatment								
CYP104 Referral to Treatment						Group-level notes for Data Providers: Referral to Treatment: To carry referral to treatment (RTT) details for the person's referral.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
C104050	**REFERRAL TO TREATMENT PERIOD START DATE**	The start date of a REFERRAL TO TREATMENT PERIOD. See NHS Data Dictionary for further details and guidance	an10 CCYY-MM-DD			All to analyse between the data item and other events	Required for measuring quality and performance - RTT	R
C104060	**REFERRAL TO TREATMENT PERIOD END DATE**	The end date of a REFERRAL TO TREATMENT PERIOD. See NHS Data Dictionary for further details and guidance	an10 CCYY-MM-DD			All to analyse between the data item and other events	Required for measuring quality and performance - RTT	R
C104070	**REFERRAL TO TREATMENT PERIOD STATUS**	The status of an ACTIVITY (or anticipated ACTIVITY) for the REFERRAL TO TREATMENT PERIOD decided by the lead CARE PROFESSIONAL.	an2		**The first ACTIVITY in a REFERRAL TO TREATMENT PERIOD where the First Definitive Treatment will be a subsequent ACTIVITY**	All to analyse between the data item and other events	Required for measuring quality and performance - RTT	R
				10	first ACTIVITY - first ACTIVITY in a REFERRAL TO TREATMENT PERIOD			
				11	Active Monitoring end - first ACTIVITY at the start of a new REFERRAL TO TREATMENT PERIOD following Active Monitoring			
				12	CONSULTANT or NHS Allied Health Professional Service (Referral To Treatment Measurement) referral - the first ACTIVITY at the start of a new REFERRAL TO TREATMENT PERIOD following a decision to refer directly to the CONSULTANT or NHS Allied Health Professional Service (Referral To Treatment Measurement) for a separate condition			
					Subsequent ACTIVITY during a REFERRAL TO TREATMENT PERIOD			
				20	subsequent ACTIVITY during a REFERRAL TO TREATMENT PERIOD - further ACTIVITIES anticipated			
				21	transfer to another Health Care Provider - subsequent ACTIVITY by another Health Care Provider during a REFERRAL TO TREATMENT PERIOD anticipated			
					ACTIVITY that ends the REFERRAL TO TREATMENT PERIOD			
				30	Start of First Definitive Treatment.			

SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI
Start of Repeating Group - CYP104 Referral to Treatment								
CYP104 Referral to Treatment						**Group-level notes for Data Providers:** Referral to Treatment: To carry referral to treatment (RTT) details for the person's referral.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
				31	start of Active Monitoring initiated by the PATIENT			
				32	start of Active Monitoring initiated by the CARE PROFESSIONAL			
				33	Did not attend - the PATIENT did not attend the first CARE ACTIVITY after the referral			
				34	decision not to treat - decision not to treat made or no further contact required			
				35	PATIENT declined offered treatment			
				36	PATIENT died before treatment			
					ACTIVITY that is not part of a REFERRAL TO TREATMENT PERIOD			
				90	after treatment - First Definitive Treatment occurred previously (e.g. admitted as an emergency from A&E or the activity is after the start of treatment)			
				91	Active Monitoring - CARE ACTIVITY during Active Monitoring			
				92	not yet referred - not yet referred for treatment, undergoing diagnostic tests by GENERAL PRACTITIONER before referral			
				98	not applicable - ACTIVITY not applicable to REFERRAL TO TREATMENT PERIODS			
					ACTIVITY where the REFERRAL TO TREATMENT PERIOD STATUS is not yet known			
				99	not yet known			

SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI
Start of Repeating Group - CYP105 Onward Referral								
CYP105 Onward Referral						**Group-level notes for Data Providers:** Onward Referral: To carry details of any onward referral of the person which has taken place.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
C105902	**SERVICE REQUEST IDENTIFIER**	The unique identifier for a SERVICE REQUEST. It would normally be automatically generated by the local system upon recording a new Referral, although could be manually assigned.	max an20			All to identify referral	Used to uniquely identify a referral	M
C105010	**ONWARD REFERRAL DATE**	This will be the date the patient was referred to another service, which may be in the same or a different organisation.	an10 CCYY-MM-DD			All to analyse between the data item and other events	Required for measuring quality and performance	M
C105020	**ONWARD REFERRAL REASON**	The reason why the patient was referred to another service, which may be in the same or a different organisation.	an2	**01**	Transfer of Clinical Responsibility	All to analyse between the data item and other events	Required for measuring quality and performance	R
				02	For Opinion Only			
				03	For Diagnostic Test Only			
				04	New Referral (Non Transfer)			
				96	Other			
				98	Onward Referral Reason Not Applicable			
				99	Onward Referral Reason Not Known			
C105030	**ORGANISATION CODE (RECEIVING)**	ORGANISATION CODE (RECEIVING) is the ORGANISATION CODE of the ORGANISATION that is receiving the PATIENT from another Health Care Provider.	an3 or an5			Used for analysis of this data item	Required for reporting on Referral Receiver	R

SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI
Start of Repeating Group - CYP201 Care Contact								
CYP201 Care Contact						**Group-level notes for Data Providers:** Care Contact: To carry details of any contacts with a person which have taken place as part of a referral.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
C201903	**CARE CONTACT IDENTIFIER**	The CARE CONTACT IDENTIFIER is used to uniquely identify the CARE CONTACT within the Health Care Provider. It would normally be automatically generated by the local system upon recording a new Care Contact, although could be manually assigned.	max an20			Uniquely identify a care contact	Required for reporting on Care Activities	M
C201902	**SERVICE REQUEST IDENTIFIER**	The unique identifier for a SERVICE REQUEST. It would normally be automatically generated by the local system upon recording a new Referral, although could be manually assigned.	max an20			All to identify referral	Used to uniquely identify a referral	M
C201010	**CARE PROFESSIONAL TEAM LOCAL IDENTIFIER**	CARE PROFESSIONAL TEAM LOCAL IDENTIFIER is a unique local CARE PROFESSIONAL TEAM IDENTIFIER within a Health Care Provider and may be assigned automatically by the computer system.	max an20			All to identify professional team	Used to uniquely identify a professional team	R
C201020	**CARE CONTACT DATE**	The date on which a Care Contact took place, or, if cancelled, was scheduled to take place. This should be recorded in the eGIF Date format CCYY-MM-DD.	an10 CCYY-MM-DD			All to analyse between the data item and other events	Required for reporting on Care Activities, Performance of Care Professionals	M
C201030	**CARE CONTACT TIME**	The time at which a Care Contact took place. The time should be recorded using the 24 hour clock format in eGIF format i.e. hh:mm:ss.	an8 HH:MM:SS			All to analyse between the data item and other events	To allow measurement waiting times between referral and first appointment for Priority/Urgent appointments.	R

SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI
Start of Repeating Group - CYP201 Care Contact								
CYP201 Care Contact						**Group-level notes for Data Providers:** Care Contact: To carry details of any contacts with a person which have taken place as part of a referral.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
C201912	**ORGANISATION CODE (CODE OF COMMISSIONER)**	ORGANISATION CODE (CODE OF COMMISSIONER) is the ORGANISATION CODE of the Organisation commissioning health care. The NHS England document "Who pays? Determining responsibility for payments to providers" sets out a framework for establishing responsibility for commissioning an individual's care within the NHS, (i.e. determining who pays for a PATIENT's care.) The document includes information on the following: •General Rules •Applying the rules to Clinical Commissioning Group commissioned services •Exceptions to the general rules •Examples to help clarify the boundaries of responsibility between commissioning Organisations. For further information on this document contact NHS England at "Contact us". ORGANISATION CODE (CODE OF COMMISSIONER) will be replaced with ORGANISATION IDENTIFIER (CODE OF COMMISSIONER), when it has been approved for use in national information standards.	an3 or an5			Used to analyse by commissioner	Required for identifying the Commissioner responsible for payment	R
C201040	**ADMINISTRATIVE CATEGORY CODE**	This is recorded for PATIENT ACTIVITY. A PATIENT who is an Overseas Visitor does not qualify for free NHS healthcare and can choose to pay for NHS treatment or for private treatment. If they pay for NHS treatment then they should be recorded as NHS PATIENTS. The PATIENT's ADMINISTRATIVE CATEGORY CODE may change during an episode or spell. For example, the PATIENT may opt to change from NHS to private health care. In this case, the start and end dates for each new ADMINISTRATIVE CATEGORY PERIOD (episode or spell) should be recorded. If the ADMINISTRATIVE CATEGORY CODE changes during a Hospital Provider Spell the ADMINISTRATIVE CATEGORY CODE (ON ADMISSION) is used to derive the 'Category of PATIENT' for Hospital Episode Statistics (HES). The category 'amenity PATIENT' is only applicable to PATIENTS using a Hospital Bed.	an2	01	NHS PATIENT, including Overseas Visitors charged under the National Health Service (Charges to Overseas Visitors) Regulations 1989 (as amended by Statutory Instrument)	All to analyse by administrative category	Used to analyse different outcome depending on administrative category	R
				02	Private PATIENT, one who uses accommodation or services authorised under the National Health Service Act 2006			
				03	Amenity PATIENT, one who pays for the use of a single room or small ward in accordance with the National Health Service Act 2006			
				04	Category II PATIENT, one for whom work is undertaken by hospital medical or dental staff within category II as defined in paragraph 37 of the Terms and Conditions of Service of Hospital Medical and Dental Staff.			

Start of Repeating Group - CYP201 Care Contact

CYP201 Care Contact

Group-level notes for Data Providers:

Care Contact: To carry details of any contacts with a person which have taken place as part of a referral.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
				98	Not applicable			
				99	Not known: a validation error			
C201050	**CLINICAL CONTACT DURATION OF CARE CONTACT**	The total duration of the direct clinical contact at CARE CONTACT in minutes, excluding any administration time prior to or after the CARE CONTACT and the CARE PROFESSIONAL's travelling time to the CARE CONTACT. CLINICAL CONTACT DURATION OF CARE CONTACT includes the time spent on the different CARE ACTIVITIES that may be performed in a single CARE CONTACT. The duration of each CARE ACTIVITY is recorded in CLINICAL CONTACT DURATION OF CARE ACTIVITY. This should be recorded in minutes.	max n4			All to analyse of the data item	Required for reporting on Care Activities, Performance of Care Professionals	R
C201060	**CONSULTATION TYPE**	This indicates the type of consultation for a SERVICE.	an2	01	Initial Consultation	All to analyse of the data item	Needed for Currency & Pricing and Capacity Planning	R
				02	Follow-up Consultation			
C201070	**CARE CONTACT SUBJECT**	The person who was the subject of the Care Contact.	an2	01	Patient	All to analyse of the data item	Required for Reporting on Quality and Performance	R
				02	Patient proxy (in lieu of a contact with the patient)			

SCCI | SCCI | SCCI | SCCI | SCCI | SCCI | SCCI | SCCI | SCCI

Start of Repeating Group - CYP201 Care Contact

CYP201 Care Contact

Group-level notes for Data Providers:

Care Contact: To carry details of any contacts with a person which have taken place as part of a referral.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C201080	**CONSULTATION MEDIUM USED**	Identifies the communication mechanism used to relay information between the CARE PROFESSIONAL and the PERSON who is the subject of the consultation, during a CARE ACTIVITY. The telephone or telemedicine consultation should directly support diagnosis and care planning and must replace a face to face Out-Patient Attendance Consultant, Clinic Attendance Nurse or Clinic Attendance Midwife, types of CARE ACTIVITY. A record of the telephone or telemedicine consultation must be retained in the	an2	01	Face to face communication	All to analyse of the data item	Required for Reporting on Quality and Performance	R
				02	Telephone			
				03	Telemedicine web camera			
				04	Talk type for a person unable to speak			
				05	Email			
				06	Short Message Service (SMS) - Text Messaging			
				98	Other			
C201909	**ACTIVITY LOCATION TYPE CODE**	The type of physical LOCATION where PATIENTS are seen or where SERVICES are provided or from which requests for services are sent.	an3		**Patient main residence or related location**	All to analyse of the data item	Required for reporting on Care Activities, Performance and Pricing	R
				A01	Patient's Home			
				A02	Carer's Home			
				A03	Patient's Workplace			
				A04	Other Patient Related Location			
					Health Centre premises			
				B01	Primary Care Health Centre			
				B02	Polyclinic			
					General Practitioner and Ophthalmic Medical Practitioner Premises			
				C01	General Medical Practitioner Practice			
				C02	Dental Practice			
				C03	Ophthalmic Medical Practitioner premises			
					Walk In Centres, Out of Hours Premises and Emergency Community Dental Services			
				D01	Walk In Centre			
				D02	Out of Hours Centre			
				D03	Emergency Community Dental Service			
					Locations on Hospital Premises			
				E01	Out-Patient Clinic			
				E02	Ward			
				E03	Day Hospital			
				E04	Accident and Emergency or Minor Injuries Department			
				E99	Other departments			
					Hospice premises			
				F01	Hospice			
					Nursing and Residential Homes			
				G01	Care Home Without Nursing			
				G02	Care Home With Nursing			
				G03	Children's Home			

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Start of Repeating Group - CYP201 Care Contact

CYP201 Care Contact

Group-level notes for Data Providers:

Care Contact: To carry details of any contacts with a person which have taken place as part of a referral.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
				G04	Integrated Care Home Without Nursing and Care Home With Nursing			
					Day Centre premises			
				H01	Day Centre			
					Resource Centre premises			
				J01	Resource Centre			
					Dedicated Facilities for Children and Families			
				K01	Sure Start Children's Centre			
				K02	Child Development Centre			
					Educational, Childcare and Training Establishments			
				L01	School			
				L02	Further Education College			
				L03	University			
				L04	Nursery Premises			
				L05	Other Childcare Premises			
				L06	Training Establishments			
				L99	Other Educational Premises			
					Justice and Home Office premises			
				M01	Prison			
				M02	Probation Service Premises			
				M03	Police Station / Police Custody Suite			
				M04	Young Offenders Institute			
				M05	Immigration Removal Centre			
					Public locations			
				N01	Street or other public open space			
				N02	Other publicly accessible area or building			
				N03	Voluntary or charitable agency premises			
				N04	Dispensing Optician premises			
				N05	Dispensing Pharmacy premises			
					Other Locations			
				X01	Other locations not elsewhere classified			

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Start of Repeating Group - CYP201 Care Contact

CYP201 Care Contact

Group-level notes for Data Providers:

Care Contact: To carry details of any contacts with a person which have taken place as part of a referral.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C201906	**SITE CODE (OF TREATMENT)**	SITE CODE (OF TREATMENT) is the ORGANISATION SITE CODE for the ORGANISATION SITE where the PATIENT was treated. This identifies the site within the ORGANISATION on which the PATIENT was treated, since facilities may vary on different hospital sites. The code recorded should always be the national code; if the treatment is sub-commissioned to another provider, the site code used should be that of the provider actually carrying out the work. If the Site Code is not available and only the Organisation Code is available then this field should contain the Organisation Code suffixed with '00' as the site code.	min an5 max an9			All to analyse of the data item	Required for reporting on Care Activities, Performance and Pricing	R
C201090	**GROUP THERAPY INDICATOR**	An indicator of whether a Care Activity was delivered as Group Therapy. Group Therapy is a SESSION where more than one PATIENT attends at the same time, to see one or more CARE PROFESSIONALS. Clinical notes are recorded in each individual PATIENT's casenotes.	an1	Y	Care Activity delivered as Group Therapy	All to analyse of the data item	Required to identify whether activities undertaken for the patient are on a one-to-one basis or delivered as group therapy to multiple patients at the same time.	R
				N	Care Activity delivered individually			
				Z	Not known if the activity was group therapy			
C201100	**ATTENDED OR DID NOT ATTEND CODE**	Indicates whether an APPOINTMENT for a CARE CONTACT took place and if the APPOINTMENT did not take place it whether advanced warning was given.	an1	5	Attended on time or, if late, before the relevant CARE PROFESSIONAL was ready to see the PATIENT	All to analyse of the data item	Required for reporting on number of scheduled activities that did not take place. For reporting on cancellations for clinical and non clinical reasons. For reporting on cancellations by Provider and by Patient.	R
				6	Arrived late, after the relevant CARE PROFESSIONAL was ready to see the PATIENT, but was seen			
				7	PATIENT arrived late and could not be seen			
				2	APPOINTMENT cancelled by, or on behalf of, the PATIENT			
				3	Did not attend - no advance warning given			
				4	APPOINTMENT cancelled or postponed by the Health Care Provider			

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Start of Repeating Group - CYP201 Care Contact								
CYP201 Care Contact						**Group-level notes for Data Providers:** Care Contact: To carry details of any contacts with a person which have taken place as part of a referral.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
C201110	**EARLIEST REASONABLE OFFER DATE**	It is the date of the earliest of the Reasonable Offers made to a PATIENT for an APPOINTMENT or Elective Admission. It should only be included on the Commissioning Data Sets where the PATIENT has declined at least two Reasonable Offers, and a Patient Pause is to be applied to the length of wait calculation performed by the Secondary Uses Service. Patient Cancellations Where, for any reason, a PATIENT cancels or does not attend an APPOINTMENT or an OFFER OF ADMISSION the EARLIEST REASONABLE OFFER DATE for the rearranged APPOINTMENT or OFFER OF ADMISSION will be the EARLIEST REASONABLE OFFER DATE of the cancelled APPOINTMENT or OFFER OF ADMISSION. Provider Cancellations Where, for any reason, any Health Care Provider cancels and re-arranges an APPOINTMENT or an OFFER OF ADMISSION, the EARLIEST REASONABLE OFFER DATE for the re-arranged APPOINTMENT or OFFER OF ADMISSION will be the date of the earliest Reasonable Offer made following the cancellation. Patients who are unavailable Where a PATIENT makes themself unavailable for a longer period of time, for example a PATIENT who is a teacher who wishes to delay their admission until the summer holidays, making a Reasonable Offer may be inappropriate. In these circumstances, so long as the Health Care Provider could have made at least two Reasonable Offers, the EARLIEST REASONABLE OFFER DATE will be the date of the earliest Reasonable Offer that the provider could have offered the PATIENT. This must be communicated to the PATIENT.	an10 ccyy-mm-dd			All to analyse between the data item and other events	Required for measuring Quality & Performance - RTT	R
C201120	**EARLIEST CLINICALLY APPROPRIATE DATE**	The earliest DATE that it was clinically appropriate for an ACTIVITY to take place.	an10 ccyy-mm-dd			All to analyse between the data item and other events	For RTT	R
C201130	**CARE CONTACT CANCELLATION DATE**	The date that a Care Contact was cancelled by the Provider or Patient.	an10 ccyy-mm-dd			All to analyse between the data item and other events	Required for reporting on number of scheduled activities that did not take place.	R

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Start of Repeating Group - CYP201 Care Contact								
CYP201 Care Contact						**Group-level notes for Data Providers:** Care Contact: To carry details of any contacts with a person which have taken place as part of a referral.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
C201140	CARE CONTACT CANCELLATION REASON	The reason that a Care Contact was cancelled.	an2	01	Cancelled for Clinical Reasons	All to analyse between the data item and other events	To monitor reasons for rescheduled appointments and for RTT	R
				02	Cancelled for Non-clinical Reasons			
C201150	REPLACEMENT APPOINTMENT DATE OFFERED	The replacement appointment date offered by the provider to the patient following the cancellation of an appointment by the SERVICE.	an10 CCYY-MM-DD			All to analyse between the data item and other events	This is required to calculate whether a new appointment was offered for a date within 28 calendar days of the cancellation of an appointment for non clinical reasons	R
C201160	REPLACEMENT APPOINTMENT BOOKED DATE	The date that a replacement appointment was booked following the cancellation of an appointment with the patient by the SERVICE.	an10 CCYY-MM-DD			All to analyse between the data item and other events	This is required to calculate whether a new appointment was offered within 5 working days of the cancellation of an appointment for non clinical reasons	R

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Start of Repeating Group - CYP202 Care Activity								
CYP202 Care Activity						**Group-level notes for Data Providers:** Care Activity: To carry details of any activities which have taken place as part of a contact with a person.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
C202904	**CARE ACTIVITY IDENTIFIER**	The unique identifier for a CARE ACTIVITY. It would normally be automatically generated by the local system upon recording a new activity, although could be manually assigned.	max an20			Uniquely identify a care activity	Required for reporting on Care Activities	M
C202903	**CARE CONTACT IDENTIFIER**	The CARE CONTACT IDENTIFIER is used to uniquely identify the CARE CONTACT within the Health Care Provider. It would normally be automatically generated by the local system upon recording a new Care Contact, although could be manually assigned.	max an20			Uniquely identify a care contact	Required for reporting on Care Activities	M
C202010	**COMMUNITY CARE ACTIVITY TYPE CODE**	The type of Care Activity performed during a Care Contact by a CARE PROFESSIONAL.	an2	01	Administering Tests	All to analyse of the data item	Required for reporting on Care Activities	M
				02	Assessment			
				03	Clinical Intervention			
				04	Counselling, Advice, Support			
				05	Patient Specific Health Promotion			
				06	Multidisciplinary Team Review			
				07	Supporting Another Clinician			
				08	Health Visitor New Birth Visit			
				09	Health Visitor Health Review (6-8 weeks)			
				10	Health Visitor Health Review (1 year)			
				11	Health Visitor Health Review (2-2.5 years)			
				12	Health Visitor Formal handover to School Nursing Service (4-5 years)			
				97	Other			
C202020	**CARE PROFESSIONAL LOCAL IDENTIFIER**	CARE PROFESSIONAL LOCAL IDENTIFIER is a unique local CARE PROFESSIONAL IDENTIFIER within a Health Care Provider and may be assigned automatically by the computer system.	max an20			Uniquely identify a care professional	Uniquely identify a care professional	R

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Start of Repeating Group - CYP202 Care Activity

CYP202 Care Activity

Group-level notes for Data Providers:

Care Activity: To carry details of any activities which have taken place as part of a contact with a person.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C202030	CLINICAL CONTACT DURATION OF CARE ACTIVITY	The duration of a CARE ACTIVITY in minutes, excluding any administration time prior to or after the CARE ACTIVITY and the CARE PROFESSIONAL's travelling time to the LOCATION where the CARE ACTIVITY was provided. This is calculated from the Start Time and End Time of the CARE ACTIVITY.	max n4			All for analysis of the data item	Required for reporting on Care Activities, Performance of Care Professionals	R
C202040	PROCEDURE SCHEME IN USE	The code scheme basis of a procedure.	an2	04	Read Coded Clinical Terms Version 2	All for analysis of the data item	Required for reporting on data quality differences between coding schemes	R
				05	Read Coded Clinical Terms Version 3 (CTV3)			
				06	Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®)			
C202050	CODED PROCEDURE (CLINICAL TERMINOLOGY)	A unique identifier for a procedure from a specific clinical terminology.	min an5 max an18			All for analysis of the data item	Required for analysis of the outcomes and activity between different activities or results	R
C202060	FINDING SCHEME IN USE	The code scheme basis of a procedure.	an2	01	ICD-10	All for analysis of the data item	Required for analysis of the outcomes and activity between different activities or results	R
				02	Read Coded Clinical Terms Version 2			
				03	Read Coded Clinical Terms Version 3 (CTV3)			
				04	Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®)			

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Start of Repeating Group - CYP202 Care Activity								
CYP202 Care Activity						**Group-level notes for Data Providers:** Care Activity: To carry details of any activities which have taken place as part of a contact with a person.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
C202070	**CODED FINDING (CODED CLINICAL ENTRY)**	A unique identifier for a finding from a specific classification or clinical terminology.	min an4 max an18			All for analysis of the data item	Required for analysis of the outcomes and activity between different activities or results	R

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Start of Repeating Group - CYP202 Care Activity								
CYP202 Care Activity						**Group-level notes for Data Providers:** Care Activity: To carry details of any activities which have taken place as part of a contact with a person.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
C202080	**OBSERVATION SCHEME IN USE**	The code scheme basis of an observation.	an2	01	Read Coded Clinical Terms Version 2	All for analysis of the data item	Required for analysis of the outcomes and activity between different activities or results	R
				02	Read Coded Clinical Terms Version 3 (CTV3)			
				03	Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®)			
C202090	**CODED OBSERVATION (CLINICAL TERMINOLOGY)**	A unique identifier for an observation from a specific clinical terminology.	min an5 max an18			All for analysis of the data item	Required for analysis of the outcomes and activity between different activities or results	R
C202100	**OBSERVATION VALUE**	The numeric value resulting from a clinical OBSERVATION.	max an10			All for analysis of the data item	Used to compare outcomes between different comparable measurements	R
C202110	**UCUM UNIT OF MEASUREMENT**	The unit of measurement used to measure the result of a clinical OBSERVATION. See http://unitsofmeasure.org/trac/.	max an10			All for analysis of the data item	Used to compare outcomes between different comparable measurements	R

Start of Repeating Group - CYP301 Group Session

CYP301 Group Session

Group-level notes for Data Providers:

Group Sessions: To carry details of any group sessions which have been provided to a group of people during the reporting period.

This data group should include details of all Group Sessions occurring within the reporting period. Cancelled Group Sessions should NOT be reported.

This data group is not linked to the rest of the data set at patient level.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C301010	GROUP SESSION IDENTIFIER	The GROUP SESSION IDENTIFIER is used to uniquely identify the GROUP SESSION within the Health Care Provider. It would normally be automatically generated by the local system upon recording a new Group Session, although could be manually assigned. This may be the same as the Community Care Contact Identifier depending upon the local system.	max an20			Uniquely identify a group session	Required for reporting on Care Activities	M
C301020	GROUP SESSION DATE	The date that a Group Session took place, or, if cancelled, was scheduled to take place. Where a Group Session spans multiple days the Start Date should be reported here. This should be reported in eGIF date format CCYY-MM-DD.	an10 CCYY-MM-DD			All to analyse between the data item and other events	Required for reporting on Care Activities, Performance of Care Professionals	M
C301912	ORGANISATION CODE (CODE OF COMMISSIONER)	This is the ORGANISATION CODE of the ORGANISATION commissioning health care. This should always be the ORGANISATION CODE of the original commissioner for Commissioning Data Sets to support Payment by Results. The Department of Health document "Who pays? Establishing the Responsible Commissioner" sets	an3 or an5			Used to analyse by commissioner	Required for reporting on Commissioning Organisation	M
C301030	CLINICAL CONTACT DURATION OF GROUP SESSION	The duration of a Group Session in minutes, excluding any administration time prior to or after the Group Session and the CARE PROFESSIONAL's travelling time to the LOCATION where the Group Session was provided.	max n4			Used for analysis of data item	Required for reporting on Care Activities, Performance of Care Professionals	R
C301040	GROUP SESSION TYPE CODE (COMMUNITY CARE)	The type of Group Session provided by a Community Health Service.	an2	01	Antenatal Session	Used for analysis of data item	Required for reporting on Group Activities	R
				02	Parent/carer and Child Session			
				03	General Health Promotion Session			
				04	Screening Programme			
				05	Stop Smoking Education Programme			

Start of Repeating Group - CYP301 Group Session

CYP301 Group Session

Group-level notes for Data Providers:

Group Sessions: To carry details of any group sessions which have been provided to a group of people during the reporting period.

This data group should include details of all Group Sessions occurring within the reporting period. Cancelled Group Sessions should NOT be reported.

This data group is not linked to the rest of the data set at patient level.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
				06	Substance Misuse			
				07	Weight Management			
				08	Contraception and Sexual Health			
				98	Other			
C301050	**NUMBER OF GROUP SESSION PARTICIPANTS**	The number of persons who participated in the Group Session excluding the care professionals.	max n3			Used for analysis of data item	Required for reporting on Group Activities in terms of population coverage	R
C301909	**ACTIVITY LOCATION TYPE CODE**	The type of physical LOCATION where PATIENTS are seen or where SERVICES are provided or from which requests for services are sent.	an3		**Patient main residence or related location**	Used for analysis of data item	Required for reporting on Care Activities, Performance and Pricing	O
				A01	Patient's home			
				A02	Carer's home			
				A03	Patient's workplace			
				A04	Other patient related location			
					Health Centre premises			
				B01	Primary Care Health Centre			
				B02	Polyclinic			
					General Practitioner and Ophthalmic Medical Practitioner Premises			
				C01	General Medical Practitioner Practice			
				C02	Dental Practice			
				C03	Ophthalmic Medical Practitioner premises			
					Walk In Centres, Out of Hours Premises and Emergency Community Dental Services			
				D01	Walk In Centre			
				D02	Out of Hours Centre			
				D03	Emergency Community Dental Service			
					Locations on Hospital Premises			
				E01	Out-Patient Clinic			
				E02	Ward			
				E03	Day Hospital			
				E04	Accident and Emergency or Minor Injuries Department			
				E99	Other departments			
					Hospice premises			
				F01	Hospice			
					Nursing and Residential Homes			
				G01	Care Home Without Nursing			
				G02	Care Home With Nursing			

Start of Repeating Group - CYP301 Group Session

CYP301 Group Session

Group-level notes for Data Providers:

Group Sessions: To carry details of any group sessions which have been provided to a group of people during the reporting period.

This data group should include details of all Group Sessions occurring within the reporting period. Cancelled Group Sessions should NOT be reported.

This data group is not linked to the rest of the data set at patient level.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
				G03	Children's Home			
				G04	Integrated Care Home Without Nursing and Care Home With Nursing			
					Day Centre premises			
				H01	Day Centre			
					Resource Centre premises			
				J01	Resource Centre			
					Dedicated Facilities for Children and Families			
				K01	Sure Start Children's Centre			
				K02	Child Development Centre			
					Educational, Childcare and Training Establishments			
				L01	School			
				L02	Further Education College			
				L03	University			
				L04	Nursery Premises			
				L05	Other Childcare Premises			
				L06	Training Establishments			
				L99	Other Educational Premises			
					Justice and Home Office premises			
				M01	Prison			
				M02	Probation Service premises			
				M03	Police Station / Police Custody Suite			
				M04	Young Offenders Institute			
				M05	Immigration Removal Centre			
					Public locations			
				N01	Street or other public open space			
				N02	Other publicly accessible area or building			
				N03	Voluntary or charitable agency premises			
				N04	Dispensing Optician premises			
				N05	Dispensing Pharmacy premises			
					Other Locations			
				X01	Other locations not elsewhere classified			

Start of Repeating Group - CYP301 Group Session

CYP301 Group Session

Group-level notes for Data Providers:

Group Sessions: To carry details of any group sessions which have been provided to a group of people during the reporting period.

This data group should include details of all Group Sessions occurring within the reporting period. Cancelled Group Sessions should NOT be reported.

This data group is not linked to the rest of the data set at patient level.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C301906	SITE CODE (OF TREATMENT)	SITE CODE (OF TREATMENT) is the ORGANISATION SITE CODE for the ORGANISATION SITE where the PATIENT was treated. This identifies the site within the ORGANISATION on which the PATIENT was treated, since facilities may vary on different hospital sites. The code recorded should always be the national code; if the treatment is sub-commissioned to another provider, the site code used should be that of the provider actually carrying out the work. If the Site Code is not available and only the Organisation Code is available then this field should contain the Organisation Code suffixed with '00' as the site code.	min an5 max an9			Used for analysis of data item	Required for reporting on Care Activities, Performance and Pricing	R
C301060	CARE PROFESSIONAL LOCAL IDENTIFIER	CARE PROFESSIONAL LOCAL IDENTIFIER is a unique local CARE PROFESSIONAL IDENTIFIER within a Health Care Provider and may be assigned automatically by the computer system.	max an20			All to identify care professional	Used to uniquely identify a care professional	R
C301905	NHS SERVICE AGREEMENT LINE NUMBER	A number (alphanumeric) to provide a unique identifier for a line within a NHS SERVICE AGREEMENT. An NHS SERVICE AGREEMENT is a formal agreement between a commissioner ORGANISATION and one or more provider ORGANISATIONS for the provision of PATIENT care services.	an10			All to identify a service agreement line	Used to uniquely identify a service agreement line	O

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Start of Repeating Group - CYP401 Special Educational Need Identified

CYP401 Special Educational Need Identified

Group-level notes for Data Providers:
Special Educational Need Identified: To carry details of the child or young person's Special Educational Need.

This group will be collected and submitted by a health organisation involved in a child's or young person's education assessment

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C401901	LOCAL PATIENT IDENTIFIER (EXTENDED)	This is 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.	max an20			All to identify individual	Used to uniquely identify an individual	M
C401010	SPECIAL EDUCATIONAL NEED TYPE	The type of special educational needs of a person	an2	01	Specific Learning Disability	8.1.3.1	Used to compare outcomes and provision for children/young people with disabilities or condition	M
				02	Learning Difficulty			
				03	Emotional and Behavioural Difficulty			
				04	Speech and Communication Difficulty			
				05	Hearing Impairment			
				06	Visual Impairment			
				07	Physical Disability			
				08	Other Difficulty / Disability			
				ZZ	Not Stated (Person asked but declined to provide a response)			

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Start of Repeating Group - CYP402 Safeguarding Vulnerability Factor								
CYP402 Safeguarding Vulnerability Factor						**Group-level notes for Data Providers:** Safeguarding Vulnerability Factor: to carry details of when the child or young person is subject to any safeguarding concerns For children with a number of Safeguarding Vulnerability Factors (SVFs), the group is repeated for each factor. This group of data may be collected and submitted by an organisation registering a child or young person with their service.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
C402901	**LOCAL PATIENT IDENTIFIER (EXTENDED)**	This is 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.	max an20			All to identify individual	Used to uniquely identify an individual	M
C402010	**SAFEGUARDING VULNERABILITY FACTORS TYPE**	The type of Child Safeguarding vulnerability factors identified.	an2	01	Repeat Accident and Emergency Attendances	Used for analysis of data item	To monitor details of children with safeguarding concerns	M
				02	Concerning parent child interaction			
				03	Worrying parent behaviour / Mental Health concerns			
				04	Worrying child behaviour			
				05	Self harm			
				06	Genital injury (excluding Female Genital Mutilation (FGM))			
				07	Referral from Social Services or Police			
				08	Previously known to Social Services			
				09	Significant injury in child (in the last 12 months)			
				10	Domestic abuse			
				11	History inconsistent with injuries			
				12	Disclosure of abuse			
				13	Bullying			
				14	Delay in presentation (Children with frequent minor injuries and there is a delay in presentation to medical staff)			
				16	Female Genital Mutilation (FGM)			
				98	Other			

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Start of Repeating Group - CYP403 Child Protection Plan

CYP403 Child Protection Plan

Group-level notes for Data Providers:

Child Protection Plan: to carry details of when the child or young person is subject to a child protection plan

This group of data may be collected and submitted by an organisation registering a child or young person with their service.

Providers will tend to send this group once when a patient is placed on a Child Protection Plan. Initially, the Child Protection Plan Start Date will be populated only, if the plan is still in force at the end of the reporting period.

Subsequently, a second record will be provided repeating the Child Protection Plan Start Date and also adding the Child Protection Plan End Date value.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C403901	**LOCAL PATIENT IDENTIFIER (EXTENDED)**	This is 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.	max an20			All to identify individual	Used to uniquely identify an individual	M
C403010	**CHILD PROTECTION PLAN REASON CODE**	The reason the Child or Young Person is subject to an active Child Protection Plan.	an2	01	Neglect	Used for analysis of data item	To monitor details of children on a child protection plan	M
				02	Physical abuse			
				03	Emotional abuse			
				04	Sexual abuse			
C403020	**CHILD PROTECTION PLAN START DATE**	The date on which a child / young person is placed on a child protection plan	an10 CCYY-MM-DD			All to analyse between the data item and other events	To monitor details of children on a child protection plan	M
C403030	**CHILD PROTECTION PLAN END DATE**	The date on which a child / young person is removed from a child protection plan	an10 CCYY-MM-DD			All to analyse between the data item and other events	To monitor details of children on a child protection plan	R

SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI
Start of Repeating Group - CYP404 Assistive Technology To Support Disability Type								

CYP404 Assistive Technology To Support Disability Type

Group-level notes for Data Providers:

Child's or Young Person's assistive technology details: To carry details of when technology is used to support a disabled child or young person.

This group of data may be collected and submitted by an organisation registering a child or young person with their service.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C404901	**LOCAL PATIENT IDENTIFIER (EXTENDED)**	This is 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.	max an20			All to identify individual	Used to uniquely identify an individual	M
C404010	**ASSISTIVE TECHNOLOGY FINDING (SNOMED CT)**	The SNOMED CT concept ID which is used to identify the finding relating to the Assistive Technology that a PERSON is dependent on.	min n6 max n18		Refer to CSDS User Guidance for recommended codes	Used for analysis of data item	To monitor data quality details of the technology type	M

SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI

Start of Repeating Group - CYP501 Immunisation

CYP501 Coded Immunisation

Group-level notes for Data Providers:

Child or Young Person's Immunisation Activity: To carry the details of coded immunisation activity for a child or young person.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C501901	LOCAL PATIENT IDENTIFIER (EXTENDED)	This is 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.	max an20			All to identify individual	Used to uniquely identify an individual	M
C501907	IMMUNISATION DATE	The date on which the immunisation was carried out	an10 CCYY-MM-DD			All to analyse between the data item and other events	Analysis of times differences	M
C501010	PROCEDURE SCHEME IN USE	The code scheme basis of a procedure.	an2	04	Read Coded Clinical Terms Version 2	All for analysis of the data item	Required for reporting on data quality differences between coding schemes	M
				05	Read Coded Clinical Terms Version 3 (CTV3)			
				06	Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®)			
C501020	IMMUNISATION PROCEDURE (CLINICAL TERMINOLOGY)	A unique identifier for an immunisation from a specific clinical terminology	min an5 max an18			All for analysis of the data item	The analyse differences in the outcomes and activity depending on immunisation procedure	M
C501908	ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION)	The ORGANISATION CODE of the ORGANISATION carrying out the immunisation.	max an6			Used for analysis of data item	Required for reporting on Care Activities, Performance and Pricing	R

Start of Repeating Group - CYP502 Immunisation

CYP502 Immunisation

Group-level notes for Data Providers:
Child or Young Person's Immunisation Activity: To carry the details of immunisation activity for a child or young person.

SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
C502901	**LOCAL PATIENT IDENTIFIER (EXTENDED)**	This is 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.	max an20			All to identify individual	Used to uniquely identify an individual	M
C502907	**IMMUNISATION DATE**	The date on which the immunisation was carried out	an10 CCYY-MM-DD			All to analyse between the data item and other events	Analysis of times differences	M
C502010	**CHILDHOOD IMMUNISATION TYPE (CHILDREN AND YOUNG PEOPLE'S HEALTH SERVICES)**	Whether or not a child's immunisations are up to date, derived from Red Book 2009	an3	010	Diphtheria	All for analysis of the data item	The analyse differences in the outcomes and activity depending on immunisation type	M
				020	Pertussis			
				030	Tetanus			
				040	Polio			
				050	Haemophilus influenzae type B			
				060	Measles, Mumps, Rubella (MMR)			
				070	Meningococcal serogroup C (MenC)			
				090	Pneumococcal (PCV)			
				100	Low dose Diphtheria			
				110	Human papillomavirus (HPV)			
				120	Rotavirus			
				130	Hepatitis B (Hep B)			
				140	Tuberculosis (BCG)			
				150	Meningococcal serogroup B (MenB)			
C502908	**ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION)**	The ORGANISATION CODE of the ORGANISATION carrying out the immunisation.	max an6			Used for analysis of data item	Required for reporting on Care Activities, Performance and Pricing	R

SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI
Start of Repeating Group - CYP601 Medical History (Previous Diagnosis)								
CYP601 Medical History (Previous Diagnosis)						**Group-level notes for Data Providers:** Medical History: To carry the details of any previous diagnoses for a person which are stated by the patient or patient proxy or recorded in medical notes. These do not necessarily have to have been diagnosed by the organisation submitting the data.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
C601901	**LOCAL PATIENT IDENTIFIER (EXTENDED)**	This is 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.	max an20			All to identify individual	Used to uniquely identify an individual	M
C601913	**DIAGNOSIS SCHEME IN USE**	The code scheme basis of the Diagnosis.	an2	02	ICD-10	Used for analysis of data item	To monitor data quality details of the diagnosis scheme	M
				04	Read Code Version 2			
				05	Read Code Clinical Terms Version 3 (CTV3)			
				06	Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®)			
C601010	**PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY)**	A unique identifier for a CLINICAL DIAGNOSIS from a specific classification or clinical terminology.	min an4 max an18			All for analysis of the data item	The analyse differences in the outcomes and activity depending on previous diagnosis	M
C601020	**DIAGNOSIS DATE**	DIAGNOSIS DATE is the PERSON PROPERTY OBSERVED DATE for the PATIENT DIAGNOSIS.	an10 CCYY-MM-DD			All to analyse between the data item and other events	Analysis of times differences	R

Start of Repeating Group - CYP602 Disability Type

CYP602 Disability Type

Group-level notes for Data Providers:

Disability Type: To carry the details of the type of disability affecting a person, based on their perception or the perception of a patient proxy.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C602901	LOCAL PATIENT IDENTIFIER (EXTENDED)	This is 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.	max an20			All to identify individual	Used to uniquely identify an individual	M
C602010	DISABILITY CODE	An indication of whether a PERSON is disabled.	an2	01	Behaviour and Emotional	Used for analysis of data item	The analyse differences in the outcomes and activity depending on disability code	M
				02	Hearing			
				03	Manual Dexterity			
				04	Memory or ability to concentrate, learn or understand (Learning Disability)			
				05	Mobility and Gross Motor			
				06	Perception of Physical Danger			
				07	Personal, Self Care and Continence			
				08	Progressive Conditions and Physical Health (such as HIV, cancer, multiple sclerosis, fits etc)			
				09	Sight			
				10	Speech			
				XX	Other			
				NN	No Disability			
				ZZ	Not Stated (Person asked but declined to provide a response)			
C602020	DISABILITY IMPACT PERCEPTION	The patient's perception of whether their day-to-day activities are limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months.	an2	01	Yes – limited a lot	Used for analysis of data item	The analyse differences in the outcomes and activity depending on impact of disability	R
				02	Yes – limited a little			
				03	No			
				04	Prefer not to say			

SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI

Start of Repeating Group - CYP603 Newborn Hearing Screening Audiology Referral

CYP603 Newborn Hearing Screening Audiology Referral

Group-level notes for Data Providers:

Newborn Hearing Screening Audiology Referral: To carry the details of how concerns following newborn hearing screening are followed up

This group may need to be compiled from Care Activity and Diagnosis sections

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C603901	**LOCAL PATIENT IDENTIFIER (EXTENDED)**	This is 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.	max an20			All to identify individual	Used to uniquely identify an individual	M
C603010	**NEWBORN HEARING SCREENING OUTCOME**	Outcome of NEWBORN HEARING SCREENING	an2	01	Clear response, no follow up required	1.4	To monitor the outcomes for those babies referred from Newborn Hearing Screening, Blood Spot Screening and Newborn and 6-8 week physical screening	R
				02	Clear response, targeted follow-up required			
				03	No clear response, bilateral referral			
				04	No clear response, unilateral referral			
				98	Incomplete			
C603020	**SERVICE REQUEST DATE (NEWBORN HEARING AUDIOLOGY)**	The date on which a referral for audiology testing was made	an10 CCYY-MM-DD			1.4.1	Monitor outcomes from newborn hearing screening	R
C603030	**PROCEDURE DATE (NEWBORN HEARING AUDIOLOGY)**	The date that a NEWBORN HEARING AUDIOLOGY TEST took place.	an10 CCYY-MM-DD			All to analyse between the data item and other events	Analysis of date differences	R
C603040	**NEWBORN HEARING AUDIOLOGY OUTCOME**	The outcome of audiology testing	an2	01	Hearing satisfactory	1.4.1	Monitor outcomes from newborn hearing screening	R
				02	Confirmed bilateral hearing loss			
				03	Confirmed unilateral hearing loss			

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Start of Repeating Group - CYP603 Newborn Hearing Screening Audiology Referral

CYP603 Newborn Hearing Screening Audiology Referral

Group-level notes for Data Providers:

Newborn Hearing Screening Audiology Referral: To carry the details of how concerns following newborn hearing screening are followed up

This group may need to be compiled from Care Activity and Diagnosis sections

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
				04	Diagnostic testing in progress			
				05	Diagnostic testing pending			

SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI
Start of Repeating Group - CYP604 Blood Spot Result								
CYP604 Blood Spot Result						**Group-level notes for Data Providers:** Blood Spot Result Follow up: To carry the details of the results of blood spot tests.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
C604901	**LOCAL PATIENT IDENTIFIER (EXTENDED)**	This is 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.	max an20			All to identify individual	Used to uniquely identify an individual	M
C604010	**BLOOD SPOT CARD COMPLETION DATE**	The blood SAMPLE COLLECTION DATE for a Newborn Blood Spot Test for a Neonate.	an10 CCYY-MM-DD			All to analyse between the data item and other events	Used to identify what date blood tests relate to.	R
C604020	**NEWBORN BLOOD SPOT TEST RESULT RECEIVED DATE**	The date that a BLOOD SPOT TEST RESULT was received by a Health Care Provider from the testing laboratory.	an10 CCYY-MM-DD			All to analyse between the data item and other events	Analysis of date differences	R
C604030	**NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (PHENYLKETONURIA)**	Result of screening for PKU	an2	01	Specimen received in laboratory	1.4	To monitor the outcomes for those babies referred from Newborn Hearing Screening, Blood Spot Screening and Newborn and 6-8 week physical screening	R
				02	Screening declined			
				03	Repeat / Further sample required			
				04	Condition not suspected			
				07	Condition not suspected, other disorders follow up			
				08	Condition suspected			
				09	Not screened/screening incomplete			
C604040	**NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (SICKLE CELL DISEASE)**	Result of screening for SCD	an2	01	Specimen received in laboratory	1.4	To monitor the outcomes for those babies referred from Newborn Hearing Screening, Blood Spot Screening and Newborn and 6-8 week physical screening	R
				02	Screening declined			
				03	Repeat / Further sample required			

Start of Repeating Group - CYP604 Blood Spot Result

CYP604 Blood Spot Result

Group-level notes for Data Providers:

Blood Spot Result Follow up: To carry the details of the results of blood spot tests.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
				04	Condition not suspected			
				05	Carrier			
				06	Sickle Cell Disease not suspected, carrier of other haemoglobin			
				07	Condition not suspected, other disorders follow up			
				08	Condition suspected			
				09	Not screened/screening incomplete			
				10	Haemoglobin S not suspected (by DNA) No other haemoglobin/thalassemia excluded			
C604050	**NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (CYSTIC FIBROSIS)**	Result of screening for CF	an2	01	Specimen received in laboratory	1.4	To monitor the outcomes for those babies referred from Newborn Hearing Screening, Blood Spot Screening and Newborn and 6-8 week physical screening	R
				02	Screening declined			
				03	Repeat / Further sample required			
				04	Condition not suspected			
				05	Carrier			
				07	Condition not suspected, other disorders follow up			
				08	Condition suspected			
				09	Not screened/screening incomplete			
C604060	**NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (CONGENITAL HYPOTHYROIDISM)**	Result of screening for CHT	an2	01	Specimen received in laboratory	1.4	To monitor the outcomes for those babies referred from Newborn Hearing Screening, Blood Spot Screening and Newborn and 6-8 week physical screening	R
				02	Screening declined			
				03	Repeat / Further sample required			
				04	Condition not suspected			
				07	Condition not suspected, other disorders follow up			
				08	Condition suspected			
				09	Not screened/screening incomplete			
C604070	**NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (MEDIUM CHAIN ACYL-COA DEHYDROGENASE DEFICIENCY)**	Result of screening for MCADD	an2	01	Specimen received in laboratory	1.4	To monitor the outcomes for those babies referred from Newborn Hearing Screening, Blood Spot Screening and Newborn and 6-8 week physical screening	R
				02	Screening declined			
				03	Repeat / Further sample required			
				04	Condition not suspected			
				05	Carrier			
				07	Condition not suspected, other disorders follow up			

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Start of Repeating Group - CYP604 Blood Spot Result

CYP604 Blood Spot Result

Group-level notes for Data Providers:

Blood Spot Result Follow up: To carry the details of the results of blood spot tests.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
				08	Condition suspected			
				09	Not screened/screening incomplete			
C604080	**NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (HOMOCYSTINURIA)**	Result of screening for HCU	an2	01	Specimen received in laboratory	1.4	To monitor the outcomes for those babies referred from Newborn Hearing Screening, Blood Spot Screening and Newborn and 6-8 week physical screening	R
				02	Screening declined			
				03	Repeat / Further sample required			
				04	Condition not suspected			
				07	Condition not suspected, other disorders follow up			
				08	Condition suspected			
				09	Not screened/screening incomplete			

SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI

Start of Repeating Group - CYP604 Blood Spot Result

CYP604 Blood Spot Result

Group-level notes for Data Providers:

Blood Spot Result Follow up: To carry the details of the results of blood spot tests.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C604090	NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (MAPLE SYRUP URINE DISEASE)	Result of screening for MSUD	an2	01	Specimen received in laboratory	1.4	To monitor the outcomes for those babies referred from Newborn Hearing Screening, Blood Spot Screening and Newborn and 6-8 week physical screening	R
				02	Screening declined			
				03	Repeat / Further sample required			
				04	Condition not suspected			
				07	Condition not suspected, other disorders follow up			
				08	Condition suspected			
				09	Not screened/screening incomplete			
C604100	NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (GLUTARIC ACIDURIA TYPE 1)	Result of screening for GA1	an2	01	Specimen received in laboratory	1.4	To monitor the outcomes for those babies referred from Newborn Hearing Screening, Blood Spot Screening and Newborn and 6-8 week physical screening	R
				02	Screening declined			
				03	Repeat / Further sample required			
				04	Condition not suspected			
				07	Condition not suspected, other disorders follow up			
				08	Condition suspected			
				09	Not screened/screening incomplete			
C604110	NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (ISOVALERIC ACIDURIA)	Result of screening for IVA	an2	01	Specimen received in laboratory	1.4	To monitor the outcomes for those babies referred from Newborn Hearing Screening, Blood Spot Screening and Newborn and 6-8 week physical screening	R
				02	Screening declined			
				03	Repeat / Further sample required			
				04	Condition not suspected			
				07	Condition not suspected, other disorders follow up			
				08	Condition suspected			
				09	Not screened/screening incomplete			

SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI
Start of Repeating Group - CYP605 Infant Physical Examination (GP Delivered)								
CYP605 Infant Physical Examination (GP Delivered)						**Group-level notes for Data Providers:** Infant Physical Examination: To carry the details of the Infant physical examination carried out by the GP.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
C605901	**LOCAL PATIENT IDENTIFIER (EXTENDED)**	This is 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.	max an20			All to identify individual	Used to uniquely identify an individual	M
C605010	**INFANT PHYSICAL EXAMINATION DATE**	The date that the PHYSICAL EXAMINATION of the INFANT took place	an10 CCYY-MM-DD			All to analyse between the data item and other events	Analysis of date differences	M
C605020	**INFANT PHYSICAL EXAMINATION RESULT (HIPS)**	Whether or not a problem was detected or suspected with hips	an2	01	Satisfactory	1.4	To monitor the outcomes for those babies referred from Newborn Hearing Screening, Blood Spot Screening and Newborn and physical screening	R
				02	Problem Identified			
				03	Problem Suspected			
				NN	Not examined			
C605030	**INFANT PHYSICAL EXAMINATION RESULT (HEART)**	Whether or not a problem was detected or suspected with the heart	an2	01	Satisfactory	1.4	To monitor the outcomes for those babies referred from Newborn Hearing Screening, Blood Spot Screening and Newborn and physical screening	R
				02	Problem Identified			
				03	Problem Suspected			
				NN	Not examined			
C605040	**INFANT PHYSICAL EXAMINATION RESULT (EYES)**	Whether or not a problem was detected or suspected with the eyes	an2	01	Satisfactory	1.4	To monitor the outcomes for those babies referred from Newborn Hearing Screening, Blood Spot Screening and Newborn and physical screening	R
				02	Problem Identified			
				03	Problem Suspected			
				NN	Not examined			
C605050	**INFANT PHYSICAL EXAMINATION RESULT (TESTES)**	Whether or not a problem was detected or suspected with the testes	an2	01	Satisfactory	1.4	To monitor the outcomes for those babies referred from Newborn Hearing Screening, Blood Spot Screening and Newborn and physical screening	R
				02	Problem Identified			
				03	Problem Suspected			

SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI
Start of Repeating Group - CYP605 Infant Physical Examination (GP Delivered)								
CYP605 Infant Physical Examination (GP Delivered)						**Group-level notes for Data Providers:** Infant Physical Examination: To carry the details of the Infant physical examination carried out by the GP.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
				NN	Not examined			

SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI
ng Group - CYP606 Provisional Diagnosis							
Provisional Diagnosis					**Group-level notes for Data Providers:** Provisional Diagnosis: To carry the details of a provisional diagnosis for a person made by the service that they were referred to.		
Data Item Name (Data Dict Element)	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
SERVICE REQUEST IDENTIFIER	The unique identifier for a SERVICE REQUEST. It would normally be automatically generated by the local system upon recording a new Referral, although could be manually assigned.	max an20			Linkage item	Relationship key to allow data linkage between referral and activity (this will normally be the referral identifier).	M
DIAGNOSIS SCHEME IN USE	The code scheme basis of a diagnosis.	an2	02	ICD-10	Used for analysis of data item	To monitor data quality details of the diagnosis scheme	M
			04	Read Code Version 2			
			05	Read Code Clinical Terms Version 3 (CTV3)			
			06	Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®)			
PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY)	This is the provisional DIAGNOSIS of the person, from a specific classification or clinical terminology, for the main condition treated or investigated during the relevant episode of healthcare.	min an4 max an18			All for analysis of the data item	The analyse differences in the outcomes and activity depending on provisional diagnosis	M
PROVISIONAL DIAGNOSIS DATE	The date of diagnosis.	an10 CCYY-MM-DD			All to analyse between the data item and other events	Analysis of times differences	R

ting Group - CYP607 Primary Diagnosis

7 Primary Diagnosis

Group-level notes for Data Providers:

Primary Diagnosis: To carry the details of the primary diagnosis for a person made by the service that they were referred to.

Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
SERVICE REQUEST IDENTIFIER	The unique identifier for a SERVICE REQUEST. It would normally be automatically generated by the local system upon recording a new Referral, although could be manually assigned.	max an20			Linkage item	Relationship key to allow link data linkage between referral and activity (this will normally be the referral identifier).	M
DIAGNOSIS SCHEME IN USE	The code scheme basis of a diagnosis.	an2	02	ICD-10	Used for analysis of data item	To monitor data quality details of the diagnosis scheme	M
			04	Read Code Version 2			
			05	Read Code Clinical Terms Version 3 (CTV3)			
			06	Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®)			
PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY)	This is the primary diagnosis of the patient, from a specific classification or clinical terminology, for the main condition treated or investigated during the relevant episode of healthcare, and where there is no definitive diagnosis, the main symptom, abnormal findings or problem.	min an4 max an18			All for analysis of the data item	The analyse differences in the outcomes and activity depending on primary diagnosis	M

SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI	SCCI
ting Group - CYP607 Primary Diagnosis							
7 Primary Diagnosis					**Group-level notes for Data Providers:** Primary Diagnosis: To carry the details of the primary diagnosis for a person made by the service that they were referred to.		
Data Item Name (Data Dict Element)	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
DIAGNOSIS DATE	The date of the primary diagnosis.	an10 CCYY-MM-DD			All to analyse between the data item and other events	Analysis of times differences	R

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ting Group - CYP608 Secondary Diagnosis

8 Secondary Diagnosis

Group-level notes for Data Providers:

Secondary Diagnosis: To carry the details of a secondary diagnosis for a person made by the service that they were referred to.

Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
SERVICE REQUEST IDENTIFIER	The unique identifier for a SERVICE REQUEST. It would normally be automatically generated	max an20			Linkage item	Relationship key to allow link data linkage between referral and activity (this will normally be the referral identifier).	M
DIAGNOSIS SCHEME IN USE	The code scheme basis of a diagnosis.	an2	02	ICD-10	Used for analysis of data item	To monitor data quality details of the diagnosis scheme	M
			04	Read Code Version 2			
			05	Read Code Clinical Terms Version 3 (CTV3)			
			06	Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®)			
SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY)	This is any other diagnosis other than the primary diagnosis, from a specific classification or clinical terminology. Multiple Secondary Diagnoses may be recorded.	min an4 max an18			All for analysis of the data item	The analyse differences in the outcomes and activity depending on secondary	M
DIAGNOSIS DATE	The date of the secondary diagnosis.	an10 CCYY-MM-DD			All to analyse between the data item and other events	Analysis of times differences	R

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Start of Repeating Group - CYP609 Coded Scored Assessment (Referral)

CYP609 Coded Scored Assessment (Referral)

Group-level notes for Data Providers:

Coded Scored Assessment (Referral): To carry details of scored assessments that are issued and completed as part of a referral period where a specific service or team is responsible for the person, but do not take place at a specific contact.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C609902	SERVICE REQUEST IDENTIFIER	The unique identifier for a SERVICE REQUEST. It would normally be automatically generated by the local system upon recording a new Referral, although could be manually assigned.	max an20			Linkage item	Relationship key to allow link data linkage between referral and activity (this will normally be the referral identifier).	M
C609910	CODED ASSESSMENT TOOL TYPE (SNOMED CT)	The SNOMED CT concept ID which is used to identify an ASSESSMENT in SNOMED CT.	min n6 max n18			Used for analysis of data item	To monitor outcomes and activities depending on Coded Assessments	M
C609911	PERSON SCORE	The observable value (score) resulting from an ASSESSMENT.	max an5			Used for analysis of data item	To monitor outcomes and activities and quantify	M

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Start of Repeating Group - CYP610 Breastfeeding Status

CYP610 Breastfeeding Status

Group-level notes for Data Providers:
Breastfeeding Status: To carry details of a child's breastfeeding status as recorded at a contact.

This group may be derived from data collected routinely by health visiting staff.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C610904	**CARE ACTIVITY IDENTIFIER**	The unique identifier for a CARE ACTIVITY. It would normally be automatically generated by the local system upon recording a new activity, although could be manually assigned.	max an20			Uniquely identify a care activity	Required for reporting on Care Activities	M
C610010	**BREASTFEEDING STATUS**	This is the type of feed a baby is receiving	an2	01	Exclusively Breast Milk Feeding	1.8.1.1	To monitor breastfeeding rates	M
				02	Partially Breast Milk Feeding			
				03	No Breast Milk Feeding at all			

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Start of Repeating Group - CYP611 Observation

CYP611 Observation

Group-level notes for Data Providers:

Observation: To carry the details of observations of a person which take place at a contact.

This group will be collected and submitted as part of the Care Activity

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C611904	**CARE ACTIVITY IDENTIFIER**	The unique identifier for a CARE ACTIVITY. It would normally be automatically generated by the local system upon recording a new activity, although could be manually assigned.	max an20			Uniquely identify a care activity	Required for reporting on Care Activities	M
C611010	**PERSON WEIGHT**	PERSON WEIGHT is the result of the Clinical Investigation which measures the PATIENT's Weight, where the UNIT OF MEASUREMENT is 'Kilograms (kg)'.	max n3.max n3			9.1.3.1	To monitor whether or not a recent measurement had been taken when prescribing drugs by body weight. Also to monitor obesity	R
C611020	**PERSON HEIGHT IN METRES**	PERSON HEIGHT IN METRES is the result of the Clinical Investigation which measures the PATIENT's Height, where the UNIT OF MEASUREMENT is 'Metres (m)'.	n1.maxn2			9.1.3.1	To monitor growth and obesity	R
C611030	**PERSON LENGTH IN CENTIMETRES**	PERSON LENGTH IN CENTIMETRES is the Length of the PATIENT, where the UNIT OF MEASUREMENT is 'Centimetres (cm)'.	max n2.n1		The length of the patient (in centimetres) should be recorded. **Default code below:**	9.1.3.1	To monitor growth and obesity	R
				99.9	Length unknown			

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Start of Repeating Group - CYP612 Coded Scored Assessment (Contact)

CYP612 Coded Scored Assessment (Contact)

Group-level notes for Data Providers:

Coded Scored Assessment: To carry details of scored assessments that are issued and completed as part of a specific contact.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C612904	CARE ACTIVITY IDENTIFIER	The unique identifier for a CARE ACTIVITY. It would normally be automatically generated by the local system upon recording a new activity, although could be manually assigned.	max an20			Uniquely identify a care activity	Required for reporting on Care Activities	M
C612910	CODED ASSESSMENT TOOL TYPE (SNOMED CT)	The SNOMED CT concept ID which is used to identify an ASSESSMENT in SNOMED CT.	min n6 max n18			Used for analysis of data item	To monitor outcomes and activities depending on Coded Assessments	M
C612911	PERSON SCORE	The observable value (score) resulting from an ASSESSMENT.	max an5			Used for analysis of data item	To monitor outcomes and activities and quantify	M

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Start of Repeating Group - CYP613 Anonymous Self-Assessment								
CYP613 Anonymous Self-Assessment						**Group-level notes for Data Providers:** Anonymous Self-Assessment: To carry details of anonymous assessments that are issued by the community health service. This data group is not linked to the rest of the data set at patient level. There are currently no assessment tools in scope for CYP613AnonSelfAssessment.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
C613010	**ASSESSMENT TOOL COMPLETION DATE**	SELF ASSESSMENT COMPLETION DATE is the DATE the completed ASSESSMENT was received.	an10 CCYY-MM-DD			All to analyse between the data item and other events	Analysis of times differences	M
C613910	**CODED ASSESSMENT TOOL TYPE (SNOMED CT)**	The SNOMED CT concept ID which is used to identify an ASSESSMENT in SNOMED CT.	min n6 max n18			Used for analysis of data item	To monitor outcomes and activities depending on Coded Assessments	M
C613911	**PERSON SCORE**	The observable value (score) resulting from an ASSESSMENT.	max an5			Used for analysis of data item	To monitor outcomes and activities and quantify	M
C613909	**ACTIVITY LOCATION TYPE CODE**	The type of physical LOCATION where PATIENTS complete the self assessment.	an3		**Patient main residence or related location**	Used for analysis of data item	To monitor self-assessment outcomes and completion rates depending on location	R
				A01	Patient's home			
				A02	Carer's home			
				A03	Patient's workplace			
				A04	Other patient related location			
					Health Centre premises			
				B01	Primary Care Health Centre			
				B02	Polyclinic			
					General Practitioner and Ophthalmic Medical Practitioner Premises			
				C01	General Medical Practitioner Practice			
				C02	Dental Practice			
				C03	Ophthalmic Medical Practitioner premises			
					Walk In Centres, Out of Hours Premises and Emergency Community Dental Services			
				D01	Walk In Centre			
				D02	Out of Hours Centre			
				D03	Emergency Community Dental Service			
					Locations on Hospital Premises			
				E01	Out-Patient Clinic			

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Start of Repeating Group - CYP613 Anonymous Self-Assessment								
CYP613 Anonymous Self-Assessment						**Group-level notes for Data Providers:** Anonymous Self-Assessment: To carry details of anonymous assessments that are issued by the community health service. This data group is not linked to the rest of the data set at patient level. There are currently no assessment tools in scope for CYP613AnonSelfAssessment.		
				E02	Ward			
				E03	Day Hospital			
				E04	Accident and Emergency or Minor Injuries Department			
				E99	Other departments			
					Hospice premises			
				F01	Hospice			
					Nursing and Residential Homes			
				G01	Care Home Without Nursing			
				G02	Care Home With Nursing			
				G03	Children's Home			
				G04	Integrated Care Home Without Nursing and Care Home With Nursing			
					Day Centre premises			
				H01	Day Centre			
					Resource Centre premises			
				J01	Resource Centre			
					Dedicated Facilities for Children and Families			
				K01	Sure Start Children's Centre			
				K02	Child Development Centre			
					Educational, Childcare and Training Establishments			
				L01	School			
				L02	Further Education College			
				L03	University			
				L04	Nursery Premises			
				L05	Other Childcare Premises			
				L06	Training Establishments			
				L99	Other Educational Premises			
					Justice and Home Office premises			
				M01	Prison			
				M02	Probation Service premises			
				M03	Police Station / Police Custody Suite			
				M04	Young Offenders Institute			
				M05	Immigration Removal Centre			
					Public locations			
				N01	Street or other public open space			
				N02	Other publicly accessible area or building			
				N03	Voluntary or charitable agency premises			
				N04	Dispensing Optician premises			
				N05	Dispensing Pharmacy premises			
					Other Locations			
				X01	Other locations not elsewhere classified			

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Start of Repeating Group - CYP613 Anonymous Self-Assessment								
CYP613 Anonymous Self-Assessment						**Group-level notes for Data Providers:** Anonymous Self-Assessment: To carry details of anonymous assessments that are issued by the community health service. This data group is not linked to the rest of the data set at patient level. There are currently no assessment tools in scope for CYP613AnonSelfAssessment.		
C613912	**ORGANISATION CODE (CODE OF COMMISSIONER)**	This is the ORGANISATION CODE of the ORGANISATION commissioning health care. This should always be the ORGANISATION CODE of the original commissioner for Commissioning Data Sets to support Payment by Results. The Department of Health document "Who pays? Establishing the Responsible Commissioner" sets out a framework for establishing responsibility for commissioning an individual's care within the NHS, (i.e. determining who pays for a PATIENT's care.) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078466 Further guidance is available on the NHS Data Dictionary Website: http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/o/org/organisation_code_(code_of_commissioner)_de.asp?shownav=1	an3 or an5			Used to analyse by commissioner	Required for identifying the Commissioner responsible for payment	R

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Start of Repeating Group - CYP901 Staff Details

CYP901 Staff Details

Group-level notes for Data Providers:

Staff Details: to carry details of the staff involved in the treatment of a person.

XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
C901010	**CARE PROFESSIONAL LOCAL IDENTIFIER**	CARE PROFESSIONAL LOCAL IDENTIFIER is a unique local CARE PROFESSIONAL IDENTIFIER within a Health Care Provider and may be assigned automatically by the	max an20			Uniquely identify a care professional	Required for reporting on Care Professionals	M
C901020	**PROFESSIONAL REGISTRATION BODY CODE**	A code which identifies the PROFESSIONAL REGISTRATION BODY or Representative Body.	an2	01	General Chiropractic Council	Used for analysis of data item	To monitor outcomes depending on professional registration	R
				02	General Dental Council			
				03	General Medical Council			
				04	General Optical Council			
				05	Care Council for Wales			
				08	Health and Care Professions Council			
				09	Nursing and Midwifery Council			
				16	General Pharmaceutical Council			
C901030	**PROFESSIONAL REGISTRATION ENTRY IDENTIFIER**	The registration identifier allocated by an ORGANISATION.	max an32			All to confirm status of professional registration body code	Used to uniquely identify an professional registration body	R
C901040	**CARE PROFESSIONAL STAFF GROUP (COMMUNITY CARE)**	The staff group of a CARE PROFESSIONAL working in a Community Health Service.	an3		**Allied Health Professionals**	Used for analysis of data item	Required for reporting on Care Activities, Performance of Care Professionals	R
				A01	Art Therapist			
				A02	Clinical Psychologist			
				A03	Dietitian			
				A04	Drama Therapist			
				A05	Music Therapist			
				A06	Occupational Therapist			
				A07	Orthotist			
				A08	Physiotherapist			
				A09	Podiatrist			
				A10	Prosthetist			
				A11	Psychotherapist			
				A12	Radiographer			
				A13	Speech and Language Therapist			
				A14	Orthoptist			
					Medical/Dental			
				M01	Community Dentist			
				M02	Consultant			
				M03	General Medical Practitioner			
				M04	General Medical Practitioner with Special Interest			
					Nursing, Health Visitors and Midwifery			
				N01	Community Midwife			
				N02	District Nurse			
				N03	Health Visitor			
				N04	Macmillan Nurse			
				N05	School Nurse			

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Start of Repeating Group - CYP901 Staff Details								
CYP901 Staff Details						Group-level notes for Data Providers: Staff Details: to carry details of the staff involved in the treatment of a person.		
XML Schema Element Name	Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition	Info Req Ref	Information Requirements (Purpose)	Mandatory/ Required/ Optional
				N06	Specialist Nursing - Active Case Management (Community Matrons)			
				N07	Specialist Nursing - Arthritis Nursing / Liaison			
				N08	Specialist Nursing - Asthma and Respiratory Nursing / Liaison			
				N09	Specialist Nursing - Breast Care Nursing / Liaison			
				N10	Specialist Nursing - Cancer Related			
				N11	Specialist Nursing - Cardiac Nursing / Liaison			
				N12	Specialist Nursing - Children's Services			
				N13	Specialist Nursing - Community Cystic Fibrosis			
				N14	Specialist Nursing - Continence Services			
				N15	Specialist Nursing - Diabetic Nursing / Liaison			
				N16	Specialist Nursing - Enteral Feeding Nursing Services			
				N17	Specialist Nursing - Haemophilia Nursing Services			
				N19	Specialist Nursing - Infectious Diseases			
				N20	Specialist Nursing - Intensive Care Nursing			
				N21	Specialist Nursing - Palliative / Respite Care			
				N22	Specialist Nursing - Parkinson and Alzheimer Nursing / Liaison			
				N23	Specialist Nursing - Rehabilitation Nursing			
				N24	Specialist Nursing - Stoma Care Services			
				N25	Specialist Nursing - Tissue Viability Nursing / Liaison			
				N26	Specialist Nursing - Transplantation Patients Nursing Services			
				N27	Specialist Nursing - Treatment Room Nursing Services			
				N28	Specialist Nursing - Tuberculosis Specialist Nursing			
				N29	Specialist Nursing - Other Specialist Nursing			
				N30	Specialist Nursing - Safeguarding			
				N32	Staff Nurse			
				N33	Other Registered Nurse			
				N34	Public Health Nurse			
					Other Care Professionals			
				C01	Appliances Technician			
				C02	Audiologist			
				C03	Counsellor			
				C04	Nursery Nurse			

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Start of Repeating Group - CYP901 Staff Details								
CYP901 Staff Details						**Group-level notes for Data Providers:** Staff Details: to carry details of the staff involved in the treatment of a person.		
XML Schema Element Name	**Data Item Name (Data Dict Element)**	**Data Item Description**	**Format**	**National Code**	**National Code Definition**	**Info Req Ref**	**Information Requirements (Purpose)**	**Mandatory/ Required/ Optional**
				C06	Play Therapist			
				C07	Social Worker			
				C08	Voluntary Care Worker			
				C09	Screener (in a National Screening Programme)			
				C10	Health Trainer (Non Clinical)			
				C11	Health Trainer (Clinical)			
				C12	Health Care Assistant			
				C13	Health Care Support Worker			
				C99	Other Care Professional			
C901050	**OCCUPATION CODE**	An NHS OCCUPATION CODE for an EMPLOYEE filling a POSITION. The NHS OCCUPATION CODES are maintained by the Health and Social Care Information Centre, on behalf of the Department of Health and can be viewed in the NHS Occupation Code Manual.	an3			Used for analysis of data item	To monitor outcomes depending on NHS occupation	R
C901060	**CARE PROFESSIONAL (JOB ROLE CODE)**	A National Code for a POSITION applicable to an EMPLOYEE.	an5			Used for analysis of data item	To monitor outcomes depending on care professional job role	R

CSDS INPA

Items from

Annexe E: Responses to EMT suggestions

This document provides responses and explanations of EMT feedbacks and suggestions:

Feedback 1:

Martin Severs, Clinical Director and Caldicott Guardian, has asked that we put a clause in the directions so that we are data controller and have the rights over whether we publish or not.

Response:

It has been confirmed between NHS England and NHS Digital Information Governance (IG) that it is not within the remit of directions to determine data controllership. However NHS England will be addressing this issue by other means. NHS England will not be amending directions currently in draft to add in a statement about data controllership.

NHS Digital IG have confirmed this with Martin Severs (email attached).

Feedback 2:

The link to Data Services Platform (DSP) needed to be made.

Response:

The data is currently landed via the Bureau Service Portal (BSP) but we would consider use of the Data Services Platform (DSP) for future versions of the data set. NHS Digital has continued to use the BSP for CSDS because it is already used for CYPHS data set submissions and the CSDS is heavily based on the CYPHS data set with minimal changes introduced.

Feedback 3:

The burden assessment wasn't clear.

The EMT paper does not sufficiently reflect the burden on the NHS, i.e. it does not recognise that the NHS will be taking on additional work. Neither does it sufficiently refer to it being beneficial to collect the additional data.

The Board paper must include sufficient detail that the NHS is taking on an additional burden, but then needs to note the considerable benefits that the NHS will gain from collecting the additional data. It also needs to refer to the cost of collecting the data, and how this will be offset by the benefits outweighing the costs.

Response:

The burden on the NHS created by the Community Services Data Set (CSDS) was assessed by the Burden Advice and Assessment Service (BAAS) as part of gaining acceptance from the Standardisation Committee for Care Information (SCCI) of the CSDS Information Standards Notice. Both the standard's developers and SCCI supported the findings of the BAAS assessment.

The CSDS is based heavily on the existing Children and Young People's Health Services (CYPHS) data set, which shares the same structure and data items but only includes patients aged 0-19. The CSDS removes this age restriction, but otherwise remains almost identical to the CYPHS data set. This approach was deliberately taken in order to minimise changes and, consequently, reduce burden on provider organisations.

The burden assessment found the total cost of the CSDS (including staff, training, IT/system and other costs) to be £2,965k across all applicable providers (around 150 in total). All trusts assessed as part of the burden assessment reported that there would be little to no change in burden between CSDS and the existing CYPHS data set. The actual increase in total burden compared with the CYPHS data set burden assessment in 2014 was £53k, caused by the inclusion of a small number of additional organisations that only provide adult services and will now have to submit CSDS data centrally.

Measures have been taken to reduce the burden on providers, for example through the central development of an XML conversion tool by NHS Digital to allow providers to submit data in the required XML format without the need for accreditation or support from middleware providers. The ongoing support for this tool, or an equivalent solution, is currently being determined at a corporate level.

The readiness/capability of care providers and their system suppliers, and any unanticipated additional burden, will be assessed through the use of a state of readiness questionnaire before the CSDS goes live. The developers have also committed to an early implementation review, planned for April 2018, and the BAAS assessment will be reviewed as part of this to ensure that any additional costs are identified and mitigated.

Benefits:

Considerable benefits will be realised through the collection of the CSDS data, and these were taken into account by SCCI when accepting the change to the existing CYPHS data set Information Standard:

National:	Providers/commissioners:	Patients:
▪ Support for the delivery of the outcomes of the Five Year Forward View, including the development and implementation of the New Models of Care. ▪ Reliable, managed, national, comparable and standardised data about Community Services that are being delivered, which will support intelligent commissioning decisions and service provision and assist with the future development of Community Services. ▪ Reduction of local data flows between providers, commissioners and Data Services for Commissioners Regional Offices (DSCROs), by retiring the local-only Community Information Data Set (CIDS). ▪ Improved information about service quality, including comparative information about service providers (benchmarking). ▪ Support for current national outcome indicators for Community Services.	▪ The opportunity to measure organisations against others to identify if they are providing high quality care. ▪ Information to support the measurement and audit of internal processes. ▪ Data to support own organisational accountability, for example contributing to outcome measures and to an organisation's quality accounts. ▪ Support for provider networks, through provision of information on characteristics of populations they serve. ▪ The opportunity for organisations with sophisticated reporting requirements and analytical capability to generate their own bespoke reports. ▪ Reduced local burden and duplication by lessening the need for other local data collections/reporting/flows, e.g. retirement of CIDS. ▪ Provision of consistent data to support better planning and evidence based commissioning.	▪ Making sure Community Services are available to all patients in all areas by measuring the care that is being delivered. ▪ Better care, through monitoring progress to allow future services to be planned. ▪ Improved accountability, making it easier for the public to access comparative information to support them in making decisions about their care. ▪ More personalised and better organised care for patients through understanding what care is needed nationally, for example finding out how many patients who are discharged from hospitals subsequently need looking after at home.

▪ Support for the delivery of integrated care pathways. ▪ Encouragement to provider organisations to flow data, as indicated in feedback from commissioner and provider engagement. ▪ Help to improve reference costs for Community Services (through providing activity data on which to base mandatory tariffs) - cost information from Community providers is currently of poor quality and not reported consistently. ▪ Help in supporting the implementation of new payment approaches for Community Services, through the development of defined currencies for Community Services (and Community Service elements of new care models) which are underpinned by consistent data. ▪ A nationally consistent clinical record for all patients across England, which can be used to support national research projects (potentially through data linkage) – for example, the ONS have expressed an interest in the data for use in public service productivity estimates. ▪ Increased transparency of Community Services at local, regional and national levels to improve patient care,	▪ Recording of outcomes to contribute to clinical risk management and governance to reduce litigation costs.	

especially in the context of the shift of services from acute hospitals to the 'out of hospital' sector.		

NHS Digital – Public Board Meeting Forward Business Schedule 2017-18 [i]

03 May 2017	31 May 2017	06 September 2017	08 November 2017	21 February 2018	21 March 2018
Board Businessand Governance	***Board Businessand Governance***	***Board Businessand Governance***	***Board Businessand Governance***	***Board Businessand Governance***	***Board Businessand Governance***
Register of Interests – for information Minutes of previous meeting – to ratify Matters Arising – for comment Progress on Action Points – for information	Register of Interests – for information Minutes of previous meeting – to ratify Matters Arising – for comment Progress on Action Points – for information	Register of Interests – for information Minutes of previous meeting – to ratify Matters Arising – for comment Progress on Action Points – for information	Register of Interests – for information Minutes of previous meeting – to ratify Matters Arising – for comment Progress on Action Points – for information	Register of Interests – for information Minutes of previous meeting – to ratify Matters Arising – for comment Progress on Action Points – for information	Register of Interests – for information Minutes of previous meeting – to ratify Matters Arising – for comment Progress on Action Points – for information
Governance and Assurance	***Governance and Assurance***	***Governance and Assurance***	***Governance and Assurance***	***Governance and Assurance***	***Governance and Assurance***
Establishment of Finance and Investment Committee (FIC) and Terms of Reference (ToR) Modern Slavery Act – Implication for NHS Digital	Annual Report and Accounts – for approval	• Sustainability Development Management Plan (CV) NED Sponsor, Dr Sarah Blackburn	Scheme of Delegated Financial Authorities 2017-18 (update)	Arrangements for the Annual Review of Board Effectiveness 2017-18	Corporate Governance Manual 2017-18 Scheme of Delegated Financial Authorities 2017-18 (update)
Strategic Operational Delivery and Performance	***Strategic Operational Delivery and Performance***	***Strategic Operational Delivery and Performance***	***Strategic Operational Delivery and Performance***	***Strategic Operational Delivery and Performance***	***Strategic Operational Delivery and Performance***
Board Performance Pack Data Release Audit	Update on Cyber Attack	• Board Performance Pack • Corporate Business Plan 2017-18 (Final)	Board Performance Pack Mid-year review of Corporate Business Plan 2017-18	Board Performance Pack Staff Survey Results 2017-18 Corporate Business Plan 2017-18 (Draft)	Board Performance Pack Information Assurance and Cyber Security Annual Report 2017-18 Corporate Business Plan 2017-18 (Final)
Strategy and Capability	***Strategy and Capability***	***Strategy and Capability***	***Strategy and Capability***	***Strategy and Capability***	***Strategy and Capability***
• GP Centric Deep Dive • Social Care Centric Deep Dive • Child Protection Information Sharing • Workforce Capabilty Planning					
System Wide Support and Engagement	***System Wide Support and Engagement***	***System Wide Support and Engagement***	***System Wide Support and Engagement***	***System Wide Support and Engagement***	***System Wide Support and Engagement***
Governance and Assurance	**Governance and Assurance**	**Governance and Assurance**	**Governance and Assurance**	**Governance and Assurance**	**Governance and Assurance**
	Reports from Sub-Committees (ARC & IC)	Reports from Sub-Committees (ARC, IACSC & IC)	Reports from Sub-Committees (ARC, IACSC & IC)	Reports from Sub-Committees (ARC, IACSC & IC)	Reports from Sub-Committees (ARC, IACSC & IC)
Directions	**Directions**	**Directions**	**Directions**	**Directions**	**Directions**
•	• The HSCIC (Establishment of Information Systems for NHS Services: Emergency Care Data Set Collection) Directions 2017' • Community Services Dataset Direction	• Client Level Adult Social Care Direction • Directions for Hospital Pharmacy Stock Control Proof of Concept • Employment Advisors in Improving Access to Psychological Therapies Dataset (for acceptance).	•	•	•
Mandatory Request	**Mandatory Request**	**Mandatory Request**	**Mandatory Request**	**Mandatory Request**	**Mandatory Request**
• Client Level Adult Social Care Data Direction (paper)	•	• Patient Level Information Costing (PLICS) Mental Health Pilot Mandatory Request'	•	•	•
Papers for Information Only	***Papers for Information Only***	***Papers for Information Only***	***Papers for Information Only***	***Papers for Information Only***	***Papers for Information Only***
Forthcoming Statistical Publications Board Forward Business Schedule 2017-18	Forthcoming Statistical Publications Board Forward Business Schedule 2017-18	Information Assurance and Cyber Security Committee (IACSC) ToR (paper) Forthcoming Statistical Publications Board Forward Business Schedule 2017-18	Forthcoming Statistical Publications Board Forward Business Schedule 2017-18	Forthcoming Statistical Publications Board Forward Business Schedule 2017-18 Board Forward Business Schedule 2017-18 and 2018-19	Forthcoming Statistical Publications Board Forward Business Schedule 2017-18 Board Forward Business Schedule 2018-19
April and May 2017	**June and July 2017**	**August and September 2017**	**October and November 2017**	**December 2017 and January 2018**	**February and March 2018**
Key Meetings	***Key Meetings***	***Key Meetings***	***Key Meetings***	***Key Meetings***	***Key Meetings***
• Board Devleopment day - 05 April 2017 • Board Development Day – 02 May 17 • Statutory Board – 03 May 17 • Assurance & Risk Committee – 10 May 17 • Board Development Day –30 May 17 • Statutory Board – 31 May 17 • Assurance & Risk Committee – 31 May 17	• Board Development Day– 04 July 17	• Board Development Day – 05 September 17 • Statutory Board – 06 September 17 • Assurance & Risk Committee – 13 September 17 • Information Assurance and Cyber Security Committee- 13 September 17	• Board Development Day – 31 October 17 • Statutory Board – 01 November 17 • Assurance & Risk Committee – 15 November 17 • Information Assurance and Cyber Security Committee – 15 November 17	• Board Timeout – 20 December 17 • Board Development Day – 30 January 18 • Statutory Board – 31 January 18	• Board Development Day – 06 March 18 • Statutory Board – 07 March 18 • Assurance & Risk Committee – 14 March 18 • Information Assurance and Cyber Security Committee – 14 March 18

[i] This is a living document and is subject to regular updates

NHS Digital

Board Meeting – Public Session

Title of paper:	**Forthcoming Statistical Publications**
Board meeting date:	31 May 2017
Agenda item no:	NHSD 17 02 06
Paper presented by:	N/A - For information
Paper prepared by:	Chris Roebuck Director of Publications and Head of Profession for Statistics
Paper approved by: (Sponsor Director)	Prof. David Hughes Director of Information and Analytics.
Purpose of the paper:	This paper describes NHS Digital Official (and National) Statistics publications published in April 2017 and planned for June and July 2017, and media and web coverage for publications released in April 2017.
Additional Documents and or Supporting Information:	N/A
Please specify the key risks and issues:	N/A
Patient/public interest:	Overview of NHS Digital Statistical Publications
Supplementary papers:	N/A
Actions required by the Board:	For information

Official

NHS Digital

Forthcoming Statistical Publications

Author Chris Roebuck

Published 31 May 2017

Information and technology
for better health and care

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Executive Summary

This paper describes:

- NHS Digital Official (and National) Statistics publications released during April 2017 and planned for June and July 2017;
- Media coverage for press released Official Statistics publications during April 2017;
- Web activity for publications released during April 2017.

Background

As at 01 April 2017, NHS Digital is responsible for 95 active (currently published or planned for future release) series of Official Statistics of which 32 are designated as National Statistics, which means that the UK Statistics Authority (UKSA) recognises them as being compliant with the Code of Practice for Official Statistics.

During the 2016/17 financial year (01/04/16 to 31/03/17), NHS Digital published 292 statistical reports.

Official Statistics are expected to evolve and improve over time, to meet the changing needs of our users, to improve their quality and utility and to respond to changes in their administrative and management data sources.

“Experimental statistics” are new Official Statistics that are undergoing evaluation. A key part of this evaluation is user engagement whereby NHS Digital invites readers to comment on the publications, which helps to inform future releases.

Most NHS Digital Official Statistics are published annually or more frequently. Generally, each edition is similar in content to previous versions but any substantial changes are noted below (note: no such changes are yet planned).

National Statistics are identified below with [NS].

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Forthcoming and recently released publications

Official and National statistics

June 2017

New releases: None planned for June 2017

Biennial

01 June 2017	Dental Working Hours - Motivation and Morale linked to Earnings 2012/13 and 2013/14, Experimental Statistics

Annual

15 June 2017	Statistics on Smoking, England - 2017 [NS]
16 June 2017	NHS Surplus Land - 2016/17 England
29 June 2017	Prescriptions Dispensed in the Community, England - 2006-2016 [NS]
29 June 2017	General Ophthalmic Services activity statistics - England, April 2016 - March 2017 [NS]

Biannual None planned for June 2017

Quarterly

01 June 2017	Learning Disabilities Health Check Scheme - England, Quarter 3, 2016-17
02 June 2017	CCG Prescribing Data - January to March 2017
08 June 2017	Data on written complaints in the NHS - 2016-17 Quarter 4, Experimental [NS]
13 June 2017	Numbers of Patients Registered at a GP Practice - June 2017
15 June 2017	Statistics on Women's Smoking Status at Time of Delivery: England - Quarter 4, January 2017 to March 2017
21 June 2017	NHS Staff Earnings Estimates - to March 2017, Provisional statistics
22 June 2017	Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation, England, January 2016 - December 2016 [NS]
22 June 2017	CCG Outcomes Indicator Set - June 2017 release

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Monthly

06 June 2017	Female Genital Mutilation - January-March 2017, Experimental Statistics, Enhanced Dataset
07 June 2017	Maternity Services Monthly Statistics - January 2017, Experimental statistics
07 June 2017	Out of Area Placements in Mental Health Services - April 2017
09 June 2017	Recorded Dementia Diagnoses - May 2017
09 June 2017	Children and Young People's Health Services Monthly Statistics - February 2017
20 June 2017	Mental Health Services Monthly Statistics - Final March 2017
21 June 2017	NHS Sickness Absence Rates - February 2017, Provisional Statistics
21 June 2017	NHS Workforce Statistics - March 2017, Provisional statistics
22 June 2017	Improving Access to Psychological Therapies Report - March 2017 Final, April 2017 Provisional and most recent quarterly data (Quarter 3 2016-17)
27 June 2017	Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - April 2016 - March 2017 (M13)
27 June 2017	Provisional Accident and Emergency Quality Indicators for England - March 2017, by provider
28 June 2017	Learning Disability Services Monthly Statistics - Commissioner Census (Assuring Transformation), May 2017, Experimental Statistics

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July 2017

New releases:	None planned for June 2017
Biennial:	None planned for June 2017
Annual:	None planned for June 2017
Biannual:	None planned for June 2017

Quarterly

12 July 2017	NICE Technology Appraisals in the NHS in England (Innovation Scorecard) - to December 2016
14 July 2017	Numbers of Patients Registered at a GP Practice - July 2017; Special Topic - Practices which have opened or closed within the last year
14 July 2017	NHS Continuing Healthcare Activity - England, Quarter 4, 2016-17

Monthly

04 July 2017	Female Genital Mutilation - April 2016-March 2017 Experimental Statistics
05 July 2017	Maternity Services Monthly Statistics - February 2017, Experimental statistics
06 July 2017	Out of Area Placements in Mental Health Services - May 2017
12 July 2017	Children and Young People's Health Services Monthly Statistics - March 2017
14 July 2017	Recorded Dementia Diagnoses - June 2017
20 July 2017	Mental Health Services Monthly Statistics - Final April, Provisional May 2017
25 July 2017	Improving Access to Psychological Therapies Report - April 2017 Final, May 2017 Provisional + Quarter 4 2016-17
25 July 2017	NHS Workforce Statistics - April 2017, Provisional statistics
25 July 2017	NHS Sickness Absence Rates - January 2017 to March 2017 and Annual Summary 2010-11 to 2016-17
27 July 2017	Learning Disability Services Monthly Statistics - Commissioner Census (Assuring Transformation), June 2017, Provisional Statistics
28 July 2017	Provisional Accident and Emergency Quality Indicators for England - April 2017, by provider
28 July 2017	Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - April 2017 - May 2017

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Clinical Audits

Clinical Audits are not currently classed as Official Statistics. The Code of Practice for Official Statistics is followed as best practice during the production cycle but the release practises differ.

June 2017

13 June 2017	National Diabetes Audit - National Diabetes Audit Transition

July 2017

13 July 2017	National Diabetes Audit - National Diabetes Audit Complications and Mortality 2013-2015
13 July 2017	National Diabetes Audit - Insulin Pump Report
26 July 2017	NHS Vacancy Statistics England - February 2015 - March 2017, Provisional Experimental Statistics
26 July 2017	National Diabetes Audit - Prevention Programme Pilot

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User and Media activity

The following tables show web and media coverage figures for Official (and National) Statistics released by NHS Digital in April 2017. Clinical Audits are not included.

Unique page views are the number of times the publication page was viewed during the two-week period following its release. Note that one user could generate more than one unique visit.

Media Units are the total articles or other media coverage for example print, online articles or broadcasts for the publication (each is counted separately i.e. an article appearing in both a newspaper's print and online instances will count as two citations) . The totals in the table include all media units for the month of publication up to the date of writing this paper (see header).

Bars in the tables below indicate the scale of interest generated by each publication.

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April 2016

Publication	Date	Unique page views	Media units
Out of Area Placements in Mental Health Services - February 2017	04 April 2017	227	
Maternity Services Monthly Statistics - November 2016, Experimental statistics	05 April 2017	340	
Health and Care of People with Learning Disabilities - 2015/16	06 April 2017	1157	
Learning Disabilities Health Check Scheme - England, Quarters 1 and 2, 2016-17	11 April 2017	192	3
Children and Young People's Health Services Monthly Statistics - December 2016	12 April 2017	314	
NICE Technology Appraisals in the NHS in England (Innovation Scorecard) - to September 2016	12 April 2017	663	
NHS Safety Thermometer Report - England March 2016 - March 2017	12 April 2017	194	
Recorded Dementia Diagnoses - March 2017	13 April 2017	299	
Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - April 2016 - February 2017	13 April 2017	125	
Provisional Accident and Emergency Quality Indicators for England - January 2017, by provider	13 April 2017	107	
Numbers of Patients Registered at a GP Practice - April 2017	19 April 2017	403	
Mental Health Services Monthly Statistics - Final January, Provisional February 2017	20 April 2017	653	
NHS Continuing Healthcare Activity - England, Quarter 3, 2016-17	20 April 2017	399	
Improving Access to Psychological Therapies Report - January 2017 Final, February 2017 Provisional + Quarter 3 2016-17	25 April 2017	580	
Seven-day Services - England, October 2015 - September 2016, Experimental statistics	26 April 2017	218	
NHS Workforce Statistics - January 2017, Provisional Statistics	26 April 2017	338	
NHS Sickness Absence Rates - October 2016 to December 2016	26 April 2017	167	
Statistics on NHS Stop Smoking Services in England - April 2016 to December 2016	27 April 2017	351	
Learning Disability Services Monthly Statistics - Commissioner Census (Assuring Transformation), March 2017, Experimental Statistics	27 April 2017	170	

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Recommendation

None – for information only.

Implications

Strategy Implications

These publications and their associated media and web coverage results form part of objective five of our strategy, “Making better use of health and care information” whereby we “are part of the Government’s Statistical Service and adhere to the UK Statistics Authority’s Code of Practice for national statistics. We publish data and statistics in formats that cannot be used to identify individual patients, service users or citizens.”

Financial Implications

There are no financial implications of this resolution/proposal.

Stakeholder Implications

This is for information purposes only, for stakeholders to review forthcoming publications and the media and web attention of those previously published..

Handling

There are no handling implications of this resolution/proposal

Risks and Issues

There are no associated risks and issues as this is for information only.

Corporate Governance and Compliance

All Official and National statistics publications adhere to the UK Statistics Authority’s Code of Practice for Official Statistics which fulfil our obligations as a producer of Official and National statistics.

Management Responsibility

Professor David Hughes, Executive Director of Information and Analytics is the sponsor director accountable for these publications. The senior manager with overall responsibility is Chris Roebuck, Director of Publications and Head of Profession for Statistics.

Actions Required of the Board

None – for information only.

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