DIGITAL HEALTH AND CARE WALES
WELSH EMERGENCY CARE DATA SET USER GUIDE

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1 ABOUT THIS DOCUMENT

1.1 PURPOSE OF THE DOCUMENT

The purpose of this document is to outline the manner by which the Welsh Emergency Care Data Set (WECDS) version 1.2 should be used and interpreted by users, system suppliers and other stakeholders by providing information on each individual data group and its constituent data items. This User Guide is applicable to all providers of Major Emergency Care Departments (EDs) (Type 01), Mono-specialty Emergency Care Departments (Type 02), Minor Injury Units (MIU) (Type 03), Same Day Emergency Care (SDEC) (Type 05) and Extended Care Episodes (Type 06) as defined by Urgent and Emergency Care Activity Type in the NHS Wales Data Dictionary[1].

This document draws on the User Guide developed and published for the Emergency Care Data Set (ECDS) which is managed by NHS England[2]. It has been amended to reflect the changes made to ECDS to develop WECDS ensuring alignment to Urgent and Emergency Care service provision across Wales.

1.2 SCOPE OF THE DOCUMENT

This document is aimed at:

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

The following areas are out of scope of this document:

- Detailed justification for the development of the data standard
- Data submission framework (i.e., how data is submitted by data providers to Digital Health and Care Wales (DHCW). Further information about this will be available in the WECDS Technical Guidance.

This document should be read in conjunction with the following documents which can be found through the Digital Health and Care Wales Information Design and Standards Development website[3]:

- 2024/12 Welsh Emergency Care Data Set v1.2 Data Standards Change Notice (DSCN)[4]
- WECDS v1.2 Enhanced Technical Output Specification[5]

1.3 SCHEDULE FOR UPDATING THIS DOCUMENT

DHCW reserves the right to review and update this guidance document as needed, such as in response to stakeholder feedback or in line with data set updates.

2 BACKGROUND

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

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

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

The relative costs and complexity of delivering Urgent and Emergency Care (UEC) have changed over recent years, due to:

[1] GEIRIADUR DATA GIG CYMRU / NHS WALES DATA DICTIONARY
[2] ECDS guidance and documents - NHS England Digital
[3] Welsh Emergency Care Data Set (WECDS) Documentation - Digital Health and Care Wales (nhs.wales)
[4] dhcw.nhs.wales/information-services/information-standards/data-standards/data-standards-files/20240718-dscn-2024-12-welsh-emergency-care-data-set-0-3-2-pdf/
[5] 20240718-DSCN 2024 12-Welsh Emergency Care Data Set v1.2 ETOS LOCKED Version 2.xlsx

- 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 EDs increased subspecialisation of hospital practice with a reduced number of 'generalist' hospital doctors.

The WECDS provides the following in response to that changing environment:

- Accurate recording of the source of the patient's referral to the UEC service, ensuring a clear record of how and why patients seek UEC.
- Consistent capture of the patient's chief complaint recording the primary clinical reason for attendance, with centralised submission for better analysis.
- Detailed recording of patient journeys during UEC attendance, such as when patients are referred for inpatient assessment or admission, providing valuable insights into care pathways.
- Clear recording of patient outcomes, including where they go after UEC treatment is complete, aiding follow-up and care continuity.
- Understanding of patient complexity and acuity, allowing an insight into the value added by UEC.
- Enhanced diagnostic data, offering a deeper understanding of patient needs, clinical activities, and outcomes.
- Standardised data on patient flow and service utilisation, helping to map patient access patterns, which supports effective planning and resource allocation.
- Ensuring safe and timely care by having insight into staff activities within UEC services and understanding who is delivering care and when.
- Integration of local and national initiatives, promoting consistency and enabling different providers to describe their work in a common language across the UEC system.
- Analysis of UEC attendances linked to injury and other modifiable factors, identifying patterns that may benefit from targeted public health interventions to reduce future visits.
- Support for targeted prevention strategies, with the potential to lower UEC attendance rates through early intervention.
- Ongoing monitoring of illness trends in UEC presentations, offering public health insights and early warnings of emerging health threats. This includes the development of a Welsh Emergency Department Syndromic Surveillance System (WEDSSS), modelled on the UK HSA's Emergency Department Syndromic Surveillance System (EDSSS), to leverage national data for better health security.

2.1 OWNERSHIP AND MAINTENANCE OF WECDS

The WECDS is owned, mandated, and enforced by Welsh Government. The structure and content of ECDS is owned by the National Clinical Director of Urgent and Emergency Care, NHS England. The majority of the clinical content of WECDS is managed by the ECDS Technical Committee, hosted by NHS England which has representation from relevant professional bodies, e.g. Royal College of Emergency Medicine (RCEM). Wales will have representation at the ECDS Technical Committee via the WECDS Clinical Lead and Data Standards project team.

A maintenance cycle for the WECDS is currently in development. This process aims to formalise the process for updating the data set and ensure that, where appropriate, WECDS aligns with ECDS.

Key elements will include:

- Annual Review: A comprehensive review of all SNOMED codes every January, with updates implemented by April.
- Welsh Representation: Welsh representation at every ECDS Technical Committee meeting, held at least once per year.
- Ad-hoc Updates: Updates to WECDS outside the annual cycle will only occur in response to significant new critical situations, (e.g. Covid-19) and will be managed accordingly.
- Assurance Process: Updates to the Data Standards Change Notice (DSCN) and Enhanced Technical Output Specification (ETOS) will be mandated via the Information Standards Assurance process.[6] Corresponding changes will be reflected in the WECDS User Guide and other supporting documentation.

The WECDS must reflect the specific needs of Wales. Change requests outside the ECDS will be managed by a multi-stakeholder group, including clinicians, administrative staff, operational teams, information systems professionals from Local Health Boards (LHBs) and Trusts, as well as representatives from Welsh Government,

[6] Information Standards Assurance - Digital Health and Care Wales

Public Health Wales, and relevant teams from Digital Health and Care Wales (DHCW).

This group will provide a level of assurance that proposed changes are thoroughly evaluated by Subject Matter Experts (SMEs) prior to being formalised. This process will help identify potential benefits and risks before any changes are implemented.

Suggested amendments to the WECDS should be submitted via the dedicated mailbox DHC.WECDS@wales.nhs.uk. The suggestions will be logged and discussed with requestors before they are raised at the maintenance meeting. It is proposed that meetings are held three times a year on the second Wednesday of the months of March, July, and November. The change requests will be collated and discussed at the next maintenance meeting. Change requests will be reviewed and discussed during these meetings, and requestors or their nominated deputies should attend to present their proposals and address any queries.

Meeting Outcomes and Decision Making:

After discussion of each change request, the Chair will ask if a consensus has been reached by members regarding the proposals.

- Approved Changes: If a change is approved, it will be taken through the Information Standards Assurance Process.
- Deferred or Rejected Changes: If a change is not approved, it will either remain on the log to be discussed at the next meeting or the group may decide it should be removed from the log altogether.
- Documentation: A formal outcome of the maintenance meeting will be circulated to all stakeholders within a week of each meeting.

Where the group has agreed amendments and they have been identified as potentially beneficial outside of Wales, i.e. there is a potential business case for addition to ECDS, these will be raised at the next ECDS Technical Committee.

The administration and maintenance of the WECDS is performed by DHCW, which is also responsible for collecting data through the National Data Resource (NDR). The NDR is a national data platform that will join up health and social care data services from across Wales. The NDR programme includes the Care Data Repository (CDR) which acts as a central hub for clinical data in Wales. Patients' care data will reside in the CDR, fostering seamless access and contribution to patients' care records by health and care applications throughout the nation. CDR ensures that patients' health and care information can accompany them wherever they receive care. The National Data and Analytics Platform (NDAP) will enable health and care organisations in Wales to store, access, and analyse data effectively and securely. This platform will manage both existing and acquired data and receive a data flow from the CDR. NDAP has the capacity to be the central hub for collecting, storing, and sharing relevant data to health and care professionals across Wales, facilitating informed analysis.[7]

Data will be prepared for inclusion in the StatsWales platform along with Welsh Government Statistics and Research 'Trends in NHS urgent and emergency care activity' reports. The data will be used for a wide range of healthcare analysis for the Welsh Government, NHS Wales and many other organisations and individuals such as Public Health Wales and the Violence Prevention Unit.

[7] National Data Resource (NDR) - Digital Health and Care Wales

2.2 WELSH EMERGENCY DEPARTMENT SYNDROMIC SURVEILLANCE SYSTEM

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

The Welsh Emergency Department Syndromic Surveillance System (WEDSSS) will monitor the daily visits in a network of Emergency Departments across Wales. A weekly report will be published which can be used to identify and describe trends for a variety of syndromic indicators including comparisons to historical baselines as well as comparisons of trends between age groups/geographical areas. WEDSSS will play a valuable role in providing intelligence on infectious diseases (including seasonal respiratory illness), and a wide range of incidents (including non-infectious events).

2.3 ED TO GP DISCHARGE SUMMARY

NHS Digital commissioned the Professional Record Standards Body (PRSB) to develop information models to improve patient safety and support the transfer of vital and accurate information to General Practice (GP) systems following an attendance at an ED. The two main outputs from this process are:

- Standardised ED to GP letters containing key information and,
- A standardised electronic messaging specification for transmission from ED to GP

The Emergency Care Discharge Summary headings were developed alongside the ECDS and therefore will align with the WECDS.

It is expected that Information Systems that have successfully implemented the ECDS will be able to generate the required data to populate Emergency Care Discharge Standard according to the PRSB information models.

The Emergency Care Discharge Summary standard has been updated to version 2.2 (May 2023).

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

The NHS Wales Executive support the use of this standard for use in EDs and SDEC.

2.4 STANDARDISING THE MANAGEMENT OF ACUTE DETERIORATION (NEWS2 AND PEWS)

The NHS Wales Executive has finalised an agreement on the standardisation of Early Warning Scores (EWS) across Wales. Published in September 2024, the Welsh Health Circular, Standardising the Management of Acute Deterioration (WHC/2024/035)[8] outlined the national approach for the use of the following EWS:

- NEWS2 (and subsequent updates): For the identification and escalation of acute deterioration in adults.
- National PEWS (and subsequent updates): For the identification and escalation of acute deterioration in children and young people.
- NEWTT2 (and subsequent updates): For the identification and escalation of acute deterioration in neonates.

2.5 ED QUALITY STATEMENT

The Quality Statement, Care in Emergency Departments, published by the Welsh Government in March 2024 recognises implementation of the WECDS as a priority action. The Quality Statement outlines the standards and expectations for providing high-quality care in EDs[9] from the point of entry to the point of exit. It emphasises the importance of accurate, detailed data to enhance patient care and inform decision-making. By aligning with national standards and focusing on patient-centred practices, the Quality Statement aims to facilitate better planning and resource allocation, ultimately leading to improved health outcomes in emergency care settings.

3 THE WELSH EMERGENCY CARE DATA SET (WECDS)

3.1 STREAMING AND REDIRECTION FROM ED TO OTHER SERVICES

When the word 'streaming' is used in Emergency Care it implies care of a patient who has had a limited assessment and is transferred into the hospital system from one organisation/site to another. Increasingly these organisations are on the same site and share IT systems.

Redirection refers to when a patient has had a limited assessment and directed to the most appropriate service.

[8] Standardising the management of acute deterioration (WHC/2024/035) [HTML] | GOV.WALES
[9] Quality statement for care in emergency departments | GOV.WALES

This can include community services such as pharmacy or other options.

(Streaming/Redirection is an active workstream under the Six Goals and this will evolve as the workstream develops. This User Guide will be updated to reflect this)

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

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

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

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

A basic streaming and redirection assessment should include:

TABLE 1 SUGGESTED DATA ITEMS TO BE COLLECTED FOR BASIC STREAMING ASSESSMENT

Data Item	Data Item
Local Patient Identifier	Organisation Site Code (of Treatment)
Organisation Code (Code of Provider)	Urgent and Emergency Care Activity Type
NHS Number	Ambulance Incident Number
NHS Number Status Indicator	Organisation Code (Conveying Ambulance Trust)
Patient's Name	Care Contact Identifier (Ambulance Service)
Name Format Code	Urgent and Emergency Care Arrival Mode e.g. *whether by ambulance*
Birth Date	Urgent and Emergency Care Attendance Category - *has the patient been seen by another health practitioner in past 7 days*
Birth Date Status	Urgent and Emergency Care Attendance Source
Patient's Usual Address	Urgent and Emergency Care Activity Start Timestamp
Postcode of Usual Address	Urgent and Emergency Care Acuity
Organisation Code (LHB Area of Residence)	Urgent and Emergency Care Chief Complaint
General Medical Practitioner (Registered)	Urgent and Emergency Care Discharge Status - *the facility to which the patient has been streamed*
Code of Registered GP Practice	Urgent and Emergency Care Activity End Timestamp - *the time at which the patient was streamed*

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

3.2 SEE AND TREAT

Patients who are "See and Treat" would generate a full WECDS episode for this activity.

3.3 MENTAL HEALTH ACT (MHA)

A Mental Health Act (MHA) data group has been added to support a better understanding of the use of the Mental Health Act in LHBs, specifically where Section 136 patients may be brought into EDs.

This data group is a required data group and should only be submitted when a patient attends a UEC service under the MHA.

3.4 EMERGENCY DEPARTMENTS (URGENT AND EMERGENCY CARE ACTIVITY TYPE 01)

A Major Emergency Care Department is Consultant led and must be a 24-hour, seven-day service, with full resuscitation facilities and designated accommodation for the reception of patients requiring emergency care, including those arriving by emergency ambulance.

3.5 SAME DAY EMERGENCY CARE (SDEC) (URGENT AND EMERGENCY CARE ACTIVITY TYPE 05)

In NHS Wales, Same Day Emergency Care is defined as "*the provision of same day acute care for patients who would otherwise be admitted to hospital.*

Under this care model, patients presenting at hospitals with relevant conditions can be rapidly assessed, diagnosed, and treated (in a designated area) without being admitted, and if clinically safe to do so, will go home the same day their care is provided.

Same Day Emergency Care is the provision of care to a patient by clinicians within an Urgent and Emergency Care Service. Same Day Emergency Care is provided within 24 hours of the 'Urgent and Emergency Care Initial Assessment Timestamp', following formal initial clinical assessment (either virtual or face to face) and referral taking place.

Same Day Emergency Care is intended to provide an alternative to an Admitted Care Episode."

WECDS plays a crucial role in supporting SDEC by enabling standardised data collection, improving patient management through data collection, and enhancing operational efficiency across UEC settings in Wales. It also incorporates the time-based milestones necessary to understand time-sensitive care pathways, which are not present in the EDDS.

3.6 MINOR INJURY UNITS (MIU) (URGENT AND EMERGENCY CARE ACTIVITY TYPE 03)

Minor Injury Units (MIU's) are units which have designated accommodation for the reception of UEC patients and can be routinely accessed with or without appointment, but which do not meet the criteria above for a Major Accident and Emergency Department (Type 01).

Only MIUs should report as Type 03 for Urgent and Emergency Care Activity Type. Alternative facilities, such as Out of Hours GP appointments, GP streaming services, Urgent Primary Care Centres, Assessment Units and Acute Clinical Units are excluded from data collection through WECDS.

3.7 INJURY DATA COLLECTION

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

When ECDS was developed in England, it contained a fully integrated collection of Information Sharing to Tackle Violence (ISTV) by RCEM. WECDS has adopted this, and the collection of this information will allow for the routine assembly of injury data which not only improves the quality of the data inputted but also ensures more comprehensive reporting.

3.7.1 THE CARDIFF MODEL

The Cardiff Model demonstrated that most violent incidents which result in emergency hospital treatment are not known to the police. Combining data from UEC services and the police on the who, when, where and how of violent events provides a much more accurate picture, which can be used to direct prevention efforts to where they are most likely to be effective.

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

3.7.2 THE WALES VIOLENCE PREVENTION UNIT

The Wales Violence Prevention Unit (VPU) work with service providers across Wales to deliver evidence-informed programmes to prevent violence. The Wales VPU is a multi-agency unit with the mission of preventing all forms of violence across Wales through the implementation of a public health approach to violence prevention. The VPU uses UEC data combined with relevant policing data to identify trends and develop localised solutions.

Established in 2019 through the Home Office Violence Reduction Unit fund, the Wales VPU is a partnership between the South Wales Police and Crime Commissioner and Public Health Wales and brings partnership data together in regular Violence Monitoring Reports. These reports analyse data from key violence prevention indicators across Wales to monitor trends, patterns, and hotspots. This "real-time" violence surveillance enables partners to initiate data-led prevention and response measures to inform violence prevention policy and practice.

WECDS implementation will centralise the collection of injury data from across Wales and then share this data via a single data sharing agreement with the Wales VPU. This will also help the VPU monitor trends and allow for national cost saving reductions due to effective information sharing partnerships between health services, police, and local government.

3.7.3 SERIOUS VIOLENCE DUTY

In April 2018, the UK government introduced the Serious Violence Strategy to address rising knife crime, gun crime, and homicides. This strategy emphasized a multi-agency approach, involving but not limited to police, local authorities, health services, and the voluntary sector, to reduce violence. In December 2019, the UK government announced new legislation for a Serious Violence Duty. The Police, Crime, Sentencing and Courts Act 2022 (PCSC Act) amends the Crime and Disorder Act 1998 and came into effect in January 2023. This Duty mandates specified authorities to collaborate in identifying and addressing local violence, its causes, and to develop and implement a violence prevention strategy.[10]

The PCSC Act includes a requirement for local partnerships to complete a strategic needs assessment (SNA) to understand how violence is affecting their communities and to help them develop a violence prevention strategy. It is anticipated that the injury characteristics data collected as part of WECDS will support LHBs with this mandate.

3.7.4 INJURY CLASSIFICATION

Within WECDS the term 'Injury' relates to harm or potential harm and is derived from the World Health Organization's definition of injury.

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

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

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

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

3.7.5 INFORMATION SHARING TO TACKLE VIOLENCE (ISTV)

As previously mentioned, the ISTV Information Standard has been integrated within the WECDS. The data covers all ED attendances resulting from violent incidents, including:

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

Additionally, the VPU requested supplemental data items that are used within the Cardiff Model and collected locally across Wales:

- Relationship to Assailant
- Injury Home Status (whether the patient was in their own home or someone else's home at the time of the incident).

For specific user guidance relating to the injury data please see section 5.13.

3.8 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.

[10] Wales Violence Prevention Unit: Serious Violence Duty Strategic Needs Assessment Guidance for Wales, March 2023

WECDS uses specific sub-sets of SNOMED CT codes in association with specified data items from the data set. SNOMED CT is managed and maintained internationally by SNOMED International[11] and in the UK by NHS England, as the UK National Release Centre (NRC for SNOMED CT)[12].

In 2015 SNOMED CT was mandated by the Welsh Health Circular WHC (2015) 053; providers implementing electronic health and care related systems must ensure those systems are SNOMED CT enabled at the point of implementation[13].

3.8.1 SNOMED CT AND WECDS DESIGN PRINCIPLES

WECDS mandates the flow of key clinical data items using SNOMED CT. Other data items use codes from the NHS Wales Data Dictionary and the Welsh Reference Data and Terminology Service (WRTS).

WECDS adopts the SNOMED CT reference sets (refsets), originally developed as part of the ECDS project in England. However, these sets have been adapted to suit the specific needs of the Welsh context. As a result, there may be additional codes included to support data collection in Wales.

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

1. The data items should be:
   - Exhaustive: the data items should cover all conditions and options commonly seen in EDs.
     - Test: If a diagnosis condition had not been seen during the >50 physician years of experience of the Emergency Medicine physicians maintaining the list, it was not included.
   - Exclusive: for any given situation, there should be one and only one best answer.
     - Test: The correct code to choose should be obvious to a F2 doctor on their first day.
2. There should be no symptoms (e.g. back pain) presented as a diagnosis code.
3. There should be no vague terms (e.g. 'unwell,' 'unspecified,' and 'other').
   - If these vague terms are available in a data set, they often become over-used in practice. Prior to WECDS UEC data was captured via the Emergency Department Data Set (EDDS). Approximately 34% of all diagnosis codes were vague and 62% were unspecified, blank, or unknown which rendered the data useless, and this is consistent with international findings[14] . Therefore, vague terms are avoided in WECDS. The exceptions to this rule occur when:
     - There are rare sub-specialty conditions e.g. neurology, endocrinology etc. for which a better group term does not exist. Refer to section 5.16.3 Urgent and Emergency Care Diagnosis.
     - The list will not be able to keep up with real life e.g. a list of recreational drugs.
4. The data items should maximise usability by being presented to IT suppliers in a form that facilitates user interfaces that promote ease of use. This promotes reliable and valid coding.
   Suggestions include:
   - Use of pick lists of 10 items or less to avoid scrolling
   - Grouping of items in similar categories
   - Hierarchical lists with common items list first
   - Listing of synonyms and alternative search terms
   - Typeahead search
5. The items that form the data set should be 'normalised' as far as reasonably possible to avoid duplication and additional clinician burden.

3.8.2 IMPLEMENTATION OF SNOMED CT

Some UEC systems may have been designed so that the use of SNOMED CT coding is invisible to the user at the front end. Where this is the case, a user will be presented with a list of options (these could be the WECDS Description or SNOMED UK Preferred Terms) and the selected option should be mapped behind the scenes to a SNOMED CT code before submission of WECDS.

The SNOMED CT system provides immensely detailed possibilities, specifically in relation to Urgent and Emergency Care Chief Complaint and Urgent and Emergency Diagnosis. In principle the granularity and wealth of detail available in a fully unconstrained SNOMED CT data set is appealing. However, in practice the overwhelming choice available in

[11] www.snomed.org
[12] https://isd.hscic.gov.uk/trud3/user/guest/group/2/home
[13] Introduction of SNOMED CT as an NHS information standard (WHC/2015/53)
[14] Dinh, M.M., Russell, S.B., Bein, K.J., 2019. Diagnoses, damned diagnoses and statistics: Dealing with disparate diagnostic coding systems within the New South Wales Emergency Department Data Collection. Emergency Medicine Australasia 31, 830–836. https://doi.org/10.1111/1742-6723.13371

an unconstrained SNOMED CT data set can be confusing to clinicians who do not have the time or inclination to search through many hundreds of options, and this often results in data that is 'spuriously accurate.'

To address this issue, WECDS uses constrained SNOMED CT refsets as described above, specifically to capture Urgent and Emergency Care Chief Complaint and Urgent and Emergency Care Diagnosis (paired with a qualifier of either suspected or confirmed).

3.8.3 MAINTENANCE OF WECDS SNOMED CT

WECDS value sets will be updated to reflect the needs of the data set, clinical practice and for other reasons.

As mentioned in section 2.1, WECDS will participate in the ECDS Technical Committee. This is a clinically led dataset maintenance group, with clinical representation recruited through the RCEM. The Technical Committee manages the content of the data items in ECDS.

The WECDS data items can be found within the WECDS Technical Output Specification available from this link.

- The ECDS SNOMED CT refsets are included in the ECDS ETOS (Enhanced Technical Output Specification).
- If a clinician finds a clinical situation that requires a new SNOMED CT code, this can be submitted to the WECDS mailbox (DHC.WECDS@wales.nhs.uk) where it will be discussed by the WECDS Maintenance Group and the ECDS Technical Committee for review and discussion.
- WECDS will adhere to the Change Management Process outlined by the WRTS.
- Any new additions/updates or removals to the WECDS SNOMED CT refsets must be implemented in line with published schedules.
- SNOMED CT reference data sets will be reviewed after a SNOMED CT major release that occurs twice a year (April and October). The WRTS Team will run a report identifying any potential changes (additions, inactivation's, and re-modelled concepts) and inform Data Standards.
- If an amendment or change to existing value set(s) is identified, Data Standards will submit a Service Point call to make this request.
- Once the change has been identified, Data Standards will discuss the proposed changes with the WECDS Maintenance Group and if an amendment is required, the Data Standards team will update the DSCN in accordance with the NHS Wales Information Standards Assurance Process.

4 SYSTEM USABILITY

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

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

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

The UK ED systems have been assessed for usability[15].

4.1 WHY URGENT AND EMERGENCY MEDICINE IS DIFFERENT

In most inpatient specialties, data is entered by professional clinical coders who have been specifically trained to understand and use code sets.

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

UEC service staff are expected to enter data into the UEC Information System in real-time, which provides particular constraints to the way the IT should be used effectively. Specific issues are that these staff:

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

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

and critically:

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

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

Features include:

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

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

The WECDS ETOS is maintained by DHCW and is updated in line with the WECDS releases and at other times as required.

4.2 WECDS SORT CODES AND GROUPING

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

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

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

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

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

We encourage clinicians to work with system suppliers to implement these in a way that they find easiest in their system.

4.3 WECDS FLAGS

The WECDS ETOS includes 'flags' in the *Chief Complaint, Diagnosis, and Injury Intent* SNOMED CT refsets.

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

- Injury flag (*Chief Complaint* and *Diagnosis*) – Helps to identify whether an attendance is likely to be the result of an injury and could be used to trigger the injury data collection. The intention is that when implementing the *Chief Complaint* and *Diagnosis* lists where a *Chief Complaint/Diagnosis* is recorded in the system which has an injury flag, the system should then ensure that the injury data items are completed for that record.
- SDEC – This indicates a diagnosis that may be amenable for Same Day Emergency Care
- Notifiable Disease – Indicates that this diagnosis is a 'Notifiable disease' and depending on the local public health protocols, there may be a statutory duty to report this to Public Health Wales officials.
- Allergy – Identifies that the *Chief Complaint* and/or *Diagnosis* are allergy related and that this information should flow as an extra and specific part of the ED to GP Transfer of Care messaging. For more information refer to section 2.3 of this user guidance.
- Male – Indicates a *Chief Complaint* and/or *Diagnosis* more likely to appear in a patient of this gender and is therefore helpful in checking data quality.

- Female – Indicates a *Chief Complaint* and/or *Diagnosis* more likely to appear in a patient of this gender and is therefore helpful in checking data quality.
- Home status flag – helps to identify whether an injury has taken place in a domestic setting, in the patient's own or someone else's home. The intention is when implementing the urgent and emergency care injury place type code list where a domestic setting is recorded in the system which has an injury flag, the system should then ensure the home status flag data item is completed for that record.
- Injury Intent flag - helps to identify the relationship between the patient and the apparent assailant(s). The intention is when implementing the *Urgent And Emergency Care Injury Intent* code list where the intent recorded is either an 'Alleged victim of physical assault by lone assailant' or an 'Alleged victim of physical assault by multiple assailants' the system should then ensure the *Urgent And Emergency Care Relationship to Assailant* data item is completed for that record.

4.4 OTHER USEFUL LINKS

Six Goals for Urgent and Emergency Care Programme: The Programme objectives, latest news, and Programme Priorities.

The Royal College of Emergency Medicine: Policy publications including reports and position statements, briefings, and letters.

StatsWales: Information on time spent waiting in EDs in Wales.

Welsh Emergency Care Data Set (WECDS) Documentation: This page will contain some of the larger code lists and supporting documentation for WECDS.

Trends in NHS Urgent and Emergency Care Activity: Reports summarising data on activity and performance in NHS urgent and emergency care, including ambulance services, emergency departments and the NHS 111 service.

SAM Society for Acute Medicine (SAM): Provides resources, education, and support for healthcare professionals in acute medicine, focusing on improving care for acutely ill patients.

Royal College of Surgeons: The site offers resources for surgeons, including training, standards, and research, while advocating for high standards in surgical practice

5 DATA ITEM GUIDANCE

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

The electronic copy of this document includes hyperlinks to the corresponding entries in the NHS Wales Data Dictionary where formal definitions of the data items can be found.

5.1 NOTATION

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

5.1.1 STATUS

TABLE 2 DATA GROUP AND DATA ITEM STATUS

Status	Meaning	Description
M	Mandatory	These data groups and data items MUST be reported. Failure to submit these will result in the rejection of the record. They are necessary for WECDS to be correctly validated and accepted for processing. In most instances, data items marked as 'Mandatory' will result in its parent data group also being marked as 'Mandatory', but this is not always the case, for example, although the Data Group: Urgent And Emergency Care Diagnoses is marked as 'R' (Required), and therefore need not actually be populated, if it is used then all data items in the group Urgent And Emergency Care Diagnosis, Urgent and Emergency Care Diagnosis Sequence Number and Urgent And Emergency Care Diagnosis Qualifier are all marked as 'Mandatory' and so must be present.
R	Required	These data groups and data items MUST be reported where they apply. Failure to submit these items will not result in the rejection of the record but may affect the derivation of national indicators or national analysis. If at the time of submission, the information remains incomplete the remaining data in the WECDS record should still be submitted. Once the organisation has updated its systems with the data, the data should be resubmitted. In some cases, for example a person leaves the ED before a diagnosis is made, then the data may never be resubmitted.
O	Optional	These data items MAY be populated on an optional basis at the submitter's discretion. Note that even if marked 'Optional', any data included in a WECDS submission must comply with the most recent DSCN published in the Change Notices Publications otherwise the data may be deemed invalid and rejected.

5.1.2 FORMAT

TABLE 3 DATA ITEM FORMAT

Format	Meaning	Description
n	Numeric	The data item is made up of digits only, that is any numerals from 1 to 9. The 'n' is followed by the number of digits. For example, SNOMED CT data items all have the format 'min n6 max18', meaning up to 18 numerals are valid.
an	Alphanumeric	The data item is made up of both letters and numerals. This includes both upper- and lower-case letters, punctuation marks, and symbols (such as /, @, &). The 'an' is followed by the number of characters allowed. For example, 'max an10' means up to 10 characters is valid.
HH:MM:SS	Time format	Specific formats such as for a time have implied validation. For example, 'HH' must be in range 0-24, 'MM' 0-60 and 'SS' 0-60.
YYYY-MM-DD	Date Format	Like above, date formats must be a valid date, for example 202-02-31 would be invalid.
max an25	Timestamp (ISO 8601 timestamp format)	WECDS v1.2 aligns to the ISO 8601 Timestamp format (max an25) for all clinical fields that capture date and time or for fields which are expected to be 'system to system' automatic data transfer. For data which is recorded by administrative staff then the date field and time fields are still separate. The standard ISO 8601 timestamp format is used to capture key milestones on the patient journey, including UTC offset. A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time. For WECDS 1.2 offset time is restricted to: • +01:00 • +00:00 • -00:00 Examples of valid formats are: • 2020-08-21T10:15:20+01:00 British Summer Time (GMT + 1 Hour) • 2020-08-21T10:15:20+00:00 Greenwich Mean Time • 2020-08-21T10:15:20-00:00 Greenwich Mean Time • 2020-08-21T09:18:00Z Greenwich Mean Time

5.1.3 SOURCE

TABLE 4 DATA ITEM SOURCE

Format	Meaning	Description
SNOMED CT	Systemized Nomenclature of Medicine Clinical Terms	Codes are sourced from the SNOMED CT terminology which is a comprehensive set of clinical phrases or terms. In the UK this is managed by NHS England, as the UK National Release Centre (NRS) for SNOMED CT.
NHS Wales DD	NHS Wales Data Dictionary	The code sets are defined and described in the NHS Wales Data Dictionary.
WRTS	Welsh Reference Data and Terminology Service	These data items must be a code published by the Welsh Reference Data and Terminology Service.

5.1.4 NHS WALES DATA DICTIONARY

Certain data items used within the WECDS were originally part of the NHS Wales Data Dictionary. Consequently, there may be occasional references to other data sets within the definitions.

5.2 DATA GROUP: PATIENT IDENTITY

5.2.1 DEFINITION, GROUP STATUS AND JUSTIFICATION FOR DATA GROUP

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

Group status: Mandatory

Justification: This information is collected to ensure the accurate identification of patients and the seamless coordination of care and continuity across different healthcare services.

5.2.2 DATA ITEMS IN THIS GROUP

TABLE 5 DATA ITEMS WITHIN THE *PATIENT IDENTITY* DATA GROUP

Data Item Name	Format	Status	Data Item Repeats	Source
Local Patient Identifier	an10	M	1..1	NHS Wales DD
Organisation Code (Code of Provider)	Min an3 max an5	M	1..1	WRTS
NHS Number	n10	M	1..1	NHS Wales DD
NHS Number Status Indicator	an2	M	1..1	NHS Wales DD
Patient's Name	Either structured with two 35 alpha character elements (forename followed by surname) or an unstructured string of 70 characters	O	0..1	NHS Wales DD
Name Format Code	n1	O	0..1	NHS Wales DD
Birth Date	n8 Format: CCYY-MM-DD If the Date of Birth is unknown; use the date '11/11/1811' (that is 18111111)	R	0..1	NHS Wales DD
Birth Date Status	n1	R	0..1	NHS Wales DD
Patient's Usual Address	175-character alpha-numeric. This is based on 5 lines of 35 characters. This relates to the physical layout of the address, not the logical layout and does not require intelligent intervention when splitting the text string into lines.	O	0..1	NHS Wales DD
Postcode of Usual Address	8-character alpha-numeric. This allows a space to be inserted to differentiate between the inward and outward segments of the code, enabling full use to be made of the Royal Mail postcode functionality.	M	1..1	NHS Wales DD
Organisation Code (LHB Area of Residence)	min an3 max an5	R	0..1	WRTS

A full description of each data item is given below.

5.2.3 LOCAL PATIENT IDENTIFIER

Definition: This is the case record number. It is a unique identifier for a patient within a health care provider.

Format: an10

Data Dictionary: Local Patient Identifier (wales.nhs.uk)

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

How to collect: This information will be auto populated once the patient has been booked in/registered in the UEC service or if there is no Information System in place this number could be allocated by clerical staff. The hospital that issued this patient identifier will be the one identified by the data item: 'Organisation Code (Code of Provider)'.

5.2.4 ORGANISATION CODE (CODE OF PROVIDER)

Definition: This is the organisation code of the health care provider. The provider code identifies the health care provider who is responsible for managing the treatment of the patient.

Notes:

1. Healthcare providers may also act as commissioners when sub-contracting patient care services to other providers of health care.
2. Although the healthcare provider identified in this data item is responsible for managing the patient's treatment, it may not necessarily be where the treatment is conducted. For example, where the treatment has been sub-contracted to another healthcare provider.
3. For OPR ds, the Organisation Code (Code of Provider) is that of the organisation receiving the referral. If the provider is a Local Health Board/Trust, use the 3-character Local Health Board/Trust code with 2 zeros placed in the 4th and 5th character position.
4. For Referral to Treatment Times (Combined), use the 3-character Local Health Board/Trust code.

Format: Min an3 max an5

Data Dictionary: Organisation Code (Code of Provider) (wales.nhs.uk)

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

How to collect: This information will be auto populated once the patient has been booked in/registered in the Urgent and Emergency Care service or if there is no Information System in place this number could be allocated by clerical staff.

5.2.5 NHS NUMBER

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

It is mandatory to record the NHS Number:

- (in the MI ds) for each woman and baby
- (in every other data set) for each patient registered with a GP practice in England and Wales.

The NHS number is allocated to an individual, to enable unique identification for NHS healthcare purposes.

The MI ds captures data relating to the woman at initial assessment and to mother and baby for all births. Each Health Board makes data available in relation to the events which they manage, and initial assessment and birth data will be linked nationally regardless of whether both events took place in the same or at different health boards. The NHS number is needed on each record to enable this data to be linked.

This NHS Number format was mandated for use effective 1st November 1997. Prior to this, the NHS Number was an alphanumeric code which ranges in size from 10 – 17 characters.

If known, the patient's Health and Care Number should be used to populate this field for patients resident in Northern Ireland.

If known, the patient's Community Health Index (CHI) Number should be used to populate this field for patients resident in Scotland.

Format: n10

Check Digit Algorithm

(This algorithm applies to the Welsh and English NHS Number and the Northern Ireland Health & Care Number. The check digit algorithm for the Scottish CHI Number is available on request from Digital Health and Care Wales.)

Step 1 Multiply each of the first nine digits by a weighting factor as follows:

TABLE 6 DIGIT POSITION AND FACTOR FOR THE CHECK DIGIT ALGORITHM

Digit Position (starting from the left)	Factor
1	10
2	9
3	8
4	7
5	6
6	5
7	4
8	3
9	2

Step 2 Add the results of each multiplication together
Step 3 Divide the total by 11 and establish the remainder
Step 4 Subtract the remainder from 11 to give the check digit
Step 5 Check the remainder matches the check digit. If it does not, the number is invalid.
If the result of Step 4 is 11 then a check digit of 0 is used
If the result of Step 4 is 10 then the number is invalid and not used

Data Dictionary: NHS Number (wales.nhs.uk)

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

How to collect: Ideally auto populated from a Patient Administration System (PAS) or otherwise entered by clerical staff.

It is mandatory to record the NHS Number for a patient.

This data item is linked with 'NHS Number Status Indicator'.

5.2.6 NHS NUMBER STATUS INDICATOR

Definition: The status indicator provides information about the potential accuracy and reliability of the NHS number and hence the use to which the number can be put. The indicator can also be used to indicate the general standard of patient data quality within Trusts. This data item became mandatory in Wales in April 1999.

Format: an2

Data Dictionary: NHS Number Status Indicator (wales.nhs.uk)

Justification: The NHS Number is used nationally to link patients' records. This data item indicates how reliable the NHS Number will be for this purpose. In most cases, this data item will be flowed with value '01 - Number present and verified'.

This status indicates that the provider has validated the number against the Welsh Patient Demographics Service (WPDS) and can be used to reliably link to other national data sets.

How to collect: This information may be auto populated if the record has originated from a Patient Administration System where available or it might otherwise be derived by the system upon entry of the NHS Number by clerical staff.

5.2.7 PATIENT'S NAME

Definition: This will be the patients preferred name. The patient is the arbiter of his/her/their name.

Format: Either structured with two 35 alpha character elements (forename followed by surname) or an unstructured string of 70 characters

Data Dictionary: Patient's Name (wales.nhs.uk)

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

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

5.2.8 NAME FORMAT CODE

Definition: This identifies how the name of the patient in the DS is formatted.

Format: n2

Data Dictionary: Name Format Code (wales.nhs.uk)

Justification: This provides additional information as to how a patient's name is formatted. e.g. structured or unstructured.

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

5.2.9 BIRTH DATE

Definition: Date of birth of patient/client.

Format: CCYY-MM-DD.

If the Date of Birth is unknown; use the date '01/01/1900' (that is 19000101)

Data Dictionary: Birth Date (wales.nhs.uk)

Justification: Birth date is one component of the unique patient identifier for patients which is necessary if the NHS Number is not available. Birth date is used to calculate the age of the patient, which is important to know to understand patterns of healthcare use.

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

5.2.10 BIRTH DATE STATUS

Definition: This allows the recording of date supplied or date not applicable for the patient's date of birth.

Format: n1

Data Dictionary: Birth Date Status (wales.nhs.uk)

Justification: To provide additional information as to if a birth date has been supplied.

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

5.2.11 PATIENT'S USUAL ADDRESS

Definition: This is the usual address:

- (in the SCPC ds) for the patient at the Pathway Start Date (Point of Suspicion of Cancer)
- (in every other data set listed above) nominated by the patient at the time of admission or attendance. If patients usually reside elsewhere are staying in hotels, hostels or other residential establishments for a short term, say a week, they should be recorded as staying at their usual place of residence. However, if long term, such as at boarding school, the school address must be recorded. University students may nominate either their home address or the address of their university accommodation. Where patients are not capable of supplying this information, because of age or mental illness, for example, then the person responsible for the patient, such as a parent or guardian, should nominate the usual address. Patients not able to provide an address should be asked for their most recent address. If this cannot be established, then you should record the address as `No fixed abode' or `Address unknown'. These patients are regarded as resident in the local geographical district for contracting purposes. For birth episodes this should refer to the mother's usual place of residence.

Format: an175. *This is based on 5 lines of 35 characters. This relates to the physical layout of the address, not the logical layout and does not require intelligent intervention when splitting the text string into lines.*

Data Dictionary: Patient's Usual Address (wales.nhs.uk)

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

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

5.2.12 POSTCODE OF USUAL ADDRESS

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

This is the usual address:

- (in the SCPC ds) for the patient at the Pathway Start Date (Point of Suspicion of Cancer)
- (in every other data set listed above) nominated by the patient at the time of admission or attendance

Organisation Data Service rules apply.

If a patient has no fixed abode, this should be recorded with the appropriate code (ZZ99 3VZ).

For overseas visitors, the postcode field must show the relevant country pseudo postcode commencing ZZ99, plus spaces followed by a numeric, then an alpha character, then a Z. For example, ZZ99 6CZ is the pseudo-postcode for India. Pseudo-postcodes can be found in the NHS Postcode Directory.

Format: an8. *This allows a space to be inserted to differentiate between the inward and outward segments of the code, enabling full use to be made of the Royal Mail postcode functionality.*

Data Dictionary: Postcode of Usual Address (wales.nhs.uk)

Justification: To provide additional information to support tracing of the NHS Number nationally and enables a range of derivations, for example Local Health Board area of residence.

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

5.2.13 ORGANISATION CODE (LHB AREA OF RESIDENCE)

Definition: The Local Health Board where the patient is a resident, identified via the NHS Postcode Directory. This ensures that the Local Health Board can receive information about the care given to its residents.

Note: For English Residents treated in Wales, use the Organisation Code of the Primary Care Trust (PCT) of Residence for all activity / waiting times data up to 31st March 2013.

From 1st April 2013 (inclusive) onwards, use the Organisation Code of the Clinical Commissioning Group (CCG).

Reference data files containing details of the Organisation Codes for English organisations, including the NHS postcode file, can be accessed via the NHS postcode file, which is available via the Technology Reference data Update Distribution (TRUD). The TRUD website can be accessed via the following link: https://isd.hscic.gov.uk

Format: min an3 max an5

Data Dictionary: Organisation Code (LHB Area of Residence) (wales.nhs.uk)

Justification: Where the record is anonymised, this data item enables access to the record in terms of the area where the patient resides.

How to collect: Derived from postcode via Welsh Reference Data and Terminology Service (WRTS).

5.3 DATA GROUP: PATIENT CHARACTERISTICS (URGENT AND EMERGENCY CARE)

5.3.1 DEFINITION, GROUP STATUS AND JUSTIFICATION FOR DATA GROUP

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

Group status: Required

Justification: These data items are collected to better understand the population accessing UEC services both locally and nationally and supports the priorities for Goal 1: Co-ordination planning and support for populations at greater risk of needing urgent or emergency care from the 6 Goals for Urgent and Emergency Care policy[16].

5.3.2 DATA ITEMS IN THIS GROUP

TABLE 7 DATA ITEMS WITHIN THE *PATIENT CHARACTERISTICS (URGENT AND EMERGENCY CARE)* DATA GROUP

Data Item Name	Format	Status	Source
Gender Identity	an1	R	NHS Wales DD
Ethnicity	an2	R	NHS Wales DD
Accommodation Status	min n6 max n18	R	SNOMED CT
Preferred Spoken Language	min n6 max n18	R	SNOMED CT
Accessible Information Professional Required Code	min n6 max n18	R	SNOMED CT
Interpreter Language	min n6 max n18	R	SNOMED CT

5.3.3 GENDER IDENTITY

Definition: The gender of a client (as stated by the client). Gender identity is a person's sense of identification with either the male, or female sex, as manifested in appearance, behaviour, and other aspects of a person's life.

Format: an1

Data Dictionary: Core Reference Data Standards

Justification: It is necessary to collect gender identity so that the anonymised WECDS data contains important and relevant gender information. This helps to understand patterns of healthcare usage to ensure that service provision matches need.

The Equality and Diversity Council (EDC) works to bring people and organisations together to realise a vision for a personal, fair, and diverse health and care system, where everyone counts.

A person's gender may change during their lifetime because of procedures known alternatively as gender reassignment or transgender reassignment.

How to collect: Gender should be accepted as reported by the respondent. This information will be auto populated from the PAS where available otherwise entered by clerical staff.

[16] Six Goals for Urgent and Emergency Care: Policy Handbook for 2021 to 2026.

5.3.4 ETHNICITY

Definition: This is the ethnic group of the patient, as selected by the patient. The patient is the arbiter of the information. Classifications are based on the ethnic group data categories used in the 2011 Census and the information recorded about ethnic group must be obtained by asking the patient/client.

Format: an2

Data Dictionary: Core Reference Data Standards

Justification: This information is necessary to ensure equity of access to medical care.

How to collect: Ethnicity should be accepted as reported by the respondent.

This information will be auto populated from the PAS where available otherwise entered by clerical staff.

Ethnic category is the classification used for the 2011 census and is the national mandatory standard for the collection and analysis of ethnicity.

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

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

Where the first character (A) is a value taken from the list in the table, and the second character (B) is a locally defined value to be used in conjunction with the nationally defined values. If no further local breakdown is required, the second character (B) should be filled with a 'Z.'

5.3.5 ACCOMMODATION STATUS

Definition: This is the SNOMED CT concept ID which is used to identify the details of the accommodation that the person is currently living in.

Format: min n6 max n18

Data Dictionary: Accommodation Status (wales.nhs.uk)

Justification: This item is necessary to identify rates UEC service delivery including 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.

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

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

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

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

For patients who choose not to disclose their usual accommodation type, 'Usual accommodation not given: patient refused: Declines to provide accommodation details' should be used.

For instances where it is not possible to ascertain the usual accommodation type (e.g. patient unconscious) then 'Usual accommodation not given: patient physically unable: Unable to provide accommodation details' should be used.

Please find further information regarding the accommodation status codes, specifically what is included and excluded for each code definition in the table 8 overleaf:

TABLE 8 WECDS *ACCOMMODATION STATUS* WITH NOTES

WECDS Description	SNOMED UK Preferred Term	Notes
Usual stable accommodation e.g. home/flat	Housed	Includes: house, farmhouse, apartment/flat, permanent place of residence, student accommodation, rented or owned property. Excludes: Abandoned or derelict house, boarding house, hotel, caravan park, refuge, squat, homeless hostel, sofa surfing, institutional place of residence.
Warden controlled accommodation	Lives in warden controlled accommodation	Includes: warden-controlled home with intermittent welfare checks. Excludes: residential/nursing home with continuous dedicated staffing.
Residential institution WITHOUT routine nursing care	Lives in a residential home	Includes: residential home, old people's home, monastery, children's home, long term residential home placements. Excludes: hospital, nursing home, hospice, psychiatric hospital.
Residential institution WITH routine nursing care	Lives in a nursing home	Includes: nursing home, care home, hospice. Excludes: hospital, residential home, psychiatric hospital.
Medical area	Lives in hospital	Includes: hospital, psychiatric hospital (long term). Excludes: hospice, nursing home.
Lives in residential hostel homeless	Lives in residential hostel	Includes: Anyone living in a single room in a shared hostel. Examples: homeless hostel, bail hostel, women's refuge, Immigration hostel. Excludes: People who live in a night shelter (where they have no access to accommodation during the day). Rough sleeping, sofa surfing, boarding house, backpackers, hotel, caravan park, squat, temporary accommodation provided by local authority.
Homeless in night shelter	Sleeping in night shelter	Includes: night shelter, homeless shelter, emergency housing. Excludes: sleeping rough.
Housing instability patient has temporary or unstable accommodation	Housing instability	Includes: boarding house, Backpackers, hotel, caravan park, squat, temporary accommodation provided by local authority, military camp, prison. Excludes: house, farmhouse, non-institutional place of residence, apartment/flat, permanent place of residence, homeless hostel.
Sofa surfer person of no fixed abode sofa surfing	Sofa surfer - person of no fixed abode	Includes: anyone sleeping temporarily in the accommodation of a family member, friend, or acquaintance where they have no formal tenancy or right to live in that accommodation permanently. The person does not need to sleep on a sofa – they could be sleeping anywhere in the accommodation. Excludes: people with any form of tenancy or current right to sleep in any form of accommodation. People who state they are on holiday. Rough sleeping. Homeless hostel.
Homeless without accommodation	Homeless	Includes: anyone perceived to be homeless who does not fit into the above categories (please try to use the above categories first).
Sleeping rough out	Sleeping out	Includes: people sleeping on the street, in parks, in cars, on buses, in bus /train stations or airports or in settings open 24 hours such as fast-food restaurants. Excludes: people who have any form of accommodation with a bed where they can sleep at night. People sleeping in boats, caravans, or campervans. People in night shelters. Sofa surfing.
Usual accommodation not given: patient refused	Declines to provide accommodation details	Includes: any situation where the patient can physically answer questions but refuses to answer this question.
Usual accommodation not given: patient physically unable	Unable to provide accommodation details	Includes: only in a situation when the patient physically is unable to respond e.g. unconscious and not able to establish by other means.

5.3.6 PREFERRED SPOKEN LANGUAGE

Definition: This is the SNOMED CT concept ID which is used to capture the preferred spoken language of the person.

Format: min n6 max n18

Data Dictionary: Preferred Spoken Language (wales.nhs.uk)

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

How to collect: This information may be captured directly within the PAS by administrative staff on patient registration with the UEC service. Where this is not available, administrative staff should ask the question in a standard format such as:

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

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

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

N.B. This data item should always be asked before enquiring about whether an accessible information Professional is required. The codes presented to support collection of this data item are from ISO 639.1 'Codes for the Representation of Names of Languages'[17].

5.3.7 ACCESSIBLE INFORMATION PROFESSIONAL REQUIRED CODE

Definition: This is the SNOMED CT concept ID which is used to identify that the patient requires support from a communication professional.

Format: min n6 max n18

Data Dictionary: Accessible Information Professional Required Code (wales.nhs.uk)

Justification: This data item is 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.

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

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

''Do you/does [patient's name] require an interpreter?"

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

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

In cases where the need is unclear, the need for an interpreter/accessible information professional can be answered by asking the question:

"If this person needed to consent for a life-threatening operation, or were concerned about safeguarding issues, does this patient require assistance to be able to communicate in English for safe and valid consent/safeguarding decisions to be made?"

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

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

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

If the person's communication language is English, 'Interpreter required' can be assumed to be 'Interpreter not needed: Interpreter not needed (finding),' unless the person has individual communication needs e.g. sign language.

This information must:

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

N.B. This data item should always be determined before enquiring about the interpreter language.

5.3.8 INTERPRETER LANGUAGE

Definition: This is the SNOMED CT concept ID which is used to record the language of the interpreter required by the person.

Format: min n6 max n18

Data Dictionary: Interpreter Language (wales.nhs.uk)

Justification: This data item identifies the language required by the Interpreter. This ensures translation resources match patient need and support population demand.

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

N.B. This data item should be captured after enquiring about the need for an accessible information professional.

5.4 DATA GROUP: MENTAL HEALTH ACT LEGAL STATUS

5.4.1 DEFINITION, GROUP STATUS AND JUSTIFICATION FOR DATA GROUP

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

Group status: Required

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

5.4.2 DATA ITEMS IN THIS GROUP

TABLE 9 DATA ITEMS WITHIN THE *MENTAL HEALTH ACT LEGAL STATUS* GROUP

Data Item Name	Format	Status	Source
Mental Health Act Legal Status Classification Code	n2	M	NHS Wales DD
Mental Health Act Legal Status Classification Assignment Period Start Timestamp	max an25	R	NHS Wales DD
Mental Health Act Legal Status Classification Expiry Timestamp	max an25	R	NHS Wales DD

5.4.3 MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE

Definition: This is a classification of a patient's legal status which is either informal or as designated in the Mental Health Act 1983 or other acts. The classification "informal" is used for those patients who are not formally detained or not receiving supervised aftercare. The classification 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 provision of the Mental Health (Patients in the Community) Act 1995.

For the APC ds99 this data item became effective from April 1999 and, with the data item Administrative Category, replaced the data item Category of Patient.

Format: n2

Data Dictionary: Legal Status (wales.nhs.uk)

Justification:

This information is required for all patients presenting to UEC Services. This information is crucial for safeguarding the patient, ensuring compliance with legal frameworks (MHA), and supporting LHBs in making timely and effective treatment decisions.

How to collect:

This information should only be captured when a person attending the UEC service is formally detained under the MHA This will most commonly be when the person has been detained under Section 136 by the Police and brought into the UEC service as a place of safety and/or/for treatment although other uses of the MHA may be applied.

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

Depending on the model of care, people presenting to UEC services with mental health needs may have a mental health triage. During this process or at any stage during the patient's stay in the service, if it is necessary to use the MHA, then the clinician should enter the details on the Information System.

It is envisaged that this data item will be entered by selecting from a list containing the appropriate options for the service: a subset provided below, may where appropriate, make entry less cumbersome.

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

TABLE 10 SUGGESTED *MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODES*

Value	Meaning	Start Date and Time	Expiry Date and Time	Extra Notes
02	Formally detained under Mental Health Act Section 2 (Admission for assessment)	Entered. The Date/ Time Section 2 of the Mental Health Act is enacted.	Auto populated Start Date / Time Plus 28 days Can be overridden.	To be used when an application for admission for assessment is made.
03	Formally detained under Mental Health Act Section 3 (Admission for treatment of non-offender to hospital for assessment, for medical treatment)	Entered. The Date / Time Section 3 of the Mental Health Act is enacted.	Auto populated Start Date / Time Plus 6 calendar months Can be overridden.	To be used when an application for admission for treatment is made.
05	Formally detained under Mental Health Act Section 5 (2) (Power to hold informal patient already in hospital, by doctor or approved clinician)	Entered. The Date / Time Section 5 (2) of the Mental Health Act is enacted.	Auto populated Start Date / Time Plus 72 hours Can be overridden.	To be used when the Mental Health Act is enacted when a patient is on a ward (e.g. If the ED has an observation ward) to detain the patient for further assessment.
20	Formally detained under Mental Health Act Section 136 (Mentally disordered person found in a public place)	Auto populated as the Emergency Care Arrival Date / Time Can be overridden.	Auto populated Start Date / Time Plus 24 hours Can be overridden.	To be used either: When a person is brought to the ED under s136 of the Mental Health Act Or When a person is detained in the ED by an enactment of s136 of the Mental Health Act. Note: See footnote: The expiry date may need to be overridden if the s136 is extended to 36 hours.
Any other valid code		Entered.	Entered / Auto populated Note: Expiry Date / Time can be derived for time limited sections	Any other use of the Mental Health Act that is defined in the NHS Wales Data Dictionary.

5.4.4 MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START TIMESTAMP

Definition: This records the date, time and time zone that the Mental Health Act Legal Status Classification Assignment Period started.

Format: max an25 (see timestamp information)

Data Dictionary: Mental Health Act Legal Status Classification Assignment Period Start Timestamp (wales.nhs.uk)

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

How to collect: The most common use of the MHA in EDs is when a person is brought in under a section 136. In this case, the ‘clock start’ is when the patient is registered at the first place of safety and so will normally be when the person arrived at the ED. In this case the 'Mental Health Act Legal Status Classification Assignment

Period Start Timestamp' can be auto populated from the 'Urgent and Emergency Care Activity Start Timestamp' with the option of being overridden by a user.

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

For other uses of the MHA, for example, if the person is detained for further assessment, then the timestamp of the assignment period must be entered for example, by a nurse during the triage process (depending on the model of care).

5.4.5 MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION EXPIRY TIMESTAMP

Definition: This is the date, time and time zone when the 'Mental Health Act Legal Status Classification' for a patient expires.

Format: max an25 (see timestamp information)

Data Dictionary: Mental Health Act Legal Status Classification Expiry Timestamp (wales.nhs.uk)

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

How to collect: For most uses of the MHA in UEC the expiry timestamp can be auto populated by the Information System once a 'Mental Health Act Legal Status Classification Code' and 'Mental Health Act Legal Status Classification Assignment Period Start Timestamp' has been collected.

(There should be an option for the user to override the default expiry date if necessary.)

5.5 DATA GROUP: GP REGISTRATION

5.5.1 DEFINITION, GROUP STATUS AND JUSTIFICATION FOR DATA GROUP

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

Group status: Required

Justification: This information will facilitate the seamless transfer of UEC attendance details to the patient's GP, ensuring continuity of care.

5.5.2 DATA ITEMS IN THIS GROUP

TABLE 11 DATA ITEMS WITHIN *GP REGISTRATION* DATA GROUP

Data Item Name	Format	Status	Source
General Medical Practitioner (Registered)	an8	O	WRTS
Code of Registered GP Practice	an7	R	WRTS

5.5.3 GENERAL MEDICAL PRACTITIONER (REGISTERED)

Definition: This is the code of the General Medical Practitioner (GMP) with whom the patient is registered.

Format: an8

DataDictionary:https://www.datadictionary.wales.nhs.uk/#!WordDocuments/informationspecification65.htm

Justification: This data item is necessary for communication of

- The patient's attendance at the UEC service.
- The patient's on-going care needs.

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

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

5.5.4 CODE OF REGISTERED GP PRACTICE

Definition: This is the code of the patient's registered General Practitioner (GP) Practice. This allows the practice to be notified about treatment received by the patient. The registered GP Practice may or may not be the same as the referring GP Practice.

Format: an7

Data Dictionary: Core Reference Data Standards

Justification:

This data item is necessary for communication of the patient's attendance at the UEC service and their on-going care needs.

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

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

5.6 DATA GROUP: URGENT AND EMERGENCY CARE ACTIVITY LOCATION

5.6.1 DEFINITION, GROUP STATUS AND JUSTIFICATION FOR DATA GROUP

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

Group status: Mandatory

Justification: This information is collected to understand UEC service demand by site. These data items help understand patient flows and activity types between LHBs. This understanding improves the modelling and prediction of demand, aiding in service delivery, research, and public health.

5.6.2 DATA ITEMS IN THIS GROUP

TABLE 12 DATA ITEMS WITHIN *URGENT AND EMERGENCY CARE ACTIVITY LOCATION* DATA GROUP

Data Item Name	Format	Status	Source
Organisation Site Code (of Treatment)	min an5 max an9	M	WRTS
Urgent and Emergency Care Activity Type	an2	M	NHS Wales DD

5.6.3 ORGANISATION SITE CODE (OF TREATMENT)

Definition: The organisation code for the site where the patient will be or is treated.

Format: an5

Data Dictionary: Site Code (of Treatment) (wales.nhs.uk)

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

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

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

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

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

5.6.4 URGENT AND EMERGENCY CARE ACTIVITY TYPE

Definition: The type of Urgent and Emergency Care activity.

TABLE 13 CODES, ACTIVITY TYPES AND DEFINITIONS FOR *URGENT AND EMERGENCY CARE ACTIVITY TYPE*

Code	Activity Type	Description	Definition
01	Major Emergency Care Department	Emergency Care Attendance at an Emergency Care Department Type 'Major Emergency Care Department'	A Major Emergency Care Department is Consultant led and must be a 24-hour, seven day service, with full resuscitation facilities and designated accommodation for the reception of patients requiring emergency care, including those arriving by emergency ambulance.
02	Mono-specialty Emergency Care Department	Emergency Care Attendance at an Emergency Care Department Type 'Mono-specialty Emergency Care Department'	A Mono-specialty Emergency Care Department is a Consultant led mono-specialty (for example Ophthalmology, Dentistry) Emergency Care service, with designated accommodation for the reception of patients requiring emergency care. This may include Patients arriving by emergency ambulance, depending on local arrangements.
03	Minor Injury Unit	Emergency Care Attendance at an Emergency Care Department Type 'Minor Injury Unit'	A Minor Injury Unit is defined as all other Emergency Departments and Minor Injury Unit's which have designated accommodation for the reception of Urgent and Emergency Care patients and can be routinely accessed with or without appointment, but which do not meet the criteria above for a Major Emergency Care Department.
04	*Deprecated*	*Deprecated*	*Deprecated*
05	Same Day Emergency Care	Emergency Care Attendance at an Emergency Care Department Type 'Same Day Emergency Care'	NHS Wales describes Same Day Emergency Care as the provision of same day acute care for patients who would otherwise be admitted to hospital. Under this care model, patients presenting at hospital with relevant conditions can be rapidly assessed, diagnosed and treated (in a designated area) without being admitted, and if clinically safe to do so, will go home the same day their care is provided. Same Day Emergency Care is the provision of care to a patient by clinicians within an Urgent and Emergency Care Service. Same Day Emergency Care is provided within 24 hours of the 'Urgent and Emergency Care Initial Assessment Timestamp', following formal initial clinical assessment (either virtual or face to face) and referral taking place. Same Day Emergency Care is intended to provide an alternative to an Admitted Care Episode.
06	Urgent & Emergency Care Extended Care Episode	Emergency Care Attendance at an Emergency Care Department Type 'Extended Care Episode'	An Urgent and Emergency Care Extended Care Episode is an episode of clinical care for a patient under the responsibility of a named Care Professional in an Urgent and Emergency Care Service, which occurs following initial assessment by a Care Professional qualified for independent practice in Urgent and Emergency Care.

Format: an2

Data Dictionary: Urgent and Emergency Care Activity Type (wales.nhs.uk)

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

Collecting this data allows a better understanding of the case mix, acuity and value added of care, which in turn enables accurate provision of resources to match patient need.

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

Additional Information for Type 06: An Urgent and Emergency Care Extended Care Episode

Typically, the decision to initiate the type 06 Urgent and Emergency Care Extended Care Episode will be taken during an ED or SDEC attendance.

The start of an Urgent and Emergency Care Extended Care Episode: An 'Urgent and Emergency Care Extended Care Episode' starts at the 'Urgent and Emergency Care Activity End Timestamp' of the ED or SDEC attendance within which the clinical decision was taken to discharge the patient to their normal place of residence, but with an ongoing duty of care to follow up under an 'Urgent and Emergency Care Extended Care Episode'.

Attendances within an Urgent and Emergency Care Extended Care Episode: An 'Urgent and Emergency Care Extended Care Episode' spans a series of planned attendances (typically SDEC attendances) for ongoing follow up care.

If during the same period the patient attends an UEC Service for unplanned attendances (for example their condition deteriorates and they attend the ED within the same LHB/Trust), then the unplanned attendance should also be recorded as being part of the 'Urgent and Emergency Care Extended Care Episode'.

Linking Attendances to the Urgent and Emergency Care Extended Care Episode: All ED and SDEC attendances, either face to face or virtual, and either planned or unplanned, that occurs during an 'Urgent and Emergency Care Extended Care Episode' period, must be linked to the 'Urgent and Emergency Care Extended Care Episode'.

The 'Urgent and Emergency Care Activity Identifier' identifies the active Urgent and Emergency Care Extended Care Episode. This must be linked in the Information System and submitted in the patient record relating to the ED or SDEC attendance.

Episode Duration and Frequency of Follow-ups: An Urgent and Emergency Care Extended Care Episode should run for no longer than 4 weeks (28 days); and within this, the maximum interval between planned face to face or virtual attendances must be no longer than 7 days.

The Urgent and Emergency Care Extended Care Episode concludes when one of the following occurs:

Planned Discharge: The patient completes all necessary care and is formally discharged from the Urgent and Emergency Care Extended Care Episode, potentially transferring follow up care to their GP.

- Inpatient Admission: A decision to admit to a ward is taken by the responsible care professional during a planned or unplanned face to face or virtual attendance which is part of the *Urgent and Emergency Care Extended Care Episode*, for example if the condition of the patient has deteriorated such that hospital admission is now clinically required.
- Specialty Referral: The patient is referred to another specialty within the same LHB, to continue treatment as an outpatient led by a responsible care professional.
- Transfer to Another Provider: The patient's ongoing care is transferred to a different LHB to continue treatment as an outpatient led by a responsible care professional.

Patient Death: The episode concludes in the event of the patient's death. When the responsible care professional formally discharges the patient and the *Urgent and Emergency Care Extended Care Episode* is complete, the *Urgent and Emergency Care Activity End Timestamp* for that specific attendance episode aligns with *Urgent and Emergency Care Activity End Timestamp* for the extended care episode.

If the decision to close the *Urgent and Emergency Care Extended Care Episode* is taken outside a planned or unplanned attendance (for example, if the patient is admitted to another healthcare provider, the patient dies, leaves the country, or misses scheduled appointments), the *Urgent and Emergency Care Activity End Timestamp* for the episode should reflect the exact date, time, and time zone of this clinical decision.

A written summary of the care provided should be provided to both the patient and the receiving LHB once the *Urgent and Emergency Care Extended Care Episode* is closed. If the patient dies, a written summary should be sent to the GP.

5.7 DATA GROUP: AMBULANCE DETAILS (URGENT AND EMERGENCY CARE)

5.7.1 DEFINITION, GROUP STATUS AND JUSTIFICATION FOR DATA GROUP

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

Group status: Required

Justification: This data will link ambulance records with UEC data, creating a continuous view of a patient's journey from the moment an ambulance is called to their hospital discharge. By capturing this full care pathway, healthcare providers can gain insights to improve services and outcomes, ultimately benefiting patients and the broader public.

TABLE 14 DATA ITEMS WITHIN AMBULANCE DETAILS (URGENT AND EMERGENCY CARE)

Data Item Name	Format	Status	Source
Ambulance Incident Number	max an20	R	NHS Wales DD
Organisation Code (Conveying Ambulance Trust)	min an3 max an5	R	WRTS
Care Contact Identifier (Ambulance Service)	max an20	R	NHS Wales DD

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

TABLE 15 *URGENT AND EMERGENCY CARE ARRIVAL MODE* CODES INDICATED FOR COLLECTION OF *AMBULANCE DETAILS (URGENT AND EMERGENCY CARE)* DATA GROUP

WECDS Description	SNOMED UK Preferred Term	SNOMED Full Specified Name
Emergency road ambulance	Arrival by emergency road ambulance	Arrival by emergency road ambulance (finding)
Emergency road ambulance with medical escort	Arrival by emergency road ambulance with medical escort	Arrival by emergency road ambulance with medical escort (finding)
Non-emergency road ambulance e.g. St Johns Ambulance Car	Arrival by non-emergency road ambulance	Arrival by non-emergency road ambulance (finding)
Helicopter	Arrival by helicopter Air Ambulance	Arrival by helicopter Air Ambulance (finding)
Fixed wing / medical repatriation by air	Arrival by medical repatriation air ambulance	Arrival by medical repatriation air ambulance (finding)

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

5.7.2 AMBULANCE INCIDENT NUMBER

Definition: When a patient arrives by ambulance, this is the incident number for that journey, allocated by the Ambulance Control.

For patients who did not arrive by ambulance, this field should be left blank.

Format: max an8

Data Dictionary: Ambulance Incident Number (wales.nhs.uk)

Justification: This data will enable linkage of ambulance and UEC data, thus providing information about a patient from the moment an ambulance is called until they leave the hospital. This will provide learning opportunities that can benefit health care services and the public.

How to collect: It is preferable that this data is automatically transferred to the UEC Information System from the ambulance Information System using transfer of care data flows e.g. ePCR, although the *Ambulance Incident Number* may be captured manually following the hand over from the ambulance staff to the UEC service.

The patient's details should then be logged on the Information System by clerical staff with the *Ambulance Incident Number* and organisation identifier of the Ambulance Trust, which in most instances will be the national code for the Welsh Ambulance Services University NHS Trust (WAST).

5.7.3 ORGANISATION CODE (CONVEYING AMBULANCE TRUST)

Definition: The Organisation Identifier of an Ambulance Service which conveys a patient on a patient transfer journey.

Format: min an3 max an5

Data Dictionary: Organisation Code (Conveying Ambulance Trust) (wales.nhs.uk)

Justification: This data will enable linking of ambulance and UEC 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, UEC services and patients.

To remove the risk of duplication of the ambulance incident numbers assigned there is also a need to identify the organisation that issued the incident number to ensure that the combination of these is unique across the system.

How to collect: Ideally this data should be automatically transferred to the UEC Information System from the ambulance Information System using transfer of care data flows e.g. ePCR. However, it could be auto populated by selecting the name of the ambulance service (and/or the Ambulance service code identifier) from a locally sourced and managed drop-down list. The Information System would then enter the correct identifier into the patient record.

For all patients conveyed to the UEC service by WAST the codes will be the same, for Ambulance Trusts operating outside of Wales the appropriate code should be captured.

Where patients are conveyed from across the border with England by ambulance trusts other than WAST there is the potential for duplication of the ambulance incident numbers assigned so there is a need to identify the organisation that issued the incident number to ensure that the combination of these is unique across the system.

5.7.4 CARE CONTACT IDENTIFIER (AMBULANCE SERVICE)

Definition: Care Contact Identifier (Ambulance Service) is the activity identifier for a care contact allocated by the Ambulance Service. It is an identifier allocated to each ambulance incident for each patient. The patient can have more than one Care Contact Identifier (Ambulance Service) if the patient is treated more than once in separate ambulance incidents.

N.B. The Care Contact Identifier (Ambulance Service) is likely to be the Electronic Patient Clinical Record (ePCR) system case ID, or another record reference from the ePCR system.

Format: max an20

Data Dictionary: Care Contact Identifier (Ambulance Service) (wales.nhs.uk)

Justification: This data item allows the linkage of UEC data to ambulance service intervention 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, UEC services and patients.

How to collect: Ideally this data should be automatically transferred to the UEC Information System from the ambulance Information System using transfer of care data flows e.g. ePCR. Manual entry is not recommended due to the likelihood of mis-keying errors.

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

5.8 DATA GROUP: EXPECTED TIME OF TREATMENT (URGENT AND EMERGENCY CARE)

5.8.1 DEFINITION, GROUP STATUS AND JUSTIFICATION FOR DATA GROUP

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

Group status: Optional

Justification: This data group has been added with the intention it be used if/when there are facilities for a patient to be booked into an appointment at a UEC service e.g. the patient has been directed to the service by NHS 111 Wales and been given a specific timeslot to attend for treatment. These data items are intended to demonstrate whether booking in is happening within agreed timescales.

5.8.2 URGENT AND EMERGENCY CARE EXPECTED TIMESTAMP OF TREATMENT

Definition: This is the date, time and time zone a patient should expect to receive treatment at an Urgent and Emergency Care service.

Format: max an25 (see timestamp information)

Data Dictionary: Urgent and Emergency Care Expected Timestamp of Treatment (wales.nhs.uk)

Justification: This captures patients who are booked into an UEC service and helps to identify whether patients are seen within agreed standards.

N.B. It is anticipated that this data group will not be widely collected across Wales at the point of WECDS implementation. However, it is envisaged that booking patients into UEC services will become more routine and that there will be a requirement to collect this information in the future.

The timestamp will allow the creation of Key Performance Indicators that track whether this service standard is being achieved. Additionally, being able to identify patients with expected times of treatment will allow more accurate tracking of whether key UEC service standards are being achieved for walk in patients.

How to collect: This item is captured when a patient attends an UEC service having been directed there by NHS 111 Wales if the patient has been given a specific timeslot to attend for treatment. Therefore, it should only be present if the Urgent and Emergency Care Attendance Source = NHS 111 telephone/internet advice. This should be the first date/time of the appointment at the UEC service, reported by the patient e.g. if the patient is re-booked for another time this is not recorded.

5.8.3 URGENT AND EMERGENCY CARE TREATMENT ALLOCATION TIMESTAMP

Definition: This is the date, time and time zone that an *Urgent and Emergency Care Expected Timestamp of Treatment* was allocated to the patient.

Format: max an25 (see timestamp information)

Data Dictionary: Urgent and Emergency Care Treatment Allocation Timestamp (wales.nhs.uk)

Justification: This data item captures when the *Urgent and Emergency Care Expected Timestamp of Treatment* is allocated to patients who have been booked into an UEC Service and helps to identify whether patients are seen within agreed standards. N.B. It is anticipated that this data group will not be widely collected across Wales at the point of WECDS implementation. However, it is envisaged that booking patients into UEC services will become more routine and that there will be a requirement to collect this information in the future.

Incorporating the timestamp of *Urgent and Emergency Care Expected Timestamp of Treatment* will allow the creation of Key Performance Indicators that track whether this service standard is being achieved. Additionally, being able to identify patients with expected times of treatment will allow more accurate tracking of whether key service standards are being achieved for walk in patients.

How to collect: Auto populated via booking system or manually input. This item is captured when the NHS 111 operator creates the slot for the patient to attend an UEC service (it is the action of creating the slot. It is not the patient's *Urgent and Emergency Care Expected Timestamp of Treatment*. Therefore, it should only be present if the *Urgent and Emergency Care Attendance Source* = NHS 111 telephone/internet advice.

5.9 DATA GROUP: URGENT AND EMERGENCY CARE ACTIVITY CHARACTERISTICS

5.9.1 DEFINITION, GROUP STATUS AND JUSTIFICATION FOR DATA GROUP

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

Group status: Mandatory

Justification: The data group collects information to support an understanding of: why patient's attend the UEC service, the acuity of those attending, which correlates with patient outcomes (risk of death, ICU admission, hospital admission), and the type of patients attending across UEC services which may inform as to the likely nature and complexity of patient loads. In addition, key timestamps aid the measurement of a patient's journey from arrival to treatment. This will help in identifying delays and improve patient flow, ensuring timely and efficient treatment.

5.9.2 DATA ITEMS IN THIS GROUP

TABLE 16 DATA ITEMS WITHIN URGENT AND EMERGENCY CARE ACTIVITY CHARACTERISTICS GROUP

Data Item Name	Format	Status	Source
Urgent and Emergency Care Activity Identifier	min an 1 max an20	M	NHS Wales DD
Urgent and Emergency Care Consultation Mechanism	an2	R	NHS Wales DD
Urgent and Emergency Care Arrival Mode	min n6 max n18	R	SNOMED CT
Urgent and Emergency Care Attendance Category	an2	R	NHS Wales DD
Urgent and Emergency Care Attendance Source	min n6 max n18	R	SNOMED CT
Organisation Code (Urgent and Emergency Care Attendance Source)	min an5 max an9	R	WRTS
Urgent and Emergency Care Activity Start Timestamp	max an25	M	NHS Wales DD
Urgent and Emergency Care Age at Activity Date	max an3	M	NHS Wales DD
Urgent and Emergency Care Initial Assessment Timestamp	max an25	R	NHS Wales DD
Urgent and Emergency Care Acuity	min n6 max n18	R	SNOMED CT
Urgent and Emergency Care Chief Complaint	min n6 max n18	R	SNOMED CT
Urgent and Emergency Care Seen for Treatment Timestamp	max an25	R	NHS Wales DD
Urgent and Emergency Care Extended Care Episode Identifier	min an1 max an20	R	NHS Wales DD

5.9.3 URGENT AND EMERGENCY CARE ACTIVITY IDENTIFIER

Definition: This is an identifier allocated by an Urgent and Emergency Care service to provide a unique identifier for each *Urgent and Emergency Care Activity Type*.

Format: min an1 max an20

Data Dictionary: Urgent and Emergency Care Attendance Identifier (wales.nhs.uk)

Justification: This identifier is allocated by an UEC service to provide a unique identifier for each UEC activity. This item is necessary to track each individual activity; and is particularly important in data that has been anonymised as it still allows individual episodes of care to be identified.

For SDEC attendances, the *Urgent and Emergency Care Activity Identifier* must include a system generated unique identifier for each attendance performed by the LHB or Trust.

For an *Urgent and Emergency Care Extended Care Episode*, the *Urgent and Emergency Care Activity Identifier* must include the *Urgent and Emergency Care Extended Care Episode Identifier*, which is a system-generated unique identifier for each such episode.

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

There should be no overlap or duplication of identifiers between *Urgent and Emergency Care Activity Identifiers* generated by the UEC services Information System used to record each of these types of activity. For example, it is not permissible to generate the same *Urgent and Emergency Care Activity Identifier* to be used for both an ED activity and a SDEC activity. Each activity identifier must be unique within the LHB/Trust and *Organisation Site Code (of Treatment)*. In the case of duplicate activity identifiers being recorded, both should be deleted and new replacement records with unique activity identifiers should be resubmitted.

All UEC attendances (whether face to face or virtual, planned, or unplanned, that occur within the duration of an *Urgent and Emergency Care Extended Care Episode*, must be appropriately linked to that specific Extended Care Episode.

The *Urgent and Emergency Care Activity Identifier* of the open *Urgent and Emergency Care Extended Care Episode* must be linked to all relevant/associated *Urgent and Emergency Care Activity Identifiers* in the Information System and submitted in the WECDS record relating to the activity.

5.9.4 URGENT AND EMERGENCY CARE CONSULTATION MECHANISM

Definition: This is the main mechanism used to undertake Urgent and Emergency Care activity.

Format: an2

Data Dictionary: Urgent and Emergency Care Consultation Mechanism (wales.nhs.uk)

Justification: Virtual consultations are now commonly conducted across UEC. This change enables WECDS to capture the range and complexity of virtual consultations and accurately reflect the activity undertaken.

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

5.9.5 URGENT AND EMERGENCY CARE ARRIVAL MODE

Definition: This is the SNOMED CT concept ID which is used to identify the transport mode by which the patient arrived at the Urgent and Emergency Care service.

Format: min n6 max n18

Data Dictionary: Urgent and Emergency Care Arrival Mode (wales.nhs.uk)

Justification: Arrival mode helps to match the records of ambulance patients to UEC and inpatient activity and is part of the information set that allows the patient journey to be analysed across different providers in the healthcare system.

Arrival mode is often used as a proxy for patient acuity in analysis and planning as patients brought to the UEC facility by ambulance are more likely to be admitted than those who have arrived by private or public transport.

How to collect: Clerical staff should capture this information when the patient is registering at the UEC service.

"How did you get here today?"

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

5.9.6 URGENT AND EMERGENCY CARE ATTENDANCE CATEGORY

Definition: The category of Urgent and Emergency Care attendance or Same Day Emergency Care attendance which provides an indication of whether a patient is making a planned or un-planned attendance at the Urgent and Emergency Care Department.

Format: n2

Data Dictionary: Attendance Category (wales.nhs.uk)

Justification: This data item is 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 UEC service.

One of the most contentious areas in acute healthcare is whether patients access UEC because other alternatives have not been used or have failed. If patients attend UEC services despite having been seen recently in other healthcare settings, it may well be that the services currently commissioned are not effective.

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

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

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

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

If *Urgent and Emergency Care Discharge Destination* is recorded for patients who are dead on arrival, then the code which should be recorded is "Mortuary."

5.9.7 URGENT AND EMERGENCY CARE ATTENDANCE SOURCE

Definition: The source of referral for each Urgent and Emergency Care activity. The source from which the patient was referred/advised to attend the Urgent and Emergency Care service.

Format: min n6 max n18

Data Dictionary: Urgent and Emergency Care Attendance Source (wales.nhs.uk)

Justification: This data item is necessary to understand why patients attend UEC. This informs the development of service provision locally and centrally.

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

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

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

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

The term 'Nurse':

Includes:

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

Excludes:

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

The 'Ambulance Service' option should only be used when an ambulance crew are transporting a patient who deteriorates during the transfer to the extent that they need to be diverted to the UEC service.

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

5.9.8 ORGANISATION CODE (URGENT AND EMERGENCY CARE ATTENDANCE SOURCE)

Definition: The unique identifier of the organisation or site from which a patient arrived at an Urgent and Emergency Care service.

Format: min an5 max an9

Data Dictionary: Organisation Code (Urgent and Emergency Care Attendance Source) (wales.nhs.uk)

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

How to collect: This information should only be captured when the patient is booked into the UEC service following a transfer from another institution belonging to the same organisation or a different organisation for continuing care. Where a patient is transferred from an overseas provider the default code 89997 is applicable.

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

This data item should be captured for all presentations where the data item *Urgent and Emergency Care Attendance Source* is recorded as one of the following: ED, MIU, SDEC, Urgent Primary Care, Outpatient Service, Inpatient Service, Urgent Care Service.

5.9.9 URGENT AND EMERGENCY CARE ACTIVITY START TIMESTAMP

Definition: This is the start date, time and time zone which is applicable to a specific type of Urgent and Emergency Care activity.

Format: max an25 (see timestamp information)

Data Dictionary: Urgent and Emergency Care Activity Start Timestamp (wales.nhs.uk)

Justification: This timestamp is the starting point for all process metrics in UEC which then flow to DHCW e.g. time-based metrics such as the four-hour standard and time to: initial assessment, seen for treatment, clinically ready to proceed, referred to service and departure.

How to collect: This information should be auto populated by the Information System at the first point that a patient contacts the UEC service.

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

The *Urgent and Emergency Care Activity Start Timestamp* is the time that the patient presents at the UEC service (either self-presented or via another means) and is the 'clock start' time for the purposes of any time-based metrics.

For a face to face SDEC attendance (where the *Urgent and Emergency Care Consultation Mechanism* is 'Face to face'), the *Urgent and Emergency Care Activity Start Timestamp* is the date and time that the patient arrived in person or in an Emergency Ambulance at the UEC Service for the provision of SDEC.

For a SDEC attendance undertaken virtually (where the *Urgent and Emergency Care Consultation Mechanism* is 'Telephone', 'Video Consultation' or 'Chat Room (Synchronous)'), the *Urgent and Emergency Care Activity Start Timestamp* is the date and time that contact was made with the patient by a care professional from a SDEC service who is qualified to deliver virtual clinical care.

5.9.10 URGENT AND EMERGENCY CARE AGE AT ACTIVITY DATE

Definition: This is the age derived as the number of completed years between the 'Birth Date' of the patient and the 'Urgent and Emergency Care Activity Start Timestamp'.

Format: max an3

Data Dictionary: Urgent and Emergency Care Age at Activity Date (wales.nhs.uk)

Justification: This data item helps to understand patient demographics in relationship to those accessing UEC services.

How to collect: This is a derived field; it should be derived at provider level and flow in the WECDS submission.

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

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

Patients under 1 year old will be recorded as '0'.

5.9.11 URGENT AND EMERGENCY CARE INITIAL ASSESSMENT TIMESTAMP

Definition: This is the date, time and time zone that the patient is first assessed during an Urgent and Emergency Care or SDEC attendance.

An initial assessment would include:

- The taking of a brief patient medical history
- Pain assessment
- Early warning scores (including vital signs)
- Mental Health

The assessment should be conducted by a care professional who has received appropriate training.

N.B. In Wales not all patients will have an initial assessment timestamp, some will move straight to seen for treatment, if this is the case then the 'Urgent and Emergency Care Initial Assessment Timestamp' will be the 'Urgent and Emergency Care Seen for Treatment Timestamp'.

Format: max an25 (see timestamp information)

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

Justification: The initial assessment timestamp is necessary to understand and optimise the care process within UEC.

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

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

How to collect: When assessment on arrival/streaming occurs, the initial assessment time will be the arrival time. Assessment may include:

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

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

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

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

5.9.12 URGENT AND EMERGENCY CARE ACUITY

Definition: This is the SNOMED CT concept ID which is used to indicate the acuity of the patient's condition on the 'Urgent and Emergency Care Initial Assessment Timestamp'.

This is a measure of the urgency and severity of the condition with which the patient has presented to the Urgent and Emergency Care service as defined by the first clinician who assesses the patient. This may be determined by a formal triage process.

Format: min n6 max n18

Data Dictionary: Urgent and Emergency Care Acuity (wales.nhs.uk)

Justification: It is important for UEC services to use one consistent measure of acuity across all modes of care within their organisation to ensure reasonable comparisons are possible.

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

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

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

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

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

For the *Urgent and Emergency Care Acuity* codes, refer to the table below.

TABLE 17 CODES, DESCRIPTIONS, NOTES AND MAPPING FOR *URGENT AND EMERGENCY CARE ACUITY*

WECDS Description	SNOMED UK Preferred Term	SNOMED Fully Specified Name	Notes: Mapping
1 - Immediate care level emergency care	Immediate resuscitation level emergency care	Immediate resuscitation level emergency care (regime/therapy)	MTS Red - Immediate (Priority 1)/'Resus'
2 - Very urgent level emergency care	Very urgent level emergency care	Very urgent level emergency care (regime/therapy)	MTS Orange - Very Urgent (Priority 2)
3 - Urgent level emergency care	Urgent level emergency care	Urgent level emergency care (regime/therapy)	MTS Yellow - Urgent (Priority 3) / 'Majors'
4 - Standard level emergency care	Standard level emergency care	Standard level emergency care (regime/therapy)	MTS Green - Standard (Priority 4)/'Minors'
5 - Low acuity level emergency care	Non-urgent level emergency care	Non-urgent level emergency care (regime/therapy)	MTS Blue - Non-Urgent (Priority 5)

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

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

5.9.13 URGENT AND EMERGENCY CARE CHIEF COMPLAINT

Definition: This 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.

Format: min n6 max n18

Data Dictionary: Urgent and Emergency Care Chief Complaint (wales.nhs.uk)

Justification: There is a need for UEC to standardise input measurement to record accurately the type of patients attending across a range of UEC services. This will help provide a greater understanding of the likely nature and complexity of patient loads. A system-wide adoption of the *Urgent and Emergency Care Chief Complaint* will allow patient pathways to be standardised with decision support, and there is ample evidence that this improves quality of care and efficiency.

How to collect: This data item captures the nature of the patient's Chief Complaint as defined by the clinician first assessing the patient, mapped to one of the items in the list of *Urgent and Emergency Care Chief Complaint*.

'Clinician' in this context MUST be a member of staff registered by a professional registration body e.g. the Nursing and Midwifery Council who has appropriate training and support for this role and who is authorised to treat patients independently – in practice this is usually a nurse. In this context 'Clinician' does NOT include trainees or Health Care Assistants but does include Physician Associates working under the direct supervision of a registered medical practitioner.

The Urgent and Emergency Care Chief Complaint must be the initial Chief Complaint. If the Chief Complaint subsequently changes e.g. on questioning by the main treating clinician, this may be recorded locally but only the first value should be submitted as the Urgent and Emergency Care Chief Complaint. Where a clinical risk management tool (e.g. MTS) is used WECDS 'Urgent and Emergency Care Chief Complaint' also MUST be captured.

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

5.9.14 URGENT AND EMERGENCY CARE TIMESTAMP SEEN FOR TREATMENT

Definition: This is the date, time and time zone that the patient is seen by a clinical decision maker (a Care Professional who can define the management plan and discharge the patient) to diagnose the problem and arrange or start definitive treatment as necessary.

Format: max an25 (see timestamp information)

Data Dictionary: Urgent and Emergency Care Seen for Treatment Timestamp (wales.nhs.uk)

Justification: This is the timestamp at which the treating clinician first assesses the patient.

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

In this context 'Clinical Decision Maker' does include practitioners and trainees (e.g. F1 doctors and Physician Associates where applicable) assessing and treating patients under the direct supervision of an appropriately qualified clinician. The supervising clinician must always review the patient prior to discharge and their review must be registered by the Information System and must be transmitted as part of the WECDS record.

Clinician in this context does NOT include Medical Student, Nursing Student, Health Care Assistant, or any staff member not specifically trained and certified by a professional registration body to operate as a fully independent practitioner. Please refer to section 5.15.1 for more information on Care Professionals.

How to collect: This data should be auto populated by the Information System when the clinician first takes responsibility for the patient, by assigning their name to the patient immediately before physically going to see the patient or input manually if automation is not available.

5.9.15 URGENT AND EMERGENCY CARE EXTENDED CARE EPISODE IDENTIFIER

Definition: This is a system-generated activity identifier which uniquely identifies an Urgent and Emergency Care Extended Care Episode within a Health Care Provider and Organisation Site Code (of Treatment).

Format: min an1 max an20

Data Dictionary: Urgent and Emergency Care Extended Care Episode Identifier (wales.nhs.uk)

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

When the activity type is recorded as 06 - Urgent and Emergency Care Extended Care Episode, it refers to a period of clinical care managed by a named care professional within an UEC service, following an initial assessment by a qualified care professional. This episode may span several planned attendances, typically at an SDEC for ongoing follow up care.

Refer to section 5.6.4 *Urgent and Emergency Care Activity Type* additional information for Type 06: An Urgent and Emergency Care Extended Care Episode.

How to collect: This is a system generated activity identifier.

5.10 DATA GROUP: CODED ASSESSMENT TOOLS (URGENT AND EMERGENCY CARE)

5.10.1 DEFINITION, GROUP STATUS AND JUSTIFICATION FOR DATA GROUP

Definition: To carry the details of the SNOMED CT coded assessment tools for the patient.

Group status: Required

Justification: This data group, along with *Coded Observations* and *Coded Findings*, is used to capture and flow patient clinical data. It is described here in generic form, together with a simple use case to illustrate how to use it in practice. For tools such as EWS, Pain Score, Delirium Score (4AT), and the Clinical Frailty Scale, only the results from the initial assessment need to be submitted.

This data supports a better understanding of the acuity and condition of the patients presenting at UEC services.

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

When submitting the scores from a clinical assessment, the whole data group is repeated once for each section (up to*(7), in addition to once for the overall total clinical assessment score giving a total of eight entries.

A comprehensive example for a patient involving both the NEWS2 and Clinical Frailty Scale assessments is included in Appendix B.

For LHBs/Trusts that have not yet adopted these tools and are using alternatives like NEWS, data can be recorded locally and will not be included in the WECDS submission.

5.10.2 DATA ITEMS IN THIS GROUP

TABLE 18 DATA ITEMS WITHIN *CODED ASSESSMENT TOOLS (URGENT AND EMERGENCY CARE)* GROUP

Data Item Name	Format	Status	Source
Coded Assessment Tool Type	min n6 max n18	M	SNOMED CT
Person Score	max an5	M	NHS Wales DD
Assessment Tool Validation Timestamp	max an25	M	NHS Wales DD

The *Coded Assessment Tools* Group is Required and the data items within it are Mandatory, which means that the data items must be completed if the data group is relevant.

5.10.3 CODED ASSESSMENT TOOL TYPES

Definition: The SNOMED CT concept ID which is used to identify an assessment tool.

Format: min n6 max n18

Data Dictionary: Coded Assessment Tool Type (wales.nhs.uk)

Justification: This data item records the type of assessment a patient undergoes in an UEC setting such as NEWS2. This data item helps to monitor outcomes and activities depending on coded assessments.

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

The WECDS Assessment Tools tab in the WECDS ETOS shows the permissible SNOMED CT values for the assessments.

5.10.4 PERSON SCORE

Definition: The score taken from an assessment tool. This could be for an individual element of, or question within, an assessment tool, a subtotal or total score.

Format: max an5

Data Dictionary: Person Score (wales.nhs.uk)

Justification: To monitor outcomes and activities and to measure changes in health and wellbeing.

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

5.10.5 ASSESSMENT TOOL VALIDATION TIMESTAMP

Definition: This is the date, time and time zone that the 'Coded Assessment Tool Type' was validated by the Care Professional.

Format: max an25 (see timestamp information)

Data Dictionary: Assessment Tool Validation Timestamp (wales.nhs.uk)

Justification: To enable the calculation of the time difference between the *Coded Observation Timestamp* taking place and the *Assessment Tool Validation Timestamp.*

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

5.10.6 EXAMPLE CODED ASSESSMENT FOR NEWS2

Example A

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

TABLE 19 CODED SCORED ASSESSMENT SUBMISSION EXAMPLE A

Data Item Name	Example Value Submitted	SNOMED Description
Coded Assessment Tool Type	1104301000000104	Royal College of Physicians National Early Warning Score 2 - respiration rate score (observable entity)
Person Score	0	Not applicable
Assessment Tool Validation Timestamp	2024-11-28T10:15:20+01:00	Not applicable

Example B

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

TABLE 20 CODED SCORED ASSESSMENT SUBMISSION EXAMPLE B

Data Item Name	Example Value Submitted	SNOMED Description
Coded Assessment Tool Type	1104051000000101	Royal College of Physicians National Early Warning Score 2 total score (observable entity)
Person Score	12	Not applicable
Assessment Tool Validation Timestamp	2024-11-28T10:15:20+01:00	Not applicable

5.11 DATA GROUP: CODED OBSERVATIONS (URGENT AND EMERGENCY CARE)

5.11.1 DEFINITION, GROUP STATUS AND JUSTIFICATION FOR DATA GROUP

Definition: To carry the details of the SNOMED CT coded clinical observations for the patient.

Group status: Required

Justification: This data group, plus *Coded Assessment Tools (Urgent and Emergency Care)* and *Coded Findings*, is used to capture and flow patient clinical data. It is described here in generic form, together with a simple use case to illustrate how to use it in practice. For NEWS2, PEWS, Pain Score, Delirium Score (4AT) and the Clinical Frailty Scale, only the results from the first assessment need to be submitted.

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

A comprehensive example for a patient involving both the NEWS2 and Clinical Frailty Scale assessments is included in Appendix B.

5.11.2 DATA ITEMS IN THIS GROUP

TABLE 21 DATA ITEMS WITHIN *CODED OBSERVATIONS (URGENT AND EMERGENCY CARE)* GROUP

Data Item Name	Format	Status	Source
Coded Observation	min n6 max n18	M	SNOMED CT
Observation Value	max an10 Note regarding NEWS2 and the ACVPU assessment: For all NEWS2 observations other than the result of the ACVPU assessment, the observation value MUST be entered as a numerical value only and an associated UCUM Unit of Measurement must be recorded and submitted. For ACVPU the Information system should allow the user to choose from the appropriate options, and in WECDS return either the letter 'A' (Alert), 'C' (Confused), 'V' (Responds to Voice), 'P' (Responds to Painful stimulus) or 'U' (Unconscious). Do NOT to put a value in the UCUM Unit of Measurement field for ACVPU observations.	M	NHS Wales DD
Unit of Measurement (UCUM)	max an20 Do NOT put a value in the UCUM Unit of Measurement field for ACVPU* observations. ACVPU level of consciousness assessment: 'A' (Alert), 'C' (Confused), 'V' (Responds to Voice), 'P' (Responds to Painful stimulus) or 'U' (Unconscious).	R	NHS Wales DD
Coded Observation Timestamp	max an25 (see timestamp information)	M	NHS Wales DD

5.11.3 CODED OBSERVATION

Definition: The SNOMED CT concept ID which is used to identify an observable entity.

An observable entity represents a question or assessment which can produce an answer or result e.g. Systolic blood pressure.

Format: min n6 max n18

Data Dictionary: Coded Observation (wales.nhs.uk)

Justification: This item is required for analysis of the outcomes and activity related to the type of assessment a patient undergoes in an UEC setting.

How to collect: The Information System should present a logical and clear way of entering the series of observations, alongside the associated values and units of measurement.

5.11.4 OBSERVATION VALUE

Definition: The value of a Clinical Investigation result item.

Format: max an10

Data Dictionary: Observation Value (wales.nhs.uk)

Justification: Used to compare outcomes between different comparable measurements.

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

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

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

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

5.11.5 UNIT OF MEASUREMENT (UCUM)

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

Format: max an20

Data Dictionary: Unit of Measurement (UCUM) (wales.nhs.uk)

Justification: Used to compare outcomes between different comparable measurements.

How to collect: These should be recorded into the IT system either by manually entering the UCUM unit of measurement where necessary, or by auto-population from connected certified medical devices.

This is mandatory for all numerical values. For more information on UCUM please go to the following website: https://ucum.org/ucum.html

Do NOT put a value in the UCUM Unit of Measurement field for ACVPU* observations.

TABLE 22 EXAMPLE UNIFIED CODE FOR UNITS OF MEASURE (UCUM) VALUES FOR OBSERVATIONS

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

5.11.6 CODED OBSERVATION TIMESTAMP

Definition: This is the date, time and time zone that the *Coded Observation* was recorded by a Care Professional.

Format: max an25 (see timestamp information)

Data Dictionary: Coded Observation Timestamp (wales.nhs.uk)

Justification: To capture the date, time and time zone the observation was completed.

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

5.11.7 EXAMPLES FOR CODED OBSERVATION USING NEWS2

Example A

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

TABLE 23 EXAMPLE A, CODED OBSERVATION FOR NEWS2 RESPIRATION RATE

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

Example B

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

TABLE 24 EXAMPLE B, CODED OBSERVATION FOR NEWS2 ACVPU

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

5.12 DATA GROUP: CODED FINDINGS (URGENT AND EMERGENCY CARE)

5.12.1 DEFINITION, GROUP STATUS AND JUSTIFICATION FOR DATA GROUP

Definition: To carry the details of the SNOMED CT coded clinical findings for the patient.

Group status: Required

Justification: This data group, plus *Coded Assessment Tools (Urgent and Emergency Care)* and *Coded Observations (Urgent and Emergency Care)*, is used to capture and flow patient clinical data. It is described here in generic form, together with a simple use case to illustrate how to use it in practice.

How to Collect: This data group is repeated once for each Clinical Finding associated with the WECDS record. For NEWS2, Pain Score, Delirium Score (4AT) and the Clinical Frailty Scale, only the results from the first assessment need to be submitted.

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

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

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

5.12.2 DATA ITEMS IN THIS GROUP

TABLE 25 DATA ITEMS WITHIN *CODED FINDINGS (URGENT AND EMERGENCY CARE)* GROUP

Data Item Name	Format	Status	Source
Coded Finding	min n6 max n18	M	SNOMED CT
Coded Finding Timestamp	max an25	M	NHS Wales DD

5.12.3 CODED FINDING

Definition: The SNOMED CT concept ID which is used to identify a Finding.

Format: min n6 max n18

Data Dictionary: Coded Finding (wales.nhs.uk)

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

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

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

The ETOS tab 'WECDS Assessment Tool' presents acceptable, applicable SNOMED codes.

NPEWS: The ETOS tab ''WECDS Assessment Tool' presents the acceptable options for submissions.

Pain Score: The ETOS tab ''WECDS Assessment Tool' presents the acceptable options for the Pain Score. One and only one of these options MUST be used for the Pain Score.

Delirium Score (4AT): The ETOS tab 'WECDS Assessment Tool' presents the acceptable options for the Delirium Score (4AT). One and only one of these options MUST be used for the Delirium Score (4AT).

Clinical Frailty Scale: The ETOS tab 'WECDS Assessment Tool' presents the acceptable options for the Clinical Frailty Scale. One and only one of these options MUST be used for the Clinical Frailty Scale.

5.12.4 CODED FINDING TIMESTAMP

Definition: This is the date, time and time zone that the Coded Finding was recorded by a Care Professional.

Format: max an25 (see timestamp information)

Data Dictionary: Coded Finding Timestamp (wales.nhs.uk)

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

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

5.12.5 EXAMPLES FOR CODED FINDING

Example A (NEWS2)

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

TABLE 26 EXAMPLE A, CODED FINDING NEWS2

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

Example B (Clinical Frailty Scale)

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

TABLE 27 EXAMPLE B, CODED FINDING CLINICAL FRAILTY SCALE

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

5.13 DATA GROUP: URGENT AND EMERGENCY CARE INJURY CHARACTERISTICS

5.13.1 DEFINITION, GROUP STATUS AND JUSTIFICATION FOR DATA GROUP

Definition: To carry the details of injuries.

Group status: Required

Justification: To date, injury data in the UK has been collected in a fragmented manner, typically focused on specific injury causes such as road trauma, major trauma, assaults, or firework related injuries. This approach has limited the development of a comprehensive understanding of the broader causes of injury. The WECDS data items are based on the World Health Organisation's injury surveillance recommendations, combined with insights from international best practices, such as the Cardiff Model and the ISTV. Clinical expertise is not required to collect this data, and many sites successfully rely on clerical (reception) staff for this task.

Collecting injury data in a more integrated way will provide valuable evidence to better understand the external causes of injury. This data will support the creation of targeted injury prevention programs, ultimately helping to reduce the number of accidents and hospital-treated unintentional injuries.

The injury surveillance section of the WECDS is the only area where injury intent is recorded, such as for assaults or self-harm. As such, injury information is a vital part of the clinical record and must be completed for all cases where the *Urgent and Emergency Care Chief Complaint* or *Urgent and Emergency Care Diagnosis* codes are injury-related (see below). Furthermore, this information must be communicated to the patient's GP and other healthcare professionals through inclusion in the patient's letter or electronic message.

The Cardiff Model for Violence Prevention demonstrated that most violent incidents which result in emergency hospital treatment are not known to the police. Combining data from UEC services and the police on the who, when, where and how of violent events, provides a much more accurate picture which can be used to direct prevention efforts to where they are most likely to be effective.

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

If the provider has implemented the *Urgent and Emergency Care Chief Complaint* and *Urgent and Emergency Care Diagnosis* code set 'flags' these will highlight the presentations where the injury information is required.

Please see below:

- Chief Complaint injury flag equals '1'

AND / OR

- Diagnosis injury flag equals '1'

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

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

The *Urgent and Emergency Care Injury Characteristics* data group only needs to be collected once, specifically when the *Urgent and Emergency Care Attendance Category* is '1 - Unplanned first Emergency Care Attendance or Same Day Emergency Care Attendance for a new clinical condition (or deterioration of a chronic condition)'.

5.13.2 DATA ITEMS IN THIS GROUP

TABLE 28 DATA ITEMS WITHIN THE *URGENT AND EMERGENCY CARE INJURY CHARACTERISTICS* GROUP

Data Item Name	Format	Status	Source
Urgent and Emergency Care Injury Date and Time	an19 YYYY-MM-DDThh:mm:ss To avoid confusion, if the injury occurs at midnight the time recorded should never be 00:00, it should always be either 23:59 or 00:01.	M	NHS Wales DD
Urgent and Emergency Care Place of Injury	min n6 max n18	R	SNOMED CT
Urgent and Emergency Care Injury Home Status	an2	R	NHS Wales DD
Urgent and Emergency Care Place of Injury (Latitude)	max n2.n6	O	NHS Wales DD
Urgent and Emergency Care Place of Injury (Longitude)	max n3.n6	O	NHS Wales DD
Urgent and Emergency Care Injury Intent	min n6 max n18	R	SNOMED CT
Urgent and Emergency Care Injury Activity Status	min n6 max n18	R	SNOMED CT

Urgent and Emergency Care Injury Activity Type	min n6 max n18	R	SNOMED CT
Urgent and Emergency Care Injury Mechanism	min n6 max n18	R	SNOMED CT
Urgent and Emergency Care Relationship to Assailant	min n6 max n18	R	SNOMED CT
Urgent and Emergency Care Injury Alcohol or Drug Involvement	min n6 max n18	R	SNOMED CT
Urgent and Emergency Care Assault Location Description	max an255	R	NHS Wales DD

5.13.3 URGENT AND EMERGENCY CARE INJURY DATE AND TIME

Definition: The date and time that the patient was injured.

Format: an19 YYYY-MM-DDThh:mm:ss

To avoid confusion, if the injury occurs at midnight the time recorded should never be 00:00, it should always be either 23:59 or 00:01.

Data Dictionary: Urgent and Emergency Care Injury Date and Time (wales.nhs.uk)

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

Delay from injury is important to know in two situations:

- In children, delay between injury time and presentation to a healthcare professional is well recognised as a 'red flag' indicating a high risk of child abuse.
- Evidence of a delay from injury to presentation will change clinical treatment e.g. avoid closing a wound when infection is likely to be present. If a subsequent complication occurs, such as wound infection, the evidence provided by this data - that there was a delay between injury and presentation would also reduce the risk of the healthcare provider being found liable.

Knowing injury date and time allows the data to be cross-referenced with other data sets. The date and time of injuries is helpful in understanding patterns of healthcare usage; if many patients are attending an UEC service for non-acute injuries, it may be that alternative healthcare provision is necessary.

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

How to collect: This should be captured by clerical staff at the point of booking in at reception and should represent the approximate date and time of when the injury occurred. If the date or time is not known, it should be estimated. Where this information cannot be obtained directly from the patient (or patient proxy) the injury date and time should be estimated.

To avoid confusion, if the injury occurs at midnight the time recorded should never be 00:00, it should always be either 23:59 or 00:01.

5.13.4 URGENT AND EMERGENCY CARE PLACE OF INJURY

Definition: The SNOMED CT concept ID which is used to identify the type of location at which the person was present when the injury occurred.

Format: min n6 max n18

Data Dictionary: Urgent and Emergency Care Place of Injury (wales.nhs.uk)

Justification: To be able to understand the patterns of injury, and more importantly how to prevent them, it is necessary to be able to collect basic information regarding the type of place where the injury occurred. This information allows the data to be aggregated in a meaningful way so that analysis can pick up patterns of injury that occur in certain contexts e.g. assaults outside a particular pub on a particular day of the week or falls downstairs occurring inside and out of the home.

For assault related injuries understanding the location/type of location where the injury took place, alongside other information collected not only enables us to understand the type of violence that may be being experienced e.g. domestic abuse related violence (own home location), Nighttime Economy (NTE) related violence (bar/club location) but also the wider intersectional dynamics.

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

If the provider has implemented the *Urgent and Emergency Care Place of Injury* code set 'flags' these will indicate when an injury has occurred in a domestic setting and require additional information to be populated in the *Urgent and Emergency Care Home Status* data item.

Please see below:

- Place of injury flag equals '1'

For examples of how to capture *Urgent and Emergency Care Place of Injury* please see below:

TABLE 29 SCENARIOS AND GUIDANCE FOR CAPTURING *URGENT AND EMERGENCY CARE PLACE OF INJURY*

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

5.13.5 URGENT AND EMERGENCY CARE INJURY HOME STATUS

Definition: The status of home in which the person was present when the injury occurred.

Format: an2

Data Dictionary: Urgent and Emergency Care Injury Home Status (wales.nhs.uk)

Justification: This data item will identify where an apparent assault has taken place in the patient's own home or someone else's home, and when collected in conjunction with injury intent and relationship to assailant data (e.g. 'apparent assault by lone person, engaged in leisure activity, in own home') can be used as a proxy for domestic abuse. This will enable a more complete picture of the total number of domestic abuse incidents in an area when cross referenced with other data sets.

Domestic assault is underreported (particularly to the police), and health data can help to provide a more accurate reflection regarding the prevalence of domestic assault related incidents. Additionally, the Serious Violence Duty (for which health is one of the specified authorities needing to respond) places a requirement on Local Health Boards to consider Violence Against Women Domestic Abuse and Sexual Violence (VAWDASV) as part of their response to the duty. Providing this level of data would therefore provide a more holistic understanding across partners for incidents and trends of Domestic Assaults.

How to collect: This information should be collected by clerical staff at the point of booking in at reception when the *Urgent and Emergency Care Place of Injury* type selected is a domestic setting e.g. kitchen, bedroom, hallway etc. If this information is disclosed during assessment/treatment it should also be possible to update/enter this information into the record.

5.13.6 URGENT AND EMERGENCY CARE PLACE OF INJURY (LATITUDE)

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

Format: max n2.n6

Data Dictionary: Urgent and Emergency Care Place of Injury (Latitude) (wales.nhs.uk)

Justification: To be able to understand the patterns of injury, and more importantly how to prevent them, it is necessary to be able to collect basic information regarding the type of place where the injury occurred. This information allows the data to be aggregated in a meaningful way so that analysis can pick up patterns of injury that occur in certain contexts e.g. assaults outside a particular pub on a particular day of the week.

Understanding the location/type of location where the injury took place, alongside other information collected not only enables us to understand the type of violence that may be being experienced e.g. domestic abuse related violence (own home location), NTE related violence (bar/club location) but also the wider intersectional dynamics.

How to collect: The latitudinal and longitudinal coordinates of the location of the injury could be collected by extraction from another electronic system e.g. ambulance electronic patient record system, from a member of

clerical staff capturing the coordinates by using mapping software e.g. Google Maps geocoding API[18], by accessing an electronic mapping system or a kiosk system with an inbuilt electronic map. *Urgent and Emergency Care Place of Injury (Latitude)* and *Urgent and Emergency Care Place of Injury (Longitude)* are shown as separate (optional) data elements within the data set. However, the items are optional under which both elements must be present if the data is submitted.

5.13.7 URGENT AND EMERGENCY CARE PLACE OF INJURY (LONGITUDE)

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

Format: max n3.n6

Data Dictionary: Urgent and Emergency Care Place of Injury (Latitude) (wales.nhs.uk)

Justification: To be able to understand the patterns of injury, and more importantly how to prevent them, it is necessary to be able to collect basic information regarding the type of place where the injury occurred. This information allows the data to be aggregated in a meaningful way so that analysis can pick up patterns of injury that occur in certain contexts e.g. assaults outside a particular pub on a particular day of the week.

Understanding the location/type of location where the injury took place, alongside other information collected not only enables us to understand the type of violence that may be being experienced e.g. domestic abuse related violence (own home location), NTE related violence (bar/club location) but also the wider intersectional dynamics.

How to collect: The latitudinal and longitudinal coordinates of the location of the injury could be collected by extraction from another electronic system e.g. ambulance electronic patient record system, from a member of clerical staff capturing the coordinates by using mapping software e.g. Google Maps geocoding API[18], by accessing an electronic mapping system or a kiosk system with an inbuilt electronic map. *Urgent and Emergency Care Place of Injury (Latitude)* and *Urgent and Emergency Care Place of Injury (Longitude)* are shown as separate (optional) data elements within the data set. However, the items are optional under which both elements must be present if the data is submitted.

5.13.8 URGENT AND EMERGENCY CARE INJURY INTENT

Definition: The SNOMED CT concept ID which is used to identify the most likely human intent in the occurrence of the injury or poisoning as assessed by the Care Professional.

Format: min n6 max n18

Data Dictionary: Urgent and Emergency Care Injury Intent (wales.nhs.uk)

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

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

- Intentional,
- An assault,
- The result of sub-optimal judgement or,
- Completely unforeseeable e.g. 'hit by meteorite.'

Understanding injury intent underpins all injury prevention work, whether at a local or national level. An example of a targeted prevention strategy specifically focusing on one area of intent is the Welsh VPU work which relies on assault related data where the intent is apparent assault.

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

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

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

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

The standard question should be:

"Was this intentional?"

Assaults will be identified using this data item and UEC services need to ensure that all patients attending as victims of assault are recorded under one of the following two codes:

TABLE 30 IDENTIFICATION OF ASSAULTS USING *URGENT AND EMERGENCY CARE INJURY INTENT*

WECDS Description	SNOMED UK Preferred Term	SNOMED Fully Specified Name
Apparent assault (single assailant)	Alleged victim of physical assault by lone assailant	Alleged victim of physical assault by lone assailant (situation)
Apparent assault (multiple assailants)	Alleged victim of physical assault by multiple assailants	Alleged victim of physical assault by multiple assailants (situation)

Where either of the above two codes are recorded, then the data item *Urgent and Emergency Care Assault Location Description* should be completed in WECDS (note this may only be completed when the assault location is not a Home or Private Address).

If the provider has implemented the *Urgent and Emergency Care Injury Intent* code set 'flags' these will indicate when an injury has occurred as the result of an apparent assault and will require additional information to be populated in the *Urgent and Emergency Care Relationship to Assailant* data item.

Please see below:

- Relationship to assailant flag equals '1'

Coding examples: The concept WECDS aims to capture is the human intent to produce the injury, NOT the intent to undertake an activity that may have happened to result in injury.

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

TABLE 31 SCENARIOS AND GUIDANCE FOR *URGENT AND EMERGENCY CARE INJURY INTENT*

Scenario	Guidance
Child ingests a parent's prescription medication	Non-intentional injury
Patient attempts suicide by ingesting 30 paracetamol tablets	Self-inflicted injury
Patient stabbed during an attempted mugging	Alleged assault by single assailant
Juggling chainsaws (unsuccessfully)	Non-intentional injury
Stray dog bites postal worker	Injury caused by animal
A dog used intentionally as a weapon	Alleged assault by multiple assailants *(Should be coded according to the human intent i.e., assault, with the involvement of the dog captured as the injury mechanism = animal bite.)*

5.13.9 URGENT AND EMERGENCY CARE INJURY ACTIVITY STATUS

Definition: The SNOMED CT concept ID which is used to identify the status of activity being undertaken by the patient when the injury occurred.

Format: min n6 max n18

Data Dictionary: Urgent and Emergency Care Injury Activity Status (wales.nhs.uk)

Justification: Injury surveillance has resulted in major reductions in injury from road traffic collisions and workplace incidents. However, the biggest rise in injury in the last ten years are injuries occurring in the home and during leisure and sport.

An ageing population has meant that the pattern and severity of injuries occurring at home has become a significant health burden to the NHS. Better data will inform prevention of these injuries, and more granular activity data is essential for this process to understand the cause.

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

- Sport (leisure),
- Coach (paid work),
- Coach (unpaid work) or,
- School activity (being educated).

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

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

To answer both this question and the following question *Urgent and Emergency Care Injury Activity Type*, the patient should be asked:

"What were you doing at the time you were injured?"

The patient's role should be clarified if necessary:

"Were you working as a chainsaw juggler, or is this just your hobby?"

Coding examples:

TABLE 32 SCENARIOS AND GUIDANCE FOR *URGENT AND EMERGENCY CARE INJURY ACTIVITY STATUS*

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

5.13.10 URGENT AND EMERGENCY CARE INJURY ACTIVITY TYPE

Definition: The SNOMED CT concept ID which is used to identify the type of activity being undertaken by the person at the moment the injury occurred.

Format: min n6 max n18

Data Dictionary: Urgent and Emergency Care Injury Activity Type (wales.nhs.uk)

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

An ageing population has meant that the pattern and severity of injuries occurring at home has become a significant health burden to the NHS. Better data will inform prevention of these injuries, and more granular activity data is essential for this process to understand the cause.

How to collect: Similar to *Urgent and Emergency Care Injury Activity Status,* please see above.

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

When an exact activity or sport is not listed, please choose the nearest appropriate one, and if there is a clear need for a new category/activity, please submit a request to the WECDS mailbox, DHC.WECDS@wales.nhs.uk.

Coding examples:

TABLE 33 SCENARIOS AND GUIDANCE FOR *URGENT AND EMERGENCY CARE INJURY ACTIVITY TYPE*

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

5.13.11 URGENT AND EMERGENCY CARE INJURY MECHANISM

Definition: The SNOMED CT concept ID which is used to identify how an injury was caused.

Format: min n6 max n18

Data Dictionary: Urgent and Emergency Care Injury Mechanism (wales.nhs.uk)

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

From an assault perspective understanding how and with what caused the injury, when considered alongside other data provides a more holistic understanding of types of violence. For example, between 40-60% of ED assault attendees are not known by police, e.g. if the mechanism of injury was 'stabbed/cut with knife' it would be possible to more accurately understand the incidence of knife crime/assault locally to inform strategic and operational interventions.

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

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

Patients frequently volunteer the mechanism of injury but if in doubt/to clarify it may be helpful to check the mechanism by 'reading back' the *WECDS mechanism that it appears to meet:*

"So, you were juggling chainsaws, and you slipped – this sounds like 'Stabbed/cut with other sharp object'?"

Coding examples:

TABLE 34 SCENARIOS AND GUIDANCE FOR *URGENT AND EMERGENCY CARE INJURY MECHANISM*

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

5.13.12 URGENT AND EMERGENCY CARE RELATIONSHIP TO ASSAILANT

Definition: Used to identify the relationship, as disclosed by the patient, between the assailant and the patient.

Format: min n6 max n18

Data Dictionary: Urgent and Emergency Care Relationship to Assailant (wales.nhs.uk)

Justification: Knowing the relationship detail of the patient to the assailant will help understand the 'type of violence' experienced by the patient, particularly when collected in conjunction with injury activity and injury place type data (e.g. 'engaged in leisure activity in own home' can be used as a proxy for domestic abuse). This will enable a more complete picture of the total number of domestic abuse incidents in an area when cross referenced with other data sets.

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

Note: This data item is not intended to assign blame to any individual. Instead, its purpose is to gather more information about injury related incidents within the area to better understand the underlying factors.

Coding examples:

TABLE 35 SCENARIOS AND GUIDANCE FOR *URGENT AND EMERGENCY CARE RELATIONSHIP TO ASSAILANT*

Scenario	Guidance
Patient is pushed while working and sprains their ankle	Injury caused by Person in Professional Capacity to the subject record.
Stabbed while at a nightclub	Injury caused by Person not known by the subject record.
Broken nose due to being punched in the face	Injury caused by Partner of the subject record.
Tripped while walking and patient cut hand	No coding required

5.13.13 URGENT AND EMERGENCY CARE INJURY ALCOHOL OR DRUG INVOLVEMENT

Definition: The SNOMED CT concept ID which is used to identify any drugs or alcohol used by the patient, which are thought likely to have contributed to the need to attend the Urgent and Emergency Care service.

Format: min n6 max n18

Data Dictionary: Urgent and Emergency Care Injury Alcohol or Drug Involvement (wales.nhs.uk)

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

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

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

This data item collects whether, in the judgement of the person collecting the information, the injury is likely to have occurred because of alcohol or drug involvement.

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

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

Coding examples:

TABLE 36 SCENARIOS AND GUIDANCE FOR URGENT AND EMERGENCY CARE INJURY ALCOHOL OR DRUG INVOLVEMENT

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

5.13.14 URGENT AND EMERGENCY CARE ASSAULT LOCATION DESCRIPTION

Definition: This data item provides further comment and/or details of the location where an assault took place.

Format: max an255

Data Dictionary: Urgent and Emergency Care Assault Location Description

Justification: To provide further detail for Community Safety Partnerships to track and prevent violent incidents. Knowing the specific location of an assault will help partners to identify any 'hotspot' areas such as specific licensed premises where further training of staff may be required to prevent further assault incidents or specific communities such as schools that may need support in violence prevention curriculum-based activities.

How to collect: This data item should be used to record any additional information relating to the location of an apparent assault e.g. the name of the night club or the pub where the assault took place or perhaps a description of where on a street an assault has taken place e.g. 'On Sea View Road, about three metres up from the Kings Arms pub.

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

NOTE: *Urgent and Emergency Care Assault Location Description* may only be completed when the assault location is NOT a Home or Private Address, as this could identify the patient.

5.14 DATA GROUP: PATIENT CLINICAL HISTORY (URGENT AND EMERGENCY CARE)

5.14.1 DEFINITION, GROUP STATUS AND JUSTIFICATION FOR DATA GROUP

Definition: To carry the details of SNOMED CT coded patient clinical history.

Group status: Required

Justification: This provides an understanding of the patient's clinical history which ensures that the right care and treatment is delivered.

How to collect: Ideally this would be auto populated from the patient's existing clinical record. This information can be volunteered by the patient.

5.14.2 DATA ITEMS IN THIS GROUP

TABLE 37 DATA ITEMS WITHIN THE *PATIENT CLINICAL HISTORY (URGENT AND EMERGENCY CARE)* GROUP

Data Item Name	Format	Status	Source
Comorbidity	min n6 max n18	R	SNOMED CT

5.14.3 COMORBIDITY

Definition: The SNOMED CT concept ID which is used to identify comorbid conditions.

Format: min n6 max n18

Data Dictionary: Comorbidity (SNOMED CT) (wales.nhs.uk)

Justification: Comorbid conditions are a key determinant of patient complexity, risk, and outcomes in patient care e.g. whether it is safe to treat a patient in the community or whether a patient should be admitted to hospital e.g. for pneumonia, cellulitis.

An accurate list of comorbid conditions is therefore an essential piece of knowledge to ensure that the right care is delivered in the right place, and to minimise avoidable harm e.g. by admitting patients unnecessarily.

Flowing this data nationally allows a better understanding of the factors that predict complexity of UEC 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 the point of care minimises risk of inappropriate treatment and can facilitate implementation of guidelines and decision support.

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

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

It is up to the local IT provider to determine how best to record comorbid condition information in the patient record once they have been disclosed by the patient, viewed in the WCP or another local source of patient information.

5.15 DATA GROUP: CARE PROFESSIONALS (URGENT AND EMERGENCY CARE)

5.15.1 DEFINITION, GROUP STATUS AND JUSTIFICATION FOR DATA GROUP

Definition: To carry the details of the care professionals active during the Urgent and Emergency Care Activity. Care professionals means treating clinician(s) and care clinician(s) according to the definitions below.

Group status: Required

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

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

This data group is necessary to understand and optimise the care process within UEC. Ensuring that a treating healthcare professional assesses patients soon after arrival minimises the risk of undiagnosed severe disease; and is an important part of risk control in UEC.

Treating Clinician

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

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

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

Care Clinician

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

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

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

How to Collect: This group is a repeating group, which means multiple treating clinicians can be recorded against the specific episode of care. This information should be auto populated by the UEC the Information System.

5.15.2 DATA ITEMS IN THIS GROUP

TABLE 38 DATA ITEMS WITHIN THE *CARE PROFESSIONALS (URGENT AND EMERGENCY CARE)* GROUP

Data Item Name	Format	Status	Source
Professional Registration Issuer Code	an2	M	NHS Wales DD
Professional Registration Entry Identifier	min an1 max an32	M	WRTS
Urgent and Emergency Care Professional Tier	an2	M	NHS Wales DD
Urgent and Emergency Care Professional Discharge Responsibility Indicator	an1	M	NHS Wales DD
Urgent and Emergency Care Professional Clinical Responsibility Timestamp	max an25	R	NHS Wales DD

5.15.3 PROFESSIONAL REGISTRATION ISSUER CODE

Definition: A code which identifies the Professional Registration Body.
Format: an2

Data Dictionary: Professional Registration Issuer Code (wales.nhs.uk)

Justification: This is the professional registration/regulatory body for the relevant healthcare provider and identifies the type of healthcare professional providing the service. GMC (General Medical Council) guidance 'Good Clinical Practice (2019)'[19] specifically states:

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

Updated standards were published by the GMC in August 2023 which are in effect from 30 January 2024. Please see: Domain 3 Colleagues culture and safety - GMC.

Similarly, the Health and Care Professions Council (HCPC) states that:

> *"Full, clear and accurate record keeping is vital to the delivery of safe and effective healthcare."*[20]

How to collect: This data should be auto populated by the UEC IT system from the list of practitioners working in the UEC facility.

5.15.4 PROFESSIONAL REGISTRATION ENTRY IDENTIFIER

Definition: The registration identifier allocated by a Professional Registration Body.
Format: min an1 max an32

Data Dictionary: Professional Registration Entry Identifier (wales.nhs.uk)
Justification: All clinicians should know their unique identifier and its incorporation in medical records is recommended in guidance issued by the Academy of Medical Royal Colleges standard for the clinical structure and content of patient records.[21]
How to collect: This data should be auto populated by the Urgent and Emergency Care IT system from the list of practitioners working in the Urgent and Emergency Care facility.

5.15.5 URGENT AND EMERGENCY CARE PROFESSIONAL TIER

Definition: The tier of Care Professional treating the patient during an Urgent and Emergency Care activity. The Care Professional Tiers 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 : Medical and Practitioner Workforce Guidance, https://rcem.ac.uk/wp-content/uploads/2021/11/RCEM_Medical_and_Practitioner_Staffing_in_EDs.pdf
Format: an2

Data Dictionary: Urgent and Emergency Care Professional Tier (wales.nhs.uk)

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

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[19] General Medical Council. 2013. Good Medical Practice. Available at: www.gmc-uk.org/guidance/good_medical_practice.asp
[20] Health and Care Professions Council (HCPC) Record keeping |
[21] Academy of Medical Royal Colleges Standards for the clinical structure and content of patient records

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

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

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

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

A simple tier system has been developed by the RCEM that integrates the medical and non-medical practitioners in a single hierarchy and this tier system is what forms the proposed code set. (see code set and examples below)

Code Set and Examples:

TABLE 39 CODE, DESCRIPTION AND EXAMPLES FOR *URGENT AND EMERGENCY CARE PROFESSIONAL TIER*

Code	Description	Examples
01	Require complete supervision. All patients must be signed off by a senior care professional before admission or discharge.	F1 doctors, trainee practitioners, physician associates
02	Require access to advice or direct supervision, or practice independently but with limited scope.	ENPs, ANPs / ACPs, most physician associates with EM training, ESPs, F2 doctors, CT1-2 doctors, some primary care clinicians
03	More senior/experienced care professional, requiring less direct supervision. Fewer limitations in scope of practice.	CT3 in EM, junior Specialty Doctors, senior ANPs / ACPs, some physician associates, most primary care clinicians
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
05	Senior care professionals (Consultants) with accredited advanced qualifications in Emergency Medicine. Full set of extended skills. Full scope of practice.	Consultants in EM

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

How to collect: This data should be auto populated by the UEC IT system from the list of practitioners working in the UEC service.

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

TABLE 40 SCENARIOS AND EXAMPLES FOR *URGENT AND EMERGENCY CARE PROFESSIONAL TIER*

Scenarios	Examples
A medical student is allocated to take a patient's history and perform an examination. Should the medical student be listed as care professional?	No, a medical student is not a registered practitioner legally allowed to practice independently and so must always be supervised by a clinician who is certified to practice independently by an appropriate body e.g. GMC / NMC/ HCPC.
Patient seen by physician associate	A physician associate is categorised as: RCEM recognises that PAs are working at Tier 1 unless they have had specific training and experience and practice at Tier 2. [22]

[22] Update on RCEM position regarding Physician Associates | RCEM

Patient seen by a F1 (intern) doctor	An F1 doctor is Tier 1
Patient seen by F2 doctor and discussed with ED consultant, before being seen in department by surgical registrar. Which of these interactions should be coded and at what grade?	Within the ED, both the trainee doctor (Tier 2) treating the patient and the senior reviewing ED consultant (Tier 5) would be recorded. The surgical referral would be captured in the referrals section and is not recorded in this section.
Patient seen by General Practitioner working in the ED	A GP working in the ED will normally be working at Tier 3 unless they have extended ED experience and scope of practice
Patient with back pain seen and discharged by physiotherapist working in ED facility as independent practitioner seeing only minor injuries.	The physiotherapist is working as an independent practitioner treating and discharging patients without supervision from other healthcare professionals and so should be recorded as the treating care professional. As the scope of practice is limited, this would be Tier 2
Child with fractured arm seen by senior nurse practitioner and who performs reduction of the fracture with sedation performed by a senior ED trainee.	The tier of the treating nurse practitioner would be 3, and the tier of the senior ED trainee is likely to be 4.

5.15.6 URGENT AND EMERGENCY CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR

Definition: An indication of whether a Care Professional is responsible for discharge of the patient from an Urgent and Emergency Care service.

Format: an1

Data Dictionary: Urgent and Emergency Care Professional Discharge Responsibility Indicator

Justification: This identifies the clinician responsible for the patient's discharge. It will be this name that will appear on the patient discharge letter.

The discharging clinician is responsible for making sure that all treatment is complete, even if they did not initiate and conduct all treatment, and for completing coding and discharge documentation.

How to collect: Only one clinician must be responsible for the patient's discharge. This data should be auto populated by the UEC IT system using the current responsible clinician, whichever is the earliest of:

EITHER

- The time the patient is discharged from the UEC service

OR

- When the GP discharge documentation is completed.

Coding Examples:

TABLE 41 SCENARIOS AND GUIDANCE FOR *URGENT AND EMERGENCY CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR*

Scenario	Guidance
An ED patient being managed by a nurse practitioner is reviewed by a registrar from an inpatient team, who advises that they will follow up the patient in outpatients and the patient is discharged.	Although advice has been given, the patient remains an ED patient and so the ED nurse practitioner is the discharging clinician.
An ED patient is discharged by an ED F2 doctor after having discussed with an ED consultant.	The junior doctor is the clinician completing the discharge documentation. The senior review is captured separately.
An ED physician associate (or ED F1 intern doctor) assesses a patient in the ED and the patient is reviewed by an ED registrar and a discharge plan is made.	The ED registrar is the discharging clinician as neither F1 doctors nor physician associates are legally allowed to discharge patients from care.
An SDEC patient is reviewed by a Senior Pharmacist and commenced on DOAC (Direct Oral Anticoagulants) and discharged home for GP follow up	The Senior Pharmacist is the Senior Clinical Decision Maker and the discharging clinician
A patient walks into an ED department and is reviewed by the Triage Nurse. The patient is identified as SDEC suitable by the triage nurse and is transferred. The patient is reviewed in SDEC by a Physician Associate and a discharge plan is made in discussion with the SDEC Medical Consultant	The SDEC Medical Consultant is the discharging Consultant as Physician Associates are not legally allowed to discharge patients from care

5.15.7 URGENT AND EMERGENCY CARE PROFESSIONAL CLINICAL RESPONSIBILITY TIMESTAMP

Definition: This is the date, time and time zone at which the Care Professional first became clinically responsible for the patient.

Format: max an25 (see timestamp information)

Data Dictionary: Urgent and Emergency Care Professional Clinical Responsibility Timestamp (wales.nhs.uk)

Justification: This timestamp shows the sequence and seniority of clinical decision-making during the patient's journey.

How to collect: This data should be auto populated by the UEC IT system from the list of practitioners working in the UEC service.

Normally, this field should be auto populated by the UEC IT system whenever a new clinician first becomes involved in the patient's care episode. This may be when a clinician formally becomes responsible for the care of the patient, or when a clinician becomes involved in the care through other means such as conducting clinical observations.

5.16 DATA GROUP: URGENT AND EMERGENCY CARE DIAGNOSES

5.16.1 DEFINITION, GROUP STATUS AND JUSTIFICATION FOR DATA GROUP

Definition: To carry the details of SNOMED CT coded Clinical Diagnoses.

Group status: Required

Justification: The diagnosis process is the central focus of the patient journey in UEC, and often the main reason a patient attends for care. This data group provides the basis for reporting all UEC diagnoses in order of relevance and with a level of (un)certainty. This is urgently needed to articulate trends in the level and nature of demand for urgent and emergency care.

How to Collect: The treating clinician will record each diagnosis and qualifier. This data group is a repeating group and the permitted occurrence of the data group, and all its individual elements are from a minimum of zero to an unlimited maximum.

5.16.2 DATA ITEMS IN THIS GROUP

TABLE 42 DATA ITEMS WITHIN THE *URGENT AND EMERGENCY CARE DIAGNOSIS* GROUP

Data Item Name	Format	Status	Source
Urgent and Emergency Care Diagnosis	min n6 max n18	M	SNOMED CT
Urgent and Emergency Care Diagnosis Sequence Number	min n1 max n5	M	NHS Wales DD
Urgent and Emergency Care Diagnosis Qualifier	min n6 max n18	M	SNOMED CT

5.16.3 URGENT AND EMERGENCY CARE DIAGNOSIS

Definition: The SNOMED CT concept ID which is used to identify the patient diagnosis recorded during an Urgent and Emergency Care activity.

Format: min n6 max n18

Data Dictionary: Urgent and Emergency Care Diagnosis (wales.nhs.uk)

Justification: The diagnosis process is the central focus of the patient journey in UEC services, and often the main reason a patient attends for care.

For EDs, MIUs and SDEC the WECDS proposes the use of a curated list of SNOMED CT terms which are:

- Exhaustive: the data items are designed to cover all conditions commonly seen in EDs, MIUs and SDEC. Test: If a diagnosis condition had not been seen during the >50 physician years of experience of the Emergency Medicine physicians developing the list, it was not included.
- Exclusive: for any given clinical situation, there should be one and only one best answer. Test: The correct code to choose should be obvious to a F2 doctor on their first day.
- There are no symptoms (e.g. back pain) presented as a diagnosis code.
- There are no vague terms ('unwell'/'unspecified'/'other').

How to collect: The treating clinician will record each diagnosis. It is recognised that no diagnosis list could capture every condition that might present to the EDs, MIUs and SDEC, as in two coding examples:

- Very rare conditions could occur e.g. pseudopseudohypoparathyroidism
- New diagnostic entities may evolve e.g. Zika virus, Covid-19

The diagnosis should be submitted according to the following protocol:

1. The clinician should search for the most appropriate diagnosis/-es as represented in the approved diagnosis code set.
2. In the majority of patients, a diagnosis from the diagnosis code set will be the only diagnosis that a clinician will need to record.
3. The diagnosis/-es that is submitted must always be one from the diagnosis code set.
4. If a more detailed diagnosis is required and is not in the approved diagnosis code set, the clinician should select a diagnosis that is the closest match (e.g. Endocrine condition (disorder) in the case of pseudopseudohypoparathyroidism) to that required and record the more detailed diagnosis in the patient local health record.
5. If a clinician makes a more detailed diagnosis that is not contained in the approved diagnosis code set, then this diagnosis must be communicated in the transfer of care documentation e.g. in the GP discharge letter.

6. If for any reason a diagnosis has been selected outside of the approved diagnosis code set and submitted as part of WECDS, the diagnosis will flagged as a data quality error and the submitter will be notified that the data item is not in WECDS diagnosis range. In this instance, the submitter should inform DHCW that the diagnosis is missing from the WECDS *Urgent and Emergency Care Diagnosis* code set by emailing the dedicated WECDS mailbox DHC.WECDS@wales.nhs.uk. This will ensure that the code set is maintained across all users and is in line with current practice.
7. In the event of new diagnosis categories that are needed before the diagnosis code set can be updated e.g. in a pandemic, then guidance may be issued to use one of the 'research' fields (See Disease Outbreak Notification) to record relevant information.

The diagnoses, together with hierarchical and search terms are designed to make it easy to find and aggregate individual diagnostic data items.

TABLE 43 SCENARIOS AND GUIDANCE FOR *URGENT AND EMERGENCY CARE DIAGNOSIS*

Scenario	Guidance
Child attends ED with suspected ingestion of grandmother's prescribed medication.	Poisoning (suspected).
No injury or illness detected.	No abnormality detected.
Overdose of multiple drugs – beta blockers, sedatives (benzodiazepines) and alcohol, due to mental health issues.	The diagnosis should be listed in order of clinical significance to the patient's care in the ED.
Learning difficulty.	Long-term issues that are not materially involved in the acute patient episode but may still be relevant are captured in the Comorbidity section, not the diagnosis section.
Headache.	'Headache' is a symptom not a diagnosis. Codes commonly used in this situation may be: tension headache, migraine, or cluster headache.
Patients with chest pain, abdominal pain.	'Chest pain' and 'abdominal pain are symptoms, not diagnoses. When a 'confirmed' diagnosis is not possible, then a 'suspected' diagnosis should be used. The use of 'no abnormality detected' as a diagnosis has increased substantially with the introduction of ECDS. A presentation with chest pain, investigations of a d-dimer and CTPA and a final diagnosis of 'no abnormality detected' tells an accurate patient story that captures the value of the patient care in a way that a chief complaint and a diagnosis of chest pain does not.
Child with minor head injury – knocked out for 10 seconds playing football.	Minor head injury is now classified according to the length of time of loss of consciousness so we can better understand the effect of traumatic brain injury.

5.16.4 URGENT AND EMERGENCY CARE DIAGNOSIS SEQUENCE NUMBER

Definition: The sequence number of an Urgent and Emergency Care Diagnosis, recorded to enable correct sequential processing of data.
Format: min n1 max n5

Data Dictionary: Urgent and Emergency Care Diagnosis Sequence Number (wales.nhs.uk)

Justification: This enables the user to order the diagnoses in terms of significance, with the first diagnosis being the most important/significant.

How to collect: The *Urgent and Emergency Care Diagnosis Sequence Number* should be assigned to each recorded *Urgent and Emergency Care Diagnosis* by the Information System, and the diagnosis sequence must be clear for patients, staff and commissioners, as usually only the primary diagnosis will be used for most service commissioning/training/workforce analysis purposes.

5.16.5 URGENT AND EMERGENCY CARE DIAGNOSIS QUALIFIER

Definition: The SNOMED CT concept ID which is used to express the level of certainty of a patient diagnosis recorded during an Urgent and Emergency Care activity.

Format: min n6 max n18

Data Dictionary: Urgent and Emergency Care Diagnosis Qualifier (wales.nhs.uk)

Justification: A qualifier enables users to express their certainty/lack of certainty regarding a diagnosis.

How to collect: The treating clinician will record each qualifier.

The options are:

- 'Suspected' diagnosis – should be used to capture situations where the threshold for proving a diagnosis is not met, and investigation and treatment are ongoing.
- 'Confirmed present' diagnosis – should be used when the diagnosis is established beyond reasonable doubt.

A default value for the qualifier should NOT be used.

If a diagnosis is not possible, e.g. for some Mental Health diagnoses, then the most relevant/likely diagnosis should be listed with the 'Suspected' qualifier.

5.17 DATA GROUP: URGENT AND EMERGENCY CARE CLINICAL INVESTIGATIONS

5.17.1 DEFINITION, GROUP STATUS AND JUSTIFICATION FOR DATA GROUP

Definition: To carry the details of SNOMED CT coded Clinical Investigations

Group status: Required

Justification: This data group is collected to understand what happened to the patient while they attended the UEC service. Capturing this is essential for timely diagnosis, accurate treatment, and patient safety.

How to Collect: This data group is a repeating group and the permitted occurrence of the data group, and all its individual elements are from a minimum of zero to an unlimited maximum.

5.17.2 DATA ITEMS IN THIS GROUP

TABLE 44 DATA ITEMS WITHIN *URGENT AND EMERGENCY CARE CLINICAL INVESTIGATIONS*

Data Item Name	Format	Status	Source
Urgent and Emergency Care Clinical Investigation	min n6 max n18	M	SNOMED CT
Urgent and Emergency Care Clinical Investigation Timestamp	Max an25	R	NHS Wales DD

5.17.3 URGENT AND EMERGENCY CARE CLINICAL INVESTIGATION

Definition: The SNOMED CT concept ID which is used to identify a clinical investigation performed while the person is under the care of an Urgent and Emergency Care service.
Format: min n6 max n18

Data Dictionary: Urgent and Emergency Care Clinical Investigation (wales.nhs.uk)

Justification: This data item is communicated to GPs in the UEC service discharge summary as it is important for the patient and GP to understand what investigations have been performed.

How to collect: This data item should capture each of the investigations performed while the patient is under the care of the UEC service.

Investigations should be captured accurately in sufficient detail for the patient record and mapped to an appropriate WECDS code for submission.

5.17.4 URGENT AND EMERGENCY CARE CLINICAL INVESTIGATION TIMESTAMP

Definition: The date, time, and time zone at which an 'Urgent and Emergency Care Clinical Investigation' was performed during an Urgent and Emergency Care activity.

Format: max an25 (see timestamp information)

Data Dictionary: Urgent and Emergency Care Clinical Investigation Timestamp (wales.nhs.uk)

Justification: Timestamps are routinely collected by IT systems in order to track patient progress through the UEC services.

They are used to help clinicians and managers optimise patient flow through the UEC system e.g. by ensuring that patient blood samples, if needed, are taken soon after the patient arrives. These data items do not require any clinician input as they are collected when the blood tests are ordered, and therefore there is no clinical burden in collecting this information.

Collating this information and flowing it centrally will allow better benchmarking of UEC systems, ensuring optimum use of resources.

How to collect: The timestamp should be auto populated by the Information System when the clinician orders the investigation.

5.18 DATA GROUP: URGENT AND EMERGENCY CARE TREATMENTS

5.18.1 DEFINITION, GROUP STATUS AND JUSTIFICATION FOR DATA GROUP

Definition: To carry the details of SNOMED CT coded Treatments

Group status: Required

Justification: This data group documents what interventions patients receive under the care of the UEC service. Accurate treatment records help prevent errors, such as drug interactions or missed doses, and support informed decision-making for ongoing care.

How to Collect: This data group is a repeating group and the permitted occurrence of the data group, and all its individual elements are from a minimum of zero to an unlimited maximum.

5.18.2 DATA ITEMS IN THIS GROUP

TABLE 45 DATA ITEMS WITHIN THE URGENT AND EMERGENCY CARE TREATMENTS GROUP

Data Item Name	Format	Status	Source
Urgent and Emergency Care Treatment	min n6 max n18	M	SNOMED CT
Urgent and Emergency Care Treatment Timestamp	max an25	R	NHS Wales DD

5.18.3 URGENT AND EMERGENCY CARE TREATMENT

Definition: The SNOMED CT concept ID which is used to identify a patient treatment performed while a patient is under the care of an Urgent and Emergency Care service.

Format: min n6 max n18

Data Dictionary: Urgent and Emergency Care Treatment (wales.nhs.uk)

Justification: This data item is communicated to GPs in the UEC discharge summary as it is important for the patient and GP to understand what investigations have been performed.

How to collect: This data item should capture each of the treatments performed while the patient is under the care of the UEC service.

Treatments should be captured accurately in sufficient detail for the patient record and mapped to an appropriate code for submission.

5.18.4 URGENT AND EMERGENCY CARE TREATMENT TIMESTAMP

Definition: This is the date, time and time zone a patient treatment was performed during an Urgent and Emergency Care activity.

Format: max an25 (see timestamp information)

Data Dictionary: Urgent and Emergency Care Treatment Timestamp (wales.nhs.uk)

Justification: Timestamps are routinely collected by IT systems to track patient progress through UEC services.

They are used to help clinicians and managers optimise patient flow through the UEC system e.g. by ensuring that patient blood samples, if needed, are taken soon after the patient arrives.

Collating this information and flowing it centrally will allow better benchmarking of UEC, ensuring optimum use of resources.

How to collect: The timestamp should be auto populated by the IT system when the clinician undertakes the treatment.

5.19 DATA GROUP: REFERRALS TO OTHER SERVICES (URGENT AND EMERGENCY CARE)

5.19.1 DEFINITION, GROUP STATUS AND JUSTIFICATION FOR DATA GROUP

Definition: To carry the details of referrals to other services

Group status: Required

Justification: Collecting referrals to other services is essential for ensuring clinical governance, operational management, and strategic planning. It helps track patient locations, manage patient flow, and ensure appropriate services are commissioned. It captures information relating to inpatient services to which the patient was referred for admission or opinion by the treating clinician and the date/time of the referral(s).

How to Collect: This data group is a repeating group and the permitted occurrence of the data group, and all its individual elements are from a minimum of zero to an unlimited maximum.

5.19.2 DATA ITEMS IN THIS GROUP

TABLE 46 DATA ITEMS WITHIN THE REFERRALS TO OTHER SERVICES (URGENT AND EMERGENCY CARE)

Data Item Name	Format	Status	Source
Urgent and Emergency Care Referred to Service	min n6 max n18	R	SNOMED CT
Urgent and Emergency Care Referred to Service Request Timestamp	max an25	M	NHS Wales DD
Urgent and Emergency Care Referred to Service Assessment Timestamp	max an25	R	NHS Wales DD

5.19.3 URGENT AND EMERGENCY CARE REFERRED TO SERVICE

Definition: Is the SNOMED CT concept ID which is used to identify the service to which a patient was referred for admission or opinion by the treating care professional.

Format: min n6 max n18

Data Dictionary: Urgent and Emergency Care Referred to Service (wales.nhs.uk)

Justification: This data is necessary to understand and optimise the care process within UEC.

This information is essential to plan bed capacity within the hospital and is also used to understand patient flow. IT systems routinely collect the time and specialty of referral of a patient. Therefore, what is proposed will not provide an additional burden, it standardises the flow of information that is generally already collected. This data also helps inform as to what services and specialty support is necessary to provide to enable efficient urgent and emergency care.

How to collect: This data item should be captured alongside the date, time, and time zone that the patient was first referred to the service for admission or opinion, this is irrespective of acceptance or otherwise by the relevant specialty.

This information will be auto populated by the IT system based on the clinical action to refer the patient to a service.

A service to which the patient was referred by the treating clinician includes specialties that may be supra-regional e.g. burns, neurosurgery, spinal, trauma, vascular, stroke and cardiac/cardiothoracic and therefore may not be based in the same hospital.

If a patient is referred to SDEC, the *Urgent and Emergency Care Referred to Service* should equal 'Same Day Emergency Care'/'Referral for Same Day Emergency Care' and *Urgent and Emergency Care Discharge Destination* should equal 'Same Day Emergency Care Service'/'Emergency Department Discharge to Ambulatory Emergency Care Service'.

If some of the services included in the code set are not provided by the LHB then they may want to remove such items from the code set used locally.

Coding examples

TABLE 47 SCENARIOS AND GUIDANCE FOR *URGENT AND EMERGENCY CARE REFERRED TO SERVICE*

Scenario	Guidance
Patient referred to surgical team with suspected appendicitis.	Referral to general surgery
Patient with abdominal pain referred to surgical team who review and decide that it is a possible gynaecological diagnosis and refer to the gynaecology team.	First referral: general surgery Second referral: gynaecology

Patient referred to respiratory specialist nurse for review /advice Should this be coded as a referral?	The specialist nurse is a member of the respiratory medicine team, so the referral should be recorded as to 'respiratory medicine'

5.19.4 URGENT AND EMERGENCY CARE REFERRED TO SERVICE REQUEST TIMESTAMP

Definition: This is the date, time and time zone when a patient was referred to another service during an Urgent and Emergency Care activity.

Format: max an25 (see timestamp information)

Data Dictionary: Urgent and Emergency Care Referred to Service Request Timestamp (wales.nhs.uk)

Justification: The date, time and time zone and speciality of initial referral is valuable as it helps understand internal bottlenecks within the care process. Capturing this data allows better benchmarking and standardisation of care processes and implementation of care protocols for specific conditions/situations e.g. reverse queuing when exit block occurs.

How to collect: The timestamp recorded is when the patient was first referred to a service. The timestamp of the first referral is taken irrespective of acceptance or otherwise by the relevant specialty.

This data item is captured automatically on a system when a referral is made and therefore although nominally a clinician entered value, ideally this data will be automatically captured in the background.

5.19.5 URGENT AND EMERGENCY CARE REFERRED TO SERVICE ASSESSMENT TIMESTAMP

Definition: The date, time and time zone a patient was assessed by a care professional from a service to which a patient has been referred.

Format: max an25 (see timestamp information)

Data Dictionary: Urgent and Emergency Care Referred to Service Assessment Timestamp (wales.nhs.uk)

Justification: This data item captures the time interval from referral to a service to the time of the physical assessment by the inpatient team/specialist services. It is important for patient flow and patient experience that the time interval from referral to time of physical assessment by the inpatient team is recorded.

This is valuable as it helps understand internal bottlenecks within the care process. Capturing this data allows better benchmarking and standardisation of care processes and implementation of care protocols for specific conditions/situations e.g. reverse queuing when exit block occurs.

How to collect: The assessment timestamp is the date, time and time zone that the clinician from the service to which the patient has been referred physically attends the UEC service independently assesses the patient.

It is not the date, time, and time zone at which the clinician starts reviewing the patient notes, radiology, or pathology results. The assessment timestamp should be entered in real-time and captured automatically and to ensure accuracy should not be able to be amended/backdated.

If a referral is made and the assessment time is not entered, the *Urgent and Emergency Care Activity End Timestamp* should be used for that referral. This also applies in the case that a referral is made to a specialty not present on the hospital site i.e. to neurosurgery in a hospital that does not have a neurosurgical unit on site.

If the patient is not independently assessed by the inpatient team/specialist service, this data item should not be completed.

5.20 DATA GROUP: DISCHARGE FROM URGENT AND EMERGENCY CARE

5.20.1 DEFINITION, GROUP STATUS AND JUSTIFICATION FOR DATA GROUP

Definition: To carry the details of discharge from Urgent and Emergency Care.

Group status: Required

Justification: This data group is necessary to understand resource needs and transfer of responsibility between different organisations. This enables clear analysis of patient pathways through UEC.

How to collect: This data group is a required group, and the permitted occurrence of the data group is a minimum of zero and maximum of one instance.

5.20.2 DATA ITEMS IN THIS GROUP

TABLE 48 DATA ITEMS WITHIN THE *DISCHARGE FROM URGENT AND EMERGENCY CARE* GROUP

Data Item Name	Format	Status	Source
Treatment Function Code	an3	R	NHS Wales DD
Urgent and Emergency Care Clinically Ready To Proceed Timestamp	Max an25	R	NHS Wales DD
Urgent and Emergency Care Discharge Status	min n6 max n18	R	SNOMED CT
Urgent and Emergency Care Activity End Timestamp	Max an25	R	NHS Wales DD
Urgent and Emergency Care Safeguarding Concern	min n6 max n18	R	SNOMED CT
Urgent and Emergency Care Discharge Destination	min n6 max n18	R	SNOMED CT
Organisation Site Identifier (Discharge from Urgent and Emergency Care)	min an5 max an9	R	WRTS
Urgent and Emergency Care Discharge Follow Up	min n6 max n18	R	SNOMED CT
Urgent and Emergency Care Discharge Information Given Indicator	an1	R	NHS Wales DD
Treatment Function Code	an3	R	NHS Wales DD

5.20.3 TREATMENT FUNCTION CODE

Definition: This is the specialty under which the patient will be or is treated. This may either be the same as the specialty function recorded as the consultant's main specialty or a different specialty function which will be the consultant's interest specialty function. Note that both the main specialty function and the interest specialty function should be based on one of the Royal College specialties.

For the Welsh Emergency Care Data Set (WECDS):

- This is the Treatment Function Code of the service to which a patient is to be admitted following an attendance at an Urgent and Emergency Care service.

Format: 3 digit numeric

Data Dictionary: Treatment Function Code (wales.nhs.uk)

Justification: This data item captures the inpatient service to which the patient will be admitted. It is necessary to understand patient flow and should be used at a local level to be able to plan inpatient bed management.

This data item enables linking of patient records and identification of trends in the type of patients being admitted to each specialty. This in turn enables services to be configured to spread the load and specific groups of patients to be supported with interventions that avoid admission.

How to collect: These codes are routinely used across Wales. This information should be captured in the background by the IT system and will be triggered by clinical staff upon deciding to admit the patient.

5.20.4 URGENT AND EMERGENCY CARE CLINICALLY READY TO PROCEED TIMESTAMP

Definition: This is the first date, time and time zone that the Care Professional, authorised to discharge the patient from an Urgent and Emergency Care service, makes a clinical decision that the patient no longer requires ongoing care in the Urgent and Emergency Care service.

Format: max an25 (see timestamp information)

Data Dictionary: Urgent and Emergency Care Clinically Ready to Proceed Timestamp (wales.nhs.uk)

Justification: This defines when a patient has completed all the key care requirements in the UEC service and is therefore 'clinically ready to proceed' to either admission or discharge.

Capturing this data helps ensure that patients who require admitting are moved to an appropriate inpatient bed as quickly as possible to support good flow through the UEC system or discharged as appropriate.

This is an important milestone in the patient journey because it defines when the care is complete. Any delay after this point is potentially avoidable.

These measures will help understand whether patients follow the most appropriate pathway for their condition: admitting patients as quickly as possible where necessary while maximising the opportunity for doctors to make clinically based, rather than process-driven, judgements about who can safely go home.

To promote flow and minimise the risk of nosocomial infection, it is necessary to define accurately the point in the patient journey at which the patient no longer requires the care of the UEC service and can be moved to another care area or discharged.

How to collect: The *Urgent and Emergency Care Clinically Ready to Proceed Timestamp* (CRTP) is a single timestamp recorded at the first instance that the treating clinician decides that the patient is clinically stable and therefore ready to go to one of the options described in the definition. A patient may have investigations and/or treatments that have been requested by an UEC clinician e.g. CT scan. This does not mean that the patient is not CRTP.

This data item is collected for all patients, but for patients who are discharged without CRTP being completed (e.g. the MIU patients who are discharged directly after they have seen a Clinician), then the CRTP timestamp should be auto populated as the *Urgent and Emergency Care Activity End Timestamp*.

If there is any disagreement as to whether a patient is CRTP the only arbiter is the most senior UEC clinician by Tier in the UEC service at that time, sometimes defined as the 'Admitting Officer.'

Further explanation: The CRTP is the time when the patient in the UEC service has had all the care that the service should provide. The CRTP-discharge (Urgent and Emergency Care Activity End) time is the duration between the CRTP and the *Urgent and Emergency Care Activity End Timestamp* from the UEC service into the hospital. i.e. a hospital that is full, and consequently has an ED with exit block, will have long CRTP-discharge (Urgent and Emergency Care Activity End) times. The expected standard for a patient who has been identified as CRTP should be less than 60 minutes. So, it is a measure of hospital operational capacity.

- A patient attends breathless, they have nursing and medical assessments, blood tests, an x-ray, and are diagnosed with pneumonia severe enough to warrant admission for IV antibiotics and oxygen via a face mask. The antibiotics are administered in the ED, oxygen is applied, and further tests that are specific to the diagnosis are conducted (e.g. sputum sample for microbiology). The patient has now had all the care that the ED should deliver and is clinically ready to proceed to a ward.
- A patient with a fall and hip pain. They are investigated along a fractured neck of femur pathway, have blood tests, x-rays, ECGs, analgesia, fascia iliaca block, intravenous fluids etc. and are then ready to go up to the ward. That is the time that they are clinically ready to proceed (to the ward).

In both those cases the patient may then be able to go to the ward straight away, or there may be a delay before the bed is available.

5.20.5 URGENT AND EMERGENCY CARE DISCHARGE STATUS

Definition: This is the SNOMED CT concept ID which records the status of the patient on discharge from an Urgent and Emergency Care service. It captures whether:

- Treatment took place within the Urgent and Emergency Care service
- If the patient was streamed to another service
- If the patient left before treatment was complete.

Format: min n6 max n18

Data Dictionary: Urgent and Emergency Care Discharge Status (wales.nhs.uk)

Justification: The data is necessary to understand patient flow accurately and is used in real time at a local level to able to plan inpatient bed management.

This data item and its counterparts *Urgent and Emergency Care Discharge Destination* and *Urgent and Emergency Care Discharge Follow up* are necessary to understand resource needs and transfer of responsibility between different organisations.

This will enable clear analysis of patient pathways through UEC, and the increased clarity will ensure that commissioners can accurately match provision with need.

How to collect: This information will be captured by clinical staff upon discharging the patient.

Where the *Urgent and Emergency Care Discharge Status* equals 'Left before initial assessment/Left care setting before initial assessment' then the *Urgent and Emergency Care Diagnosis* must be equal to 'Left before clinical assessment/Patient walked out.'

Where the *Urgent and Emergency Care Discharge Status* equals 'Dead on arrival/Dead on arrival at hospital' then the *Urgent and Emergency Care Diagnosis* must be equal to 'Dead on arrival/Dead on arrival in Accident and Emergency Department.'

TABLE 49 CODING EXAMPLES FOR *URGENT AND EMERGENCYCARE DISCHARGE STATUS*

WECDS Description	SNOMED UK Preferred Term	SNOMED Fully Specified Name
Left before initial assessment	Left care setting before initial assessment	Left care setting before initial assessment (finding)
Left after assessment with intent to attend other healthcare provider	Left care setting after initial assessment	Left care setting after initial assessment (finding)
Left after assessment but before treatment complete (destination unknown)	Left care setting before treatment completed	Left care setting before treatment completed (finding)
Dead on arrival	Dead on arrival at hospital	Dead on arrival at hospital (finding)

5.20.6 URGENT AND EMERGENCY CARE ACTIVITY END TIMESTAMP

Definition: This is the date, time and time zone when the patient physically leaves an Urgent and Emergency Care service after an Urgent and Emergency Care activity has concluded.

Notes: For patients who die in an Urgent and Emergency Care service this is the date, time and time zone that the body was removed from the Urgent and Emergency Care service.

The patient may leave the Urgent and Emergency Care service temporarily during an Urgent and Emergency Care attendance, for example for an X-ray, but they remain under the care of an Urgent and Emergency Care Consultant.

Format: max an25 (see timestamp information)

Data Dictionary: Urgent and Emergency Care Activity End Timestamp (wales.nhs.uk)

Justification: This data item defines the end of the patient's care in the UEC service and therefore is essential to calculate the elapsed time spent in the service from patient arrival.

A patient that is being cared for by UEC staff has not departed the UEC service, unless they are being cared for in a designated observation/short stay/clinical decision unit that is managed by the UEC service, and which satisfies the NHS Wales definition of such areas.

The elapsed time is the single most cited key performance indicator for UEC that is calculated – the four-hour standard of care, which is defined as from patient arrival to departure. This measure is calculated using: *Urgent and Emergency Care Activity Start Timestamp - Urgent and Emergency Care Activity End Timestamp*.

How to collect: This captures the date, time, and time zone when the patient physically left the UEC area. This is the 'clock stop' time for the purposes of any time-based standard that applies to UEC. This data item is collected for all patients.

- For an UEC attendance where the *Urgent and Emergency Care Consultation Mechanism* is national code 'Face to face,' the end of this activity is recorded as the *Urgent and Emergency Care Activity End Timestamp*.
- For an UEC attendance undertaken virtually (where the *Urgent and Emergency Care Consultation Mechanism* is national code 'Telephone', 'Video Consultation' or 'Chat Room (Synchronous)'), the *Urgent and Emergency Care Activity End Timestamp* is the date and time that contact with the patient is completed and the virtual UEC attendance concludes.

For an *Urgent and Emergency Care Extended Care Episode* the *Urgent and Emergency Care Activity End Timestamp* is the date and time that the *Urgent and Emergency Care Activity Type* (06 Urgent and Emergency Care Extended Care Episode) closes.

Notes: For patients who die during an UEC attendance (or dead on arrival), the *Urgent and Emergency Care Activity End Timestamp* is the date the body was removed from the UEC service premises.

The patient may leave the UEC service temporarily during an UEC activity, for example for an X-ray, but they remain under the care of a consultant in the UEC service.

5.20.7 URGENT AND EMERGENCY CARE SAFEGUARDING CONCERN

Definition: This 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.

Format: min n6 max n18

Data Dictionary: Urgent and Emergency Care Safeguarding Concern (wales.nhs.uk)

Justification: Safeguarding information is routinely collected at a local level as part of normal safeguarding requirements but is collected inconsistently. There is no consistent central information regarding number and nature of referrals for safeguarding.

The SNOMED CT refset was developed in conjunction with the NHS England Safeguarding team and specialty colleges e.g. Royal College of Paediatrics and Child Health and Royal College of Emergency Medicine during development to allow clinicians to record their concerns about patient welfare in a structured manner.

How to collect: Within the UEC IT system, the list should be headed 'Safeguarding issues/follow up required.' This data item does not imply that there is necessarily a problem, rather, it allows clinicians to identify patients where:

- There are concerns regarding the patient's welfare or that of other vulnerable persons
- There are identified risks to the patient's welfare or other vulnerable persons
- There is evidence of harm to the patient or other vulnerable persons.

Recording a safeguarding concern does not imply that there is necessarily a significant safeguarding issue rather that the clinician has identified the need for more information and that follow up is necessary to ensure the welfare of the patient or other potentially vulnerable individuals.

This should be phrased as:

"Follow up is requested regarding concerns of UEC staff regarding specific safeguarding concerns."

The safeguarding data item in the WECDS MUST be completed before a patient leaves the UEC service unless the patient leaves before care is completed.

In the case that a patient leaves the UEC service before care is completed, the safeguarding data item must still be completed, as these individuals are more likely than the general UEC population to have safeguarding issues.

5.20.8 URGENT AND EMERGENCY CARE DISCHARGE DESTINATION

Definition: This is the SNOMED CT concept ID which is used to identify the intended destination of the patient following discharge from an Urgent and Emergency Care activity.

Format: min n6 max n18

Data Dictionary: Urgent and Emergency Care Discharge Destination (wales.nhs.uk)

Justification: The physical destination of the patient is used to understand the patient's journey and, at the most basic level, whether they are admitted to hospital or discharged.

In addition, it also collects information about the care level of the ward in which the patient is admitted e.g. Intensive Care Unit/High Dependency Unit. This is useful to understand patterns of acuity, especially at a high level or if services are under severe pressure e.g. pandemic/disaster.

This data item and its counterparts *Urgent and Emergency Care Discharge Status* and *Urgent and Emergency Care Discharge Follow up* are necessary to understand resource needs and transfer of responsibility between different organisations.

How to collect: This information will be captured by clinical staff upon discharging the patient and will generally be coded in the background e.g. discharge to 'Oak Ward' will be coded as 'Admitted – ward bed outside ED'/'Discharged to ward'.

Coding examples

TABLE 50 CODING EXAMPLES FOR *URGENT AND EMERGENCY CARE DISCHARGE DESTINATION*

Scenario	Guidance
13-year-old male attends with suspected torsion of testis. Paediatric Surgery is not provided at the hospital of attendance, so the patient is transferred as an emergency to another hospital.	Transfer to another hospital/healthcare facility / Patient transfer, to another health care facility
Patient brought to ED unconscious but wakes up and becomes increasingly aggressive and assaults a member of	Police/Discharge to police custody

staff. After excluding conditions requiring acute medical or psychiatric intervention, police remove the patient.	
Patient did not wait to be seen in the UEC service.	The UEC system should be set up so that if a patient leaves before being seen, it is not necessary to input a Discharge Destination. If the *Urgent and Emergency Care Discharge Status* = Left before initial assessment/ Left care setting before initial assessment, the record will be valid with a null value in *Urgent and Emergency Care Discharge Destination*.
A patient who normally resides in a nursing home attends ED and is treated and discharged back to the nursing home.	Residential care facility with 24-hour nursing care (e.g. nursing home)/ Discharge to nursing home

5.20.9 ORGANISATION SITE IDENTIFIER (DISCHARGE FROM URGENT AND EMERGENCY CARE)

Definition: The organisation identifier of the healthcare facility to which a patient is discharged following an Urgent and Emergency Care activity.

Format: min an5 max an9

Data Dictionary: Organisation Site Identifier (Discharge from Urgent and Emergency Care) (wales.nhs.uk)

Justification: This is designed to collect information regarding transfers of acute patients between healthcare facilities (including private healthcare facilities).

As UEC 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 be able to follow the patient journey and understand how resources are used.

How to collect: This information should only be recorded where *Urgent Emergency Care Discharge Destination* is code 'Transfer to another hospital/healthcare facility'/'Patient transfer to another health facility', irrespective of whether or not the patient is admitted at the sending hospital e.g. to Short Stay/Acute Clinical Unit/Observation ward.

Clerical staff will enter the name of the transfer organisation which will auto-populate the organisation's WRTS national code.

5.20.10 URGENT AND EMERGENCY CARE DISCHARGE FOLLOW UP

Definition: This is the SNOMED CT concept ID which is used to identify the service to which a patient was referred for continuing care following an Urgent and Emergency Care activity.

Format: min n6 max n18

Data Dictionary: Urgent and Emergency Care Discharge Follow Up (wales.nhs.uk)

Justification: This data item and its counterparts *Urgent and Emergency Care Discharge Destination* and *Urgent and Emergency Care Discharge Follow up* are necessary to understand resource needs and transfer of responsibility between different organisations.

The follow up options specified in this coded/structured section would normally be complemented by free text in the clinical narrative that would be sent to the GP. This is particularly important when the follow up requires more detail or specific/unusual consideration.

How to collect: This information will be captured by clinical staff upon discharging the patient. This will usually be via a list of local options for follow up e.g. fracture clinic/Deep Vein Thrombosis clinic which will then be coded to the relevant options in the WECDS code list.

TABLE 51 CODING EXAMPLES FOR URGENT AND EMERGENCY CARE DISCHARGE FOLLOW-UP

Scenario	Guidance
Patient admitted to inpatient bed	No coding required for this data item
Patients who die in the department	No coding required for this data item
Patient is having follow-up in outpatients and their GP; what do we code?	Referral to outpatient department

5.20.11 URGENT AND EMERGENCY CARE DISCHARGE INFORMATION GIVEN INDICATOR

Definition: This is used to identify whether a copy of the General Practitioner letter has been given to the patient on discharge from an Urgent and Emergency Care service.

Format: an1

Data Dictionary: Urgent and Emergency Care Discharge Information Given Indicator (wales.nhs.uk)

Justification: This is designed to ensure that the patient is provided with a physical, printed copy of the letter to the GP. This minimises the risk of miscommunication and ensures that the patient always has a written follow-up plan.

Giving the patient a copy of the discharge letter:

- Improves and ensures consistency of communication between the UEC 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 their understanding. This reduces the risk of complaints and provides the hospital with a good defence against complaints or legal action e.g. a patient who has a fit is told they cannot drive. If such a patient subsequently drives and injures other road users and there is evidence that the patient had a letter printed that contained the instruction not to drive, this ensures the NHS is not potentially liable.
- It ensures the doctor has entered all the relevant clinical information before the patient leaves.

Note: this is not a substitute for an electronic copy of the letter, which will be sent anyway as part of the service specification.

However, it is well known that a relatively high proportion of UEC patients do not have a GP or may be itinerant, so this document may be the only record they have to take to another healthcare provider.

While an electronic copy may also be provided e.g. through a patient portal, a paper copy allows all patients to access this information, and if necessary, to share it with other parties e.g. to help the patient understand items within it, and this is particularly important if there are barriers to communication.

How to collect: Answers the question:

"Has the GP letter been printed and given to the patient?"

The field should be auto populated e.g. auto ticked when the GP letter is generated by the system. It should be possible to override (e.g. un-tick) this if the letter is not given to the patient.

5.21 DATA GROUP: RESEARCH AND DISEASE OUTBREAK NOTIFICATION (URGENT AND EMERGENCY CARE)

5.21.1 DEFINITION, GROUP STATUS AND JUSTIFICATION FOR DATA GROUP

Definition: To carry details of any Research and/or Disease Outbreak Notifications.

Group status: Optional

Justification: This purpose of this data group is to support the capture and flow of data regarding major public health threats and clinical research trials. Capturing research and disease outbreak data is crucial for early detection, monitoring, and controlling the spread of diseases. It enables public health authorities to make informed decisions about interventions, allocate resources effectively, and prevent further transmission. This data helps identify risk factors, understand disease patterns, and assess the effectiveness of treatments and vaccines.

How to Collect: These items are to be collected when either patients present at and are enrolled on clinical trials or when patients are diagnosed with infectious disease health threats.

Data Item Name	Format	Status	Source
Clinical Trial Identifier	max an20	O	NHS Wales DD
Urgent and Emergency Care Disease Outbreak Notification Description	max an20	R	NHS Wales DD
Urgent and Emergency Care Disease Outbreak Notification	min n6 max n18	R	SNOMED CT

5.21.2 CLINICAL TRIAL IDENTIFIER

Definition: A unique identifier assigned to a Clinical Trial.

Format: max an20

Data Dictionary: Clinical Trial Identifier (wales.nhs.uk)

Justification: This field identifies when a patient attends the UEC service and is either enrolled in or being recruited for a clinical trial during their visit. Nearly all research in Urgent and Emergency Care in the UK is government funded, and therefore data collection and aggregation are an important direct cost for any research. At present, the customisation of any software to aggregate the results of patient recruitment into clinical trials is a significant barrier and cost to such research. Inability to do research harms the NHS' ability to better understand emergency care and commission care that meets patient needs.

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

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

By including this field, the data set will address key PHW National Institute of Health Research (NIHR) priorities for efficient research design. Researchers will be able to collect patient data from one or more organisations and/or sites.

How to collect: The IT system should provide the ability to enter a trial identifier which is recognised and registered with an organisation which is a Primary Registry in the World Health Organization International Clinical Trials Registry Platform.

5.21.3 URGENT AND EMERGENCY CARE DISEASE OUTBREAK NOTIFICATION DESCRIPTION

Definition: This supports the collection of nationally notifiable data relating to outbreaks of disease which are identified in Urgent and Emergency Care Services, where a SNOMED CT code is NOT available.

Format: max an20

Data Dictionary: Urgent and Emergency Care Disease Outbreak Notification Description (wales.nhs.uk)

Justification: This data item supports collection of nationally notifiable data relating to outbreaks of disease which are identified in UEC services.

Ability to capture and flow data regarding major public health threats will enable research into and rapid response with automatic data aggregation, which will save considerable time at a local and national level. This will enable scarce resources to be concentrated on patient care rather than on collecting/transmitting/aggregating and reporting data.

By including this field, the data set will address key PHW and NIHR priorities for efficient research design and will enable research into and rapid response to major infectious disease health threats.

How to collect: Where a SNOMED CT code is NOT available, the *Urgent and Emergency Care Disease Outbreak Notification Description* field should be completed. It will be permissible to submit locally agreed codes as specified by Public Health officials in this field.

5.21.4 URGENT AND EMERGENCY CARE DISEASE OUTBREAK NOTIFICATION

Definition: This is the SNOMED CT concept ID describing nationally notifiable outbreaks of disease which are identified in Urgent and Emergency Care Services.
Format: min n6 max n18

Data Dictionary: Urgent and Emergency Care Disease Outbreak Notification (wales.nhs.uk)

Justification: This data item supports collection of nationally notifiable data relating to outbreaks of disease which are identified in UEC services.

Ability to capture and flow data regarding major public health threats will enable research into and rapid response with automatic data aggregation, which will save considerable time at a local and national level. This will enable scarce resources to be concentrated on patient care rather than on collecting/transmitting/aggregating and reporting data.

By including this field, the data set will address key PHW and NIHR priorities for efficient research design and will enable research into and rapid response to major infectious disease health threats.

How to collect: Where a SNOMED CT code is available, the *Urgent and Emergency Care Disease Outbreak Notification* field should be completed.

6 ATTACHMENTS / APPENDIX

6.1 APPENDIX A: OVERVIEW OF EACH DATA GROUP

TABLE 52 OVERVIEW OF EACH DATA GROUP INCLUDING MANDATE, REPEATS AND DATA ITEMS WITHIN THE GROUP

Name of Data Group	Associated Tabs	Group Description	Group Mandate	Group Repeats	Data Items within Group
Patient Identity	1.1 NHS Number Status Indicator 1.2 Birth Date Status 1.3 Name Format Code	To carry the identity of the patient.	M	1..1	Local Patient Identifier Organisation Code (Code of Provider) NHS Number NHS Number Status Indicator Patient's Name Name Format Code Birth Date Birth Date Status Patient's Usual Address Postcode of Usual Address Organisation Code (LHB Area of Residence)
Patient Characteristics (Urgent and Emergency Care)	2.1 Gender Identity 2.2 Ethnic Group 2.3 Accommodation Status 2.4 Preferred Spoken Language 2.5 Accessible Information Professional Required Code 2.6 Interpreter Language	To carry the characteristics of the Patient for an Emergency Care Attendance.	R	0..1	Gender Identity Ethnicity Accommodation Status Preferred Spoken Language Accessible Information Professional Required Code Interpreter Language
Mental Health Act Legal Status	3.1 Mental Health Act Legal Status Classification Code	To carry the patient's Mental Health Act Legal Status.	R	0..*	Mental Health Act Legal Status Classification Code Mental Health Act Legal Status Classification Assignment Period Start Timestamp Mental Health Act Legal Status Classification Expiry Timestamp
GP Registration		To carry the Patient's General Medical Practitioner and the General Practice details.	R	0..1	General Medical Practitioner (Registered) Code of Registered GP Practice
Urgent And Emergency Care Activity Location	5.1 Organisation Site Code (of Treatment) 5.2 Urgent and Emergency Care Activity Type	To carry the details of the Urgent and Emergency Care Activity location.	M	1..1	Organisation Site Code (of Treatment)Urgent and Emergency Care Activity Type
Ambulance Details (Urgent and Emergency Care)		To carry ambulance details relating to the patient's arrival at Urgent and Emergency Care.	R	0..1	Ambulance Incident Number Organisation Code (Conveying Ambulance Trust) Care Contact Identifier (Ambulance Service)
Expected Time of Treatment (Urgent and Emergency Care)		To carry the expected date and time of treatment that is given to the patient.	O	0..1	Urgent and Emergency Care Expected Timestamp of Treatment Urgent and Emergency Care Treatment Allocation Timestamp
Urgent And Emergency Care	8.1 Urgent and Emergency Care Consultation Mechanism	To carry the characteristics of the Urgent and Emergency Care Activity.	M	1..1	Urgent and Emergency Care Activity Identifier Urgent and Emergency Care Consultation Mechanism Urgent and Emergency Care Arrival Mode

Activity Characteristics	8.2 Urgent and Emergency Care Arrival Mode 8.3 Urgent and Emergency Care Attendance Category 8.4 Urgent and Emergency Care Attendance Source 8.5 Organisation Code (Urgent and Emergency Care Attendance Source) 8.6 Urgent and Emergency Care Acuity 8.7 Urgent and Emergency Care Chief Complaint				Urgent and Emergency Care Attendance Category Urgent and Emergency Care Attendance Source Organisation Code (Urgent and Emergency Care Attendance Source) Urgent and Emergency Care Activity Start Timestamp Urgent and Emergency Care Age at Activity Date Urgent and Emergency Care Initial Assessment Timestamp Urgent and Emergency Care Acuity Urgent and Emergency Care Chief Complaint Urgent and Emergency Care Seen for Treatment Timestamp Urgent and Emergency Care Extended Care Episode Identifier
Coded Assessment Tools (Urgent and Emergency Care)	WECDS Assessment Tools 9.1 Coded Assessment Tool Type	To carry the details of the SNOMED CT coded assessment tools for the patient. The Coded Scored Assessment data group would be repeated once for each of the completed sections of the (NEWS2) assessment (up to*(7) and once for the overall (NEWS2) score giving a total of 8.	R	0..*	Coded Assessment Tool Type Person Score Assessment Tool Validation Timestamp
Coded Observations (Urgent and Emergency Care)	WECDS Assessment Tools 10.1 Coded Observation	To carry the details of the SNOMED CT coded clinical observations for the patient.	R	0..*	Coded Observation Observation Value Unit of Measurement (UCUM) Coded Observation Timestamp
Coded Findings (Urgent and Emergency Care)	WECDS Assessment Tools 11.1 Coded Finding	To carry the details of the SNOMED CT coded clinical findings for the patient.	R	0..*	Coded Finding Coded Finding Timestamp
Urgent and Emergency Care Injury Characteristics	12.1 Urgent and Emergency Care Place of Injury 12.2 Urgent and Emergency Care Injury Home Status 12.3 Urgent and Emergency Care Injury Intent 12.4 Urgent and Emergency Care Injury Activity Status 12.5 Urgent and Emergency Care Injury Activity Type 12.6 Urgent and Emergency Care Injury Mechanism 12.7 Urgent and Emergency Care Relationship to Assailant 12.8 Urgent and Emergency Care Injury Alcohol or Drug Involvement	To carry the details of injuries.	R	0..1	Urgent and Emergency Care Injury Date and Time Urgent and Emergency Care Place of Injury Urgent and Emergency Care Injury Home Status Urgent and Emergency Care Place of Injury (Latitude) Urgent and Emergency Care Place of Injury (Longitude) Urgent and Emergency Care Injury Intent Urgent and Emergency Care Injury Activity Status Urgent and Emergency Care Injury Activity Type Urgent and Emergency Care Injury Mechanism Urgent and Emergency Care Relationship to Assailant Urgent and Emergency Care Injury Alcohol or Drug Involvement Urgent and Emergency Care Assault Location Description

Patient Clinical History (Urgent and Emergency Care)	13.1 Comorbidity	To carry the patient clinical history details.	R	0..1	Comorbidity
Care Professionals (Urgent and Emergency Care)	14.1 Professional Registration Issuer Code 14.2 Urgent and Emergency Care Professional Tier 14.3 Urgent and Emergency Care Professional Discharge Responsibility Indicator	To carry the details of the Care Professionals active during the Urgent and Emergency Care Activity.	R	0..*	Professional Registration Issuer Code Professional Registration Entry Identifier Urgent and Emergency Care Professional Tier Urgent and Emergency Care Professional Discharge Responsibility Indicator Urgent and Emergency Care Professional Clinical Responsibility Timestamp
Urgent And Emergency Care Diagnoses	15.1 Urgent and Emergency Care Diagnosis 15.2 Urgent and Emergency Care Diagnosis Qualifier	To carry the details of SNOMED CT coded Clinical Diagnoses.	R	0..*	Urgent and Emergency Care Diagnosis Urgent and Emergency Care Diagnosis Sequence Number Urgent and Emergency Care Diagnosis Qualifier
Urgent And Emergency Care Clinical Investigations	16.1 Urgent and Emergency Care Investigations	To carry the details of SNOMED CT coded Clinical Investigations.	R	0..*	Urgent and Emergency Care Clinical Investigation Urgent and Emergency Care Clinical Investigation Timestamp
Urgent And Emergency Care Treatments	17.1 Urgent and Emergency Care Treatment	To carry the details of SNOMED CT coded Treatments.	R	0..*	Urgent and Emergency Care Treatment Urgent and Emergency Care Treatment Timestamp
Referrals To Other Services (Urgent and Emergency Care)	18.1 Urgent and Emergency Care Referred to Service 18.2 Treatment Function Code	To carry the details of referrals to other services.	R	0..*	Urgent and Emergency Care Referred to Service Urgent and Emergency Care Referred to Service Request Timestamp Urgent and Emergency Care Referred to Service Assessment Timestamp
Discharge From Urgent and Emergency Care	19.1 Urgent and Emergency Care Discharge Status 19.2 Urgent and Emergency Care Safeguarding Concern 19.3 Urgent and Emergency Care Discharge 19.4 Organisation Site Identifier (Discharge from Urgent and Emergency Care) 19.5 Urgent and Emergency Care Discharge Follow Up 19.6 Urgent and Emergency Care Discharge Information Given Indicator	To carry the details of discharge from Urgent and Emergency Care	R	0..1	Treatment Function Code Urgent and Emergency Care Clinically Ready to Proceed Timestamp Urgent and Emergency Care Discharge Status Urgent and Emergency Care Activity End Timestamp Urgent and Emergency Care Safeguarding Concern Urgent and Emergency Care Discharge Destination Organisation Site Identifier (Discharge from Urgent and Emergency Care) Urgent and Emergency Care Discharge Follow Up Urgent and Emergency Care Discharge Information Given Indicator
Research And Disease Outbreak Notification (Urgent and Emergency Care)		To carry details of any Research and/or Disease Outbreak Notifications.	R	0..1	Clinical Trial Identifier Urgent and Emergency Care Disease Outbreak Notification Description Urgent and Emergency Care Disease Outbreak Notification

6.2 APPENDIX B: NEWS2, UEC PAIN SCALE, 4AT SCORE AND CFS WORKED EXAMPLE

Scenario: 78y/o female attends with chest pain on breathing. She undergoes an initial assessment at 15:23 on 01/08/2023, which includes measuring vital signs, calculating a NEWS-2 score, calculating a 4AT score, measuring her pain, and assessing her Clinical Frailty Score. She is not known to have a history of type 2 respiratory failure.

Observations

- Respiratory rate: 30/min – NEWS-2 score of 3
- Peripheral oxygen Saturation: 93% – NEWS-2 score of 2
- Systolic blood pressure: 130 mmHg – NEWS-2 score of 0
- Heart rate: 115 beats per minute – NEWS-2 score of 2
- Consciousness level: Alert – NEWS-2 score of 0
- Temperature: 38.2°C – NEWS-2 score of 1
- She is breathing air – NEWS-2 score of 0
- Total NEWS-2 score 8
- Pain score is 1/3

Delirium using the 4AT Score

1. She was alert (0/4 in 4AT)
2. She made one mistake when asked to name her age, date of birth and place (name of the hospital), and current year (1/4 in 4AT)
3. She started but was unable to complete seven months when asked to say the months of the year backwards (1/4 in 4AT)
4. There was no evidence of significant change or fluctuation in alertness, cognition, or other mental functions in the preceding 2 weeks (0/4 in 4AT)

Clinical Frailty Score*[23]

Two weeks prior to assessment, she was not dependent on others for daily help, but symptoms associated with chronic problems such as osteoarthritis meant that her activities were often limited. She walked with a stick and had done for some time. Her Rockwood Clinical Frailty Scale was assessed as 4.

Coded Assessment Tool Type

Her six clinical observations and the fact she is breathing room air each generate a NEWS-2 component score, the total NEWS-2 score, her pain score, 4AT score and CFS should be submitted as 33 values in three data items which use 11 *Coded Assessment Tool Types,* refer to Table 53.

TABLE 53 EXAMPLE *CODED ASSESSMENT TOOL TYPES*

Coded Assessment Tool Type		Person Score	Assessment Tool Validation Timestamp
SNOMED Fully Specified Name	SNOMED CT Code		
Royal College of Physicians National Early Warning Score 2 - respiration rate score (observable entity)	1104301000000104	3	2023:08:01T15:23:00+01:00
Royal College of Physicians National Early Warning Score 2 - oxygen saturation scale 1 score (observable entity)	1104311000000102	2	2023:08:01T15:23:00+01:00
Royal College of Physicians National Early Warning Score 2 - air or oxygen score (observable entity)	1104331000000105	0	2023:08:01T15:23:00+01:00
Royal College of Physicians National Early Warning Score 2 - systolic blood pressure score (observable entity)	1104341000000101	0	2023:08:01T15:23:00+01:00
Royal College of Physicians National Early Warning Score 2 - pulse score (observable entity)	1104351000000103	2	2023:08:01T15:23:00+01:00
Royal College of Physicians National Early Warning Score 2 - consciousness score (observable entity)	1104361000000100	0	2023:08:01T15:23:00+01:00

[23] Clinical Frailty Score (CFS) is only validated for people aged ≥ 65 Clinical Frailty Scale – Specialised Clinical Frailty Network

Royal College of Physicians National Early Warning Score 2 - temperature score (observable entity)	1104371000000107	1	2023:08:01T15:23:00+01:00
Royal College of Physicians National Early Warning Score 2 total score (observable entity)	1104051000000101	8	2023:08:01T15:23:00+01:00
Verbal Rating Scale pain intensity score (observable entity)	1144798005	2	2023:08:01T15:23:00+01:00
4 A's Test for delirium and cognitive impairment score (observable entity)	1239211000000103	2	2023:08:01T15:23:00+01:00
Canadian Study of Health and Aging Clinical Frailty Scale score (observable entity)	763264000	4	2023:08:01T15:23:00+01:00

Coded Observations Group

Her six *Coded Observations* should be submitted as 24 values in four data items using six *Coded Observations,* Table 54.

TABLE 54 EXAMPLE CODED OBSERVATIONS

Coded Observation		Observation Value	Unit Of Measurement (UCUM)	Coded Observation Timestamp
SNOMED Fully Specified Name	SNOMED CT Code			
Respiratory rate (observable entity)	86290005	30	/min	2023:08:01T15:23:00+01:00
Hemoglobin saturation with oxygen (observable entity)	103228002	93	%	2023:08:01T15:23:00+01:00
Systolic arterial pressure (observable entity)	72313002	130	mmHg	2023:08:01T15:23:00+01:00
Heart rate measured at systemic artery (observable entity)	78564009	115	/min	2023:08:01T15:23:00+01:00
Alert Confusion Voice Pain Unresponsive scale score (observable entity)	1104441000000100	Alert	A	2023:08:01T15:23:00+01:00
Core body temperature (observable entity)	276885007	38.2	◦C	2023:08:01T15:23:00+01:00

Coded Findings Group

The fact that she is breathing air should be submitted in the *Coded Finding* Group as below, in addition to the data submitted in the *Coded Assessment Tool Types* Group, Table 55.

TABLE 55 EXAMPLE CODED ASSESSMENT TOOL TYPES

Coded Finding		Coded Finding Timestamp
SNOMED Fully Specified Name	SNOMED CT Code	
Breathing room air (finding)	722742002	2023:08:01T15:23:00+01:00

IMPORTANT NOTICE re Rockwood Clinical Frailty Score (CFS) data: There are two ways to submit the CFS: as a *Coded Assessment Tool Type* or as a *Coded Finding*. It is preferable to submit as a *Coded Assessment Tool Type*) because in future iterations of WECDS it will not be possible to submit CFS as a *Coded Finding,* however currently either can be used. Sites should never submit using both methods. In this example, her Rockwood Clinical Frailty Score is 4, Table 56. Two values should be submitted in two data items using one *Coded Finding*.

TABLE 56 EXAMPLE CODING FINDING

Coded Finding		Coded Finding Timestamp
SNOMED Fully Specified Name	SNOMED CT Code	
Canadian Study of Health and Aging Clinical Frailty Scale level 4 - vulnerable (finding)	1129361000000106	2023:08:01T15:23:00+01:00