1. Introduction

The Emergency Care Data Set (ECDS) programme aims to develop and implement a new minimum data set for emergency care. The ECDS will provide a consistent and improved level of information from type 1 and 2 Emergency Departments (EDs) across England (and potentially from type 3 and 4 EDs) by replacing the existing Accident & Emergency Commissioning Data Set (CDS type 010) with a data set that can properly capture and represent the full extent and granularity of ED activity. This will facilitate improved healthcare commissioning, effective delivery of healthcare strategy and policy, enable an accurate understanding of the cost and value of emergency care and improve the quality of patient care in England’s Emergency Departments.

The ECDS aims to be approved as an information standard via the HSCIC Standardisation Committee for Care Information (SCCI) approvals process.

As part of the ECDS project stakeholder engagement plan, and to support the development of the data set, the ECDS programme Board agreed that the data set should be subject to early stakeholder consultation, with further consultation planned as part of the SCCI approval process.

The ECDS Board has been working to update and amend the ECDS based on the comments received from the first consultation held in May 2015. This paper summarises the changes which have been made to version 1 of the Emergency Care Data Set (ECDS).

The ECDS project has been established as a collaborative project between the Department for Health, Royal College of Emergency Medicine, NHS England, HSCIC, Monitor, NHS Providers and Public Health England. The project is governed and directed by a project board which is chaired by Professor Jonathan Benger (National Clinical Director for Urgent Care, NHS England) and includes representatives from the organisations listed above and also lay representation.

2. Consultation

The ECDS consultation in May 2015 focused on the general principle, content and structure of the ECDS. The aim of the consultation was to use early engagement with stakeholders to enable the further revision and refinement of the data set, and also help to better understand the challenges and issues associated with implementing a new data set for emergency care.
Version 1.0 of the ECDS was made available for public comment via the Health and Social Care Information Centre (HSCIC) online consultation hub on the 26th May 2015 for 6 weeks (the consultation closed on the 7th July 2015).

A stakeholder consultation event was held at the Royal College of Emergency Medicine in central London on the 26th June 2015, where interested stakeholders were given the opportunity to discuss the data items proposed in the Emergency Care Data Set. 19 people attended this event. The programme for the day focused on the following topics:

- Review of ECDS version 1
- ECDS – What’s missing; what could be better; what can be removed?
- ECDS – Future plans and the challenges of implementation.
- ECDS – Resolving areas of controversy.

It is anticipated that further consultation will be required during the development of the ECDS. This will consider implementation, data storage, extraction and data reporting requirements.

3. Results of the ECDS Consultation

3.1 Number and type of responses

There was overwhelming support for the need to develop a new data set with 88% of responders commenting that they believed that there was a need for a new data set to capture emergency care data.

In total the ECDS consultation received 73 responses via the HSCIC consultation hub, with 37 (51%) coming from organisations and 36 (49%) from individuals.

Figure 1 illustrates the distribution of respondents by organisation type (please see Appendix A for a list of the organisations that responded to the online consultation).
3.2 ECDS Data Dictionary Structure

Our first observation from the consultation responses was that there were a number of comments that could be attributed to a lack of information relating to the provenance of data items (whether they were being collected or were new data items) and a lack of clear justification for the collection of data items. Concerns focused on the potential for an increase in the burden (in terms of cost and resource) for the collection of data via the ECDS and a need for greater understanding of the benefits of collecting data via the ECDS.

In response to these observations the ECDS has been updated to ensure that data items now have a clear information structure which includes greater information relating to formatting, provenance and the justification for their inclusion. Please see page 16 of ECDS v2 (section 1.4 of ECDS v2) for detailed explanation of the ECDS Data Dictionary Structure. The new data structure headings are listed below for information:

- **Field name** – the name of the data item
- **Definition** – the meaning of the data item
- **Format** - how the data item should be presented
- **Source** - where the data is sourced from
- **Entry** - how the data should be populated
- **Requirement** – the collection requirement
- **Provenance** – the origin of the data field
- **Justification** – why it is necessary to collect
- **Notes** – Other information
- **Code set** – the code set to be used
4. The consultation questions

There were a total of 31 questions in the online consultation (please see Appendix B for a list of all consultation questions).

- Questions 1-4 captured the identity of responder and whether they were responding to the consultation as an individual or on behalf of an organisation.
- Questions 5-8 focused on the benefits, risks and barriers relevant to implementing a new data set for emergency care.
- Questions 9-28 highlight new data items and proposals to collect data in new formats.
- Questions 29-31 asked responders if they wanted to receive further information about the project and whether they wanted to attend future consultation events.

4.1 Consultation questions (Q5-Q8)

- Q5 - Do you believe there is a need to introduce a new data set to capture and represent the full extent and detail of emergency department activity?

14 % of responders did not feel that there was a need for a new data set for emergency care, commenting that emergency department staff already spend too much time collecting data, and also that greater justification for the proposed data items was required. Comments also suggested that the current A&E Commissioning Data Set (CDS) was fit for purpose and that a review/update of this data set should be conducted rather than developing a new data set.

ECDS response - The ECDS Board recognises the pressure that collecting data places on EDs, and this is why the Board believes that the data collected should capture the information needed to fully understand the true complexity and granularity of emergency care and which supports service planning, healthcare and improved patient care.

Unfortunately simply updating the current data items in CDS Type 010 would not deliver improvement in the data collected from emergency departments. This is because the current A&E CDS was developed in the late 1970’s and is only well suited to the measurement of activity relating to minor injuries and occasional major trauma which were the primary focus of A&E activity in the 1970s.

86% of responders were in support of developing and implementing a new data set for emergency care. Reasons highlighted included appropriate pricing and payment of emergency care, consistency of data collection, appropriate workforce allocation,
understanding patterns and trends in service utilisation, community and public health planning, adequate safeguarding and supporting audit and research.

ECDS response - The ECDS will be conducting benefits identification and realisation work with the HSCIC and all of the above comments will be considered in this work.

- **Q6 - There are a number of benefits which could be achieved by introducing a new Emergency Care Data Set in England. Are there any other benefits which you feel the introduction of a new data set for emergency care could bring about?**

The following benefits were identified:

- Injury Surveillance
- Improving Data Quality
- Improved Patient Care
- Appropriate access to services
- Supports integration of systems/service
- Supports data sharing
- Supports education/training/appraisal
- Encourages system interoperability
- Better measurement/audit
- Better costing/payment

ECDS response - The ECDS project team will be conducting benefits identification and realisation work with the HSCIC and all of the above comments will be considered in this work. Two benefits workshops are due to be held in November 2015; for further information regarding these events please contact the project manager: Aaron.Haile@rcem.ac.uk.

- **Q7 - There are a number of risks and challenges that may impact on the development and implementation of a new Emergency Care Data Set in England. Are there any other risks and challenges which you feel may impact on the introduction of a new data set for emergency care?**

The following risks were identified:

- Overlaps with other standards
- Increased burden
- Data extraction
- Data quality will decrease
- Definitions not clear
- Implementation time/cost
- System integration not ready to support
- Use of data for inappropriate measurement
- Information system development
ECDS response – The risks identified above have been considered and where relevant have been captured in the ECDS project risk register and mitigating actions are being implemented as the project progresses.

As part of the SCCI process we are able to identify any overlapping information standards and are working to ensure that where possible the ECDS aligns to these and national data dictionary standards. It is anticipated that further standards will be identified as the project progresses through the SCCI process. Information standards already identified include:

- A&E Care Quality Indicators
- Ambulance Electronic Patient Record
- Ambulatory Emergency Care
- Child Protection - Information Sharing (CPIS)
- Information Sharing for Tackling Violence (ISTV)
- Trauma and Audit Research Network (TARN)

A burden assessment of the development and implementation of the new data set will also be conducted as part of the SCCI process, and the ECDS project team will work with the HSCIC to assess burden and consider how best to reduce the burden of implementation and collection. The project also aims to reduce the burden of data collection by working with IT suppliers to develop user friendly systems and to reduce the amount of unnecessary data collection.

The ECDS project board is working with the HSCIC to complete an impact assessment looking at the implications of replacing CDS Type 010 with the ECDS. This will include options for extracting the data and how this data is stored and reported on nationally. Further information regarding this work will be made available by the end of December 2015.

The ECDS project team has already begun conversations with Emergency Department Information System (EDIS) suppliers and shared version 1 of the ECDS with them to understand the impact the new data set will have on their systems. We are establishing a vendors’ working group, and will meet with them regularly to discuss and support implementation. To support the implementation of the data set the ECDS includes information which outlines how data fields could be implemented and also a proposed structure for code sets to improve system usability and reduce burden.

It is not within the remit of the ECDS programme to change current measures/metrics of urgent and emergency care. However, it is anticipated that data collected via the ECDS
will represent the full complexity and granularity of emergency care and that this will facilitate the development of appropriate measures in the future.

- **Q8 - Are you aware of any problems or barriers that are likely to impact on the successful implementation of the proposed ECDS in Emergency Departments in England?**

  The following barriers were identified:
  
  - Burden
  - Misinterpretation
  - Drivers for change
  - Cost to local providers
  - IT - local implementation
  - IT - System development
  - Information Governance

  **ECDS response** – The ECDS project team acknowledges all of the barriers identified above and believes that early conversations with providers, information system suppliers and data users is key to ensuring the successful implementation of the data set.

  As part of the HSCIC SCCI process a burden assessment will be conducted to assess the burden of developing, implementing and collecting data via the ECDS. This assessment will enable the ECDS project team to focus on areas where there is an additional burden and to work on reducing this burden and/or mitigating the implications of additional burden.

  The ECDS project is conducting a Privacy Impact Assessment to identify privacy risks associated with the implementation of the new data set. This will be updated throughout the project and we will work closely with NHS England and the HSCIC to ensure that all privacy risk are identified and all relevant steps are taken to ensure that they are addressed appropriately.

5. Consultation questions looking at new data fields (Q9-Q25)

The data set introduces a number of new data items. Responders were asked to consider each new data item and state whether they were in support of its inclusion and their reasons for their response.
• **Q9 Person_Residence_Type** — The type of residence where the patient normally resides. Do you support the inclusion of this data item (pg. 21 ECDS v1 & pg. 40 v2)?

No – 10  
Yes – 60  
Not answered – 3  

14% of responders were not in favour of capturing person residence type as they did not feel that the burden of collecting justified its inclusion. Please refer to version 2 of the ECDS which now includes an additional justification of this data item. One response queried whether there was a risk to privacy by capturing residence type. As a result of this Person_Residence_Type has been included in the list of new data items being considered in the ECDS Privacy Impact Assessment (PIA).

86% of responders supported the inclusion of person residence type as they felt that it would help identify rates of attendance from particular population groups and services which would influence service provision and also support decision making relating to discharge or admission.

This data item has also been updated so that the code set aligns to that used to capture Accommodation Status in the Mental Health Services Data Set.

• **Q10 Person_Residence_LSOA** – Lower Super Output Area (LSOA) of patient’s current place of residence. Do you support the inclusion of this data item (pg. 23 ECDS v1 & 42 v2)?

No – 22  
Yes – 49  
Not answered – 2  

28% of responders did not support the inclusion of person residence LSOA (Lower Super Output Area). A number of these responses queried the purpose of collecting this item and raised concerns regarding the additional burden of collecting this data item.

The ECDS now includes further information which explains the purpose and justification for collection of LSOA. This data item is proposed to be auto-populated from person postcode so we do not anticipate an increase in the burden of collection, although we appreciate this functionality may need to be developed by some information system suppliers.
• **Q11 Person_Email – Patients email address. Do you support the inclusion of this data item (pg. 26 ECDS v1 & pg. 43 v2)?**

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65% of responders felt that there was a need to capture email as it would support better communication with patients. Rather than collecting this individually the ECDS now includes a data item called ‘Person_Preferred_Contact’ which includes an option to record either phone number, mobile phone number or email. The ECDS team recognises the potential privacy risk to collecting email address and this item has been highlighted in the ECDS Privacy Impact Assessment.

• **Q12 Person_Comorbidities – A record of whether the person has one or more of the NHS list of medical co-morbidities. Do you support the inclusion of this data item (pg. 43 ECDS v1 & pg. 59 v2)?**

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85% of responders were in support on the inclusion of Person_Comorbidities as a new data field in the ECDS as long as it was as a part of an integrated care record, such as being drawn from the Summary Care Record (SCR). It was highlighted that it may not always be possible to ‘draw’ such information from the SCR, and the ECDS team is working with the SCR team to understand how the ECDS could access information captured by the SCR.

• **Q13 Person_Current Meds – The list of current medications from the Summary Care Letter. Do you support the inclusion of this data item (pg. 44 ECDS v1 & pg. 61 v2)?**

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60% of responders supported the inclusion of person current meds as they believed that knowledge of a person’s medications would improve decision making and care, however responders (both those who were in support and those who were not) also highlighted concerns around the burden of collecting this information and stated that it should be drawn from the SCR. As with Person_Comorbidities, the ECDS team is working with the SCR team to understand how the ECDS could access information held in the SCR.
• **Q14 EmCare_Arrive_Referred** – The source from which the patient was referred to the Emergency Department. Do you support the inclusion of this data item (pg. 53 ECDS v1 & pg. 77 v2)?

No – 5    Yes – 64    Not answered – 4

The majority of responders (81%) agreed that recording a patient’s source of referral would enable a better understanding of service use and support long term service and workforce planning.

Responders who did not support the inclusion of this data item commented that there would be an increase in burden due to its collection. This data item is currently collected in CDS type 010 (Source of Referral for A&E) and we do not anticipate any increase in burden in its collection.

This data item has been amended to ‘EmCare_Referral_Source and the code set used to capture referral source in the current CDS type 010 has been updated to include greater granularity (from 11 codes to 25 codes).

• **Q15 EmCare_Arrive_Transfer_Source** – ODS code of the healthcare facility from which the patient has been transferred. Do you support the inclusion of this data item (pg. 55 ECDS v1 & pg. 79 v2)?

No – 8    Yes – 58    Not answered – 7

10% of responders felt that the reason for including this data item did not justify the burden of collecting it. However, 73% of responders commented that the collection of this new data item would enable better understanding of demand, trends and inform future service delivery.

Responders suggested that all healthcare facilities (GP, other ED types, nursing homes, residential homes etc.) should have their ODS codes recorded. The ECDS team is currently reviewing this with the HSCIC Data Dictionary and Messaging team.

• **Q16 EmCare_CPR_Chk** – Has the child protection register been checked in respect of this attendance? Do you support the inclusion of this data item (pg. 57 ECDS v1)?

No – 18    Yes – 45    Not answered – 10
20% of responders queried the rationale for the inclusion of this new data field and the benefit of its collection. Responses also queried whether this was the most appropriate way to collect and record this type of information. Following the consultation and conversations with the Child Protection Information Sharing team (CP-IS) the ECDS Board agrees that this data item would be difficult to collect and would increase burden. As a result this data item has been removed.

- **Q17 EmCare_SCR_Chk** – Has the GP record or NHS Summary Care Record been seen by the treating clinician? Do you support the inclusion of this data item (page 58 ECDS v1)?

  - No – 31
  - Yes – 34
  - Not answered – 8

  42% of responders queried the rationale for the inclusion of this new data field and the benefits for its collection. The ECDS Board agrees that this data item would be difficult to collect, would increase burden and as a result this data item has been removed.

- **Q18 EmCare_RefOpinion_DateTime** – The time the patient was first referred to an inpatient service for an opinion. Do you support the inclusion of this data item (page 55 ECDS v1)?

  - No – 13
  - Yes – 54
  - Not answered – 6

  74% of responders felt that there was a benefit to collecting the date/time that a patient is first referred to an inpatient service for an opinion. However, a number of responders felt that this introduced another data field which would increase the burden of collection and some highlighted that it may be difficult to synchronise the event and the record as this may not always happen in real time. Timeliness of data entry is still being discussed and there is potential for this to be considered further during the forthcoming ECDS pilot.

  Whilst it was widely accepted that this data item would support a better understanding of patient flow there was also a strong view that it should be auto-populated. As a result of these comments this data item has been merged with ‘EmCare_Referred_Service’ so that it is auto-populated when the referred service field (see below) is populated by the treating clinician.
• **Q19 EmCare_Referred_Service – The service to which the patient was first referred for admission or opinion by the treating clinician. Do you support the inclusion of this data item (pg. 63 ECDS v1 & pg.87 v2)?**

No – 11

Yes – 55

Not answered – 7

75% of responders supported the inclusion of EmCare_Referred_Service and commented that they believed that this data item would support a better understanding of where delays or bottlenecks occur in acute care, thereby enabling appropriate service planning.

Both those in support of and those who did not support the inclusion of this item queried why SNOMED codes were being used when it would save time and cost if we used current treatment functions codes. The ECDS project team have been working with the HSCIC Data Dictionary & Messaging team and Terminology team to ensure that the data set aligns to a move towards the use of SNOMED as a single clinical terminology to support all care records to be digital, real time and interoperable by 2020 in accordance with the strategy set out by the National Information Board.

• **Q20 EmCare_Discharge_GP_Letter – Has the GP letter been printed and given to the patient? Do you support the inclusion of this data item (pg. 106 ECDS v1 & pg. 147 v2)?**

No – 25

Yes – 38

Not answered – 10

34% of responders did not support the inclusion of the above data item. The reasoning for this seemed to focus on the lack of a clear explanation for the justification and some confusion regarding its purpose. Some responders thought that this item would replace the letter to the GP or was a replacement for a discharge summary. The justification for inclusion now includes information explaining that this data item is auto populated when a copy of the discharge letter has been printed. This will improve the consistency of communication between the emergency care clinician, patient and GP, will help to ensure that patients are treated as a partner in their care and when a patient does not have a GP may be the only record the patient has to take to another healthcare provider.
Comments also highlighted a potential increase in the burden of collection, however this item will be auto-populated for all patients who are discharged (where EmCare_Discharge_Status is less than 20).

This data item has been amended to EmCare_Discharge_Information_Given (page 147 ECDS v2).

- **Q21 EmCare_Transfer_Destination – ODS code of the destination organisation.**  
*Do you support the inclusion of this data item (pg. 109 ECDS v1 & pg. 151 v2)?*

No – 5  
Yes – 58  
Not answered – 10

The majority of responders (79%) were in support of the inclusion of EmCare_Transfer_Destination and commented that this data item would help to enable tracking of patient flows between providers, and support service planning. This item has been retained in the data set.

- **Q22 EmCare_Clinician_Type – The type/grade of the treating clinician.**  
*Do you support the inclusion of this data item (pg. 112 ECDS v1 & pg. 83 v2)?*

No – 14  
Yes – 53  
Not answered – 6

Those responders who were not in favour of collecting this data item highlighted their concerns regarding the potential additional burden for its collection. We propose that this data item is auto-populated from the ED IT system and recognise concerns raised regarding the maintenance of clinical information relating to type and grade at a local level. This will be tested during the pilot phase of the ECDS development.

- **Q23 EmCare.Doc_Review – GMC number of up to three middle grade/senior doctors who have treated the patient or reviewed the patient’s treatment plan.**  
*Do you support the inclusion of this data item (pg. 114 ECDS v1 & pg. 83 v2)?*

No – 25  
Yes – 38  
Not answered – 10

Those responders in support of the inclusion of this data item highlighted that more than 3 clinicians should be included and that all grades should be recorded, not just senior clinicians. Please see the comment below Q24.
• **Q24 EmCare_Doc_Review_Type – The type/grade of the most senior doctor who has reviewed the patient's treatment. Do you support the inclusion of this data item (pg. 115 ECDS v1 & pg. 83 v2)?**

No – 17  
Yes – 47  
Not answered – 9

Whilst there was broad support for the inclusion of EmCare_Doc_Review_Type there were multiple comments which queried why only the ‘most senior’ doctor was to be captured by this data item and the benefit that its inclusion would bring. Following the consultation we now propose to collect a data item called EmCare_Clinicians (ECDS v2 page 83) within the Episode Demographics section of the ECDS, and the section with a specific focus on clinician information has been deleted. This data item will capture a record of the clinical encounters between a patient and their treating clinician(s) and will record up to 20 clinical encounters. The justification for capturing clinician information is that it will enable operational planning and clinical governance by ensuring that the right grade of clinician is responsible for the right acuity/complexity of patient management. It will also support workforce planning, training and performance. We propose that this data item will capture the following information and will be auto populated by the ED IT system.

- Type – The regulatory body responsible for issuing the unique identifier of the treating clinician (GMC, GDC, NMC & HCP).
- Unique identifier
- Tier – Tier of professional practice (please see ECDS v2 pg. 16).
- Time Date stamp – captures the time at which the clinician first interacts with the patient
- Discharging clinician

6. Consultation questions focused on specific categories of information (Q25- Q26)

6.1 **Q25 – Clinical Information (pg. 70 ECDS v2 & pg.95 v2)**

This category included proposed methods to capture patient presentation, chief complaint, diagnosis and investigation/treatment data. Responders were asked whether they supported the proposals to collect information via the proposed data fields or not, and also asked them to state the reason for their response.
- **EmCare_Presentation_Acuity** – the acuity of the patient on first assessment in the ED (pg. 70 ECDS v1 & pg. 96 & 100 v2).

No – 11  
Yes – 55  
Not answered – 7

75% of responders supported the capture of an acuity measure, however there were multiple comments regarding the proposed method/system to capture acuity. There is no consensus regarding the optimum scoring system to be used and we now propose to capture acuity by recording both the type of system in use and the score assigned by that system (please see ECDS v2 page 96 & 100).

We believe that this revised method to capture acuity along with the acuity score will allow data from the many disparate scoring systems to be collated. This will enable a consensus at some future point regarding the optimum type of acuity measurement.

- **EmCare_Presentation_ChiefComplaint** – The nature of the patient’s chief complaint as assessed by the clinician first assessing the patient (pg. 73 ECDS v1 & pg. 102 v2).

No – 5  
Yes – 62  
Not answered – 6

EmCare_Presentation_ChiefComplaint proposes to replace the data item ‘A&E Patient Group’ which is found in the current A&E CDS type 010. It is proposed that this new data field will enable accurate recording of the reasons why people attend emergency departments. 85% of responders supported the inclusion of this new data item and stated that they could see the benefit that this item would bring to ensuring patients have a comprehensive clinical record to support their direct care and also to enable secondary uses such as reporting and analysis to support service planning.

Some responders queried whether this item should be collected by clerical or clinical staff and this is something that will be considered further.

- **EmCare_Clinical_Narrative** – Text description of the patient’s reason for attendance, diagnostic and treatment process and recommendations for further management and follow up (pg. 79 ECDS v1 & pg. 104 v2).

No – 15  
Yes – 49  
Not answered – 9

67% of responders were in support of the inclusion of Clinical_Narrative to enable capture of the detail of a person’s reason for attendance, results from diagnostics.
and treatment process and recommendations for further management. It is already common practice to collect this information as it forms the basis for the GP letter, and this proposal therefore establishes a common term for a process already happening in most departments.

Those responders who did not support the inclusion of this data item highlighted concerns about how information collected would flow nationally and the associated privacy risks. The ECDS project team recognises this risk, and it is not intended for information in the Clinical_Narrative field to flow nationally. This field has been updated to be ‘optional’ rather than mandatory for all presentations.

- **EmCare_Diagnosis – Diagnosis of the patient in order of their relevance to the emergency presentation (pg. 80 ECDS v1 & pg. 106).**

  No – 6    Yes – 59   Not answered – 8

  81% of the consultation responders were in support of collecting information relating to diagnosis. Diagnosis is currently collected via CDS type 010 (Clinical Diagnosis Group) and the ECDS proposes to improve the quality of diagnostic data by using a subset of SNOMED diagnosis codes, aiming to strike a balance between a code set that has insufficient detail, and one that has too much, with a modifier (please see EmCare_Diagnosis page 106 ECDS v2). This data field has been amended to support the collection of up to 10 diagnosis.

- **Diagnosis Modifier Code set (pg. 80 ECDS v1 & pg. 109 v2).**

  No – 11   Yes – 55   Not answered – 7

  80% of responders were in support of the inclusion of a modifier to support appropriate diagnosis. However, following feedback from stakeholders and from the stakeholder consultation event we now propose that the ECDS uses 2 modifiers ‘working diagnosis’ and ‘proven/confirmed diagnosis’ (please see EmCare_Diagnosis page 106 ECDS v2).

- **EmCare_Invest_Treat – Investigations and Treatments performed in the Emergency Department (pg. 82 ECDS v1 & pg. 110/112 v2).**

  No – 4    Yes – 60   Not answered – 8
82% of responders were in support of collecting Investigations and Treatments as it is essential to continue to collect these items to ensure that we can continue to support the existing tariff system while the ECDS is implemented. It was also felt that these data items were desirable for analysis of variation, and for operational improvement and policy.

ECDS v1 proposed to collect investigation and treatment information under one data item EmCare_Invest_Treat. Following the consultation this data item has been split to separately record Investigations and Treatments as currently collected via CDS Type 010.

6.2 Q26 Patient Injury

This category proposed a new way to record injury related data. Responders were asked to state whether they supported the proposals or not, and the reasons for their response.

There was a broad consensus that there is value in the collection of injury related data, specifically to contribute to a comprehensive clinical record that can be used in direct patient care and which can also help identify local risks and patterns of injury, whilst supporting the development of prevention programmes and risk reduction.

Some respondents highlighted concerns regarding the additional burden of collecting injury data items, and whether it was appropriate for clerical staff to collect this information. The data set will be subject to testing and also burden assessment to understand the implications and resources required to implement these new data items.

- **EmCare_Inj_DateTime – The date/time that the injury occurred (pg. 86 ECDS v1 & pg.117 v2).**

  No – 7 Yes – 60 Not answered – 6

  82% of responders were in support of collecting EmCare_Inj_DateTime, however there were concerns that it might be difficult to collect this information accurately and that where possible this information should be derived from the ambulance service record.

- **EmCare_Inj_Place_LatLong – The latitude and longitude of the exact place at which the injury occurred (pg. 87 ECDS v1 & pg. 119).**

  No – 33 Yes – 35 Not answered – 5
There was 50/50 split regarding whether Injury_Place_LatLong should be captured. The majority of responders were concerned that this would be difficult to collect if not populated automatically, either from the ambulance/police record or by the information system, although many responders recognised that this functionality was not currently available.

Lat/Long has now been amended to be captured optionally, with EmCare_Inj_Place_Exact required for all presentations.

- **EmCare_Inj_Place_Exact** – *A description of the exact locality at which the injury occurred (pg. 88 ECDS v1 & pg. 121 v2)*.
  
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EmCare_Inj_Place_Exact is included in the ECDS to support injury data collection and also because it is a key requirement of Information Sharing for Tackling Violence (ISTV). The collection of this data item supports the identification of patterns and hotspots of violence that are amenable to mitigating interventions.

Concerns were raised regarding the risk to privacy if information relating to either home or private addresses was captured in this field. The ISTV standard stipulates that this data field should only be populated when the Injury Place Type (EmCare_Inj_Place_Type) is populated as something other than Home/private address. The ECDS captures greater granularity in the code set for EmCare_Injury_Place_Type and we propose that this data field is only populated when the injury place type is selected from the following groups; Road, Work, Educational, Leisure, Outdoor and medical. We will look at each of these groups and any further privacy risk associated with this as part of the ECDS Privacy Impact Assessment.

- **EmCare_Inj_Place_Type** – *The type of location at which the person was present when the injury occurred (pg. 89 ECDS v1 & pg. 123 v2)*.
  
<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Not answered</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>59</td>
<td>6</td>
</tr>
</tbody>
</table>

There were no specific comments relating to the collection of EmCare_Inj_Place_Type and 81% were in support of collecting this data item.
• EmCare_Inj_Activity – The type of activity being undertaken by the person at the moment the injury occurred (pg. 91 ECDS v1 & pg. 127 v2).

No – 10  Yes – 54  Not answered – 9

There were no specific comments relating to the collection of EmCare_Inj_Activity and 74% were in support of collecting this data item.

• EmCare_Inj_Mechanism – How the injury was caused (pg. 94 ECDS v1 & pg. 130 v2).

No – 12  Yes – 54  Not answered – 7

There were no specific comments relating to the collection of EmCare_Inj_Mechanism and 74% were in support of collecting this data item.

7. Items for further consideration, Q27

Responders to the consultation were asked if there were any data items which they believed should be added, modified or removed. A summary of responses follows:

• Access to services – One response queried whether it would be possible to identify when patients have attempted to access other health care providers. The project team believe the ECDS will capture this information via the following data fields: EmCare_Attendance_Type (page 75 ECDS v2), EmCare_Referral_Source (page 77 ECDS v2) and EmCare_Transfer_Source (page 79 ECDS v2).

• EmCare_Companion - In patients < 19yrs it was suggested that it could be added whether the accompanying adult/next of kin has parental responsibility. We believe that the ECDS data field, Person_Companion (page 52 ECDS v2), can capture this information as it specifies that the person attending with the patient should be captured as free text and that the role of the companion should also be described.

• A request was made to include “reserve” data items that could be allocated temporarily to a specific purpose such as 1) to monitor and identify cases related to an emergency threat to health (pandemic infection), 2) to facilitate multicentre national evaluations of changes to health service delivery or organisation. The ECDS
has included a new data item to address this, which can be found under EmCare_Research (page114 ECDS v2).

- EmCare_Site_Type has been amended to include a wider range of destination codes (page 67 ECDS v2).

- EmCare_Arrive_Transport_Mode has been revised to include a wider range of destination codes (page 71 ECDS v2).

8. Other changes made following the consultation.

- Person_Age_At_Attendance has been revised to enable age to be captured in years and months.

- Code sets for diagnosis, chief complaint and treatments/investigations now include codes specific to mental health, emergency paediatrics, emergency eye care, pharmacy and emergency dental care. It is anticipated that these code sets will require further revision to ensure that they capture all required options.

- EmCare_Arrive_Referred has been updated to include ‘Advanced Clinical Practitioner – Community’ to capture AHPs, physiotherapists, nurses and paramedics working in community services.

- Ambulance_Incident_Number has been amended to Ambulance_Unique_Identifier (page 72 ECSD v2) as the ambulance unique identifier specific to each patient episode rather than a specific incident with multiple patients.

- EmCare_Clinical_Narrative has been updated to be recorded as a local requirement rather than a national requirement.

- EmCare_Inj_Intent, code 97 (Euthanasia) has been removed.

- EmCare_Discharge_Safeguarding has been updated to include ‘risk to sibling’ and ‘concern about child environment’, and also ‘concern regarding risk to carer’.
Appendix A

Organisations who responded to the ECDS May 2015 consultation

- Association of Ambulance Chief Executives
- Barts Health NHS Trust.
- Belfast Trust
- British Dental Association
- British Dental Association
- British Geriatrics Society
- British Medical Association
- CQC
- CSC
- East Cheshire NHS Trust
- Fylde and Wyre CCG
- Kingston CCG
- Mersey Care NHS Trust
- Midlands and Lancashire CSU
- Monitor
- North West Ambulance Service
- North West Ambulance Service NHS Trust
- Peterborough and Stamford Hospitals Trust
- Public Health England
- Queen Mary’s University London
- Royal College of Emergency Medicine
- Royal College of Physicians
- Royal Pharmaceutical Society
- Royal Society for the Protection of Accidents (ROSPA)
- Royal United Hospital, Bath
- Sheffield Children's NHS Foundation Trust
- Sheffield Teaching Hospitals
- St Helens and Knowsley Hospitals NHS Trust
• System C
• The College of Paramedics
• The Dudley Group NHS Foundation Trust
• University Hospitals Birmingham
• University Hospitals Bristol
• University Hospitals Bristol NHS Foundation
• University Hospitals of North Midlands
• York Teaching Hospital NHS Foundation Trust
Appendix B

1. What is your name?

2. What is your email address?

3. Are you responding to this consultation as an individual or on behalf of an organisation?
   ☐ Individual  ☐ Organisation

4. If you are responding as an individual we would like to understand your particular interest in this data set. Please specify below: (free text)

5. If applicable, please tell us what type of organisation you work for - tick all that apply:
   - Acute Provider
   - Ambulance Provider
   - Commissioner (CCG’s/CSU’s)
   - Community Provider
   - Emergency Department IT system supplier
   - Health regulator
   - Health Education England / LETB
   - Independent/private provider
   - Individual
   - Membership organisation
   - NHS England
   - Organisation associated with health and social care policy
   - Organisation associated with information/records standards and quality
   - Patient/public representative
   - Public Health England
   - Royal College (not Emergency Medicine)
   - Royal College of Emergency Medicine
   - Special interest group
   - University or other academic institution
   - Other (free text box)

6. Do you believe there is a need to introduce a new data set to capture and represent the full extent and detail of emergency department activity?
   ☐ Yes  ☐ No
   Reason (free text)
7. There are a number of benefits which could be achieved by introducing a new Emergency Care Data Set in England. These include but are not limited to:
   - Improved quality of data collected in Emergency Departments relating to patient presentation, diagnosis, discharge and follow up.
   - The information generated will allow commissioners to accurately fund demand, and implement strategic changes, e.g. through payment and CQUIN mechanisms.
   - Support for future healthcare policy and strategy development to ensure an improved quality of patient care.
   - Improved capacity for clinical audit and research, including effective comparison between different Emergency Departments.

Are there any other benefits which you feel the introduction of a new data set for emergency care could bring about?
   □ Yes  □ No
   Reason (free text)

8. There are a number of risks and challenges that may impact on the development and implementation of a new Emergency Care Data Set in England. These include but are not limited to:
   - Increased burden on NHS staff (administration and clinical) who enter emergency care data.
   - The challenge of engaging with multiple Emergency Department information system suppliers to ensure that all Emergency Departments are able to collect the required information.
   - The cost of making the change, and ensuring it is universally implemented.

Are there any other risk and challenges which you feel may impact on the introduction of a new data set for emergency care?
   □ Yes  □ No
   Reason (free text)

9. Are you aware of any problems or barriers that are likely to impact on the successful implementation of the proposed ECDS in Emergency Departments in England?
   □ Yes  □ No
   Reason (free text)
The data set introduces a number of new data items; these are detailed in the draft data set. Each of these new data items is listed below. Please state whether you support their inclusion or not, and the reason for your response.

10. Person_Residence_Type — The type of residence where the patient normally resides (Item number 1.1.13, page 21). Do you support the inclusion of this data item?
   □ Yes  □ No
   Reason (free text)

11. Person_Residence_LSOA – Lower Super Output Area of patients current place of residence (Item number 1.1.14, page 23). Do you support the inclusion of this data item?
   □ Yes  □ No
   Reason (free text)

12. Person_Email – Patients email address (Item number 1.1.17, page 26). Do you support the inclusion of this data item?
   □ Yes  □ No
   Reason (free text)

13. Person_Comorbidities – If the person has one of more of the NHS list of medical co-morbidities (Item number 1.1.30, page 43). Do you support the inclusion of this data item?
   □ Yes  □ No
   Reason (free text)

14. Person_Current_Meds – The list of current medications from the Summary Care Record (Item number 1.1.31, page 44). Do you support the inclusion of this data item?
   □ Yes  □ No
   Reason (free text)
15. EmCare_Arrive_Referred – The source from which the patient was referred to the Emergency Department (Item number 1.2.8, page 53). Do you support the inclusion of this data item?
   □ Yes □ No
   Reason (free text)

16. EmCare_Arrive_Transfer_Source – ODS code of the healthcare facility from which the patient has been transferred (Item number 1.2.9, page 55). Do you support the inclusion of this data item?
   □ Yes □ No
   Reason (free text)

17. EmCare_CPR_Chk – Has the child protection register been checked in respect of this attendance? (Item number 1.2.11, page 57). Do you support the inclusion of this data item?
   □ Yes □ No
   Reason (free text)

18. EmCare_SCR_Chk – Has the GP record or NHS Summary Care Record been seen by the treating clinician? (Item number 1.2.12, page 58). Do you support the inclusion of this data item?
   □ Yes □ No
   Reason (free text)

19. EmCare_RefOpinion_DateTime – The time the patient was first referred to an inpatient service for an opinion. (Item number 1.2.14, page 61). Do you support the inclusion of this data item?
   □ Yes □ No
   Reason (free text)

20. EmCare_Referred_Service – The service to which the patient was first referred for admission or opinion by the treating clinician. (Item number 1.2.16, page 63). Do you support the inclusion of this data item?
21. EmCare_Discharge_GP_Letter – Has the GP letter been printed and given to the patient? (Item number 1.5.5, page 106). Do you support the inclusion of this data item?
   □ Yes  □ No
   Reason (free text)

22. EmCare_Transfer_Destination – ODS code of the destination organisation (Item number 1.5.7, page 109). Do you support the inclusion of this data item?
   □ Yes  □ No
   Reason (free text)

23. EmCare_Clinician_Type – The type/grade of the treating clinician. (Item number 1.6.2, page 112). Do you support the inclusion of this data item?
   □ Yes  □ No
   Reason (free text)

24. EmCare_Doc_Review – GMC number of up to three middle grade/senior doctors who have treated the patient or reviewed the patient’s treatment plan. (Item number 1.6.3, page 114).
   □ Yes  □ No
   Reason (free text)

25. EmCare_Doc_Review_Type – The type/grade of the most senior doctor who has reviewed the patient’s treatment. (Item number 1.6.4, page 115). Do you support the inclusion of this data item?
   □ Yes  □ No
   Reason (free text)

26. Section 1.3 (pg. 69) refers to data items captured under ‘Clinical Information’. This category includes proposed methods to capture patient presentation, chief complaint, diagnosis and investigation/ treatment data. Please state whether you support the proposals or not, and the reason for your response.
• EmCare_Presentation_Acuity – the acuity of the patient on first assessment in the ED (Item number 1.3.1, page 70).

☐ Yes  ☐ No

• EmCare_Presenation_ChiefComplaint – The nature of the patient's chief complaint as assessed by the clinician first assessing the patient (Item number 1.3.2, page 73).

☐ Yes  ☐ No

• EmCare_Clinical_Narrative – Text description of the patient's reason for attendance, diagnostic and treatment process and recommendations for further management and follow up (Item number 1.3.3, page 79).

☐ Yes  ☐ No

• EmCare_Diagnosis – Diagnosis of the patient in order of their relevance to the emergency presentation (Item number 1.3.4, page 80).

☐ Yes  ☐ No

• Diagnosis Modifier Code set (Item number 1.3.4, page 80).

☐ Yes  ☐ No

• EmCare_Invest_Treat – Investigations and Treatments performed in the Emergency Department (Item number 1.3.5, page 82).

☐ Yes  ☐ No

Reasons for your responses: (free text)

27. Section 1.4 (page 85) refers to data items captured under ‘Patient Injury’. This category proposes a new way to record injury related data. Please state whether you support the proposals or not, and the reasons for your response.

• EmCare_Inj_DateTime – The date/time that the injury occurred (Item number 1.4.1, page 86).

☐ Yes  ☐ No

• EmCare_Inj_Place_LatLong – The latitude and longitude of the exact place at which the injury occurred. (Item number 1.4.2, page 87).

☐ Yes  ☐ No
• EmCare_Inj_Place_Exact – A description of the exact locality at which the injury occurred. (Item number 1.4.3, page 88).
  □ Yes □ No

• EmCare_Inj_Place_Type – The type of location at which the person was present when the injury occurred. (Item number 1.4.4, page 89).
  □ Yes □ No

• EmCare_Inj_Activity – The type of activity being undertaken by the person at the moment the injury occurred. (Item number 1.4.5, page 91).
  □ Yes □ No

• EmCare_Inj_Mechanism – How the injury was caused. (Item number 1.4.6, page 94).
  □ Yes □ No

Reasons for your response: (free text)

28. In your view, which areas or items in the Emergency Care Data Set (ECDS) require further refinement or consideration?

• Are there any data items that you would like to see added?
  □ Yes □ No

• Are there any data items that you would like to see removed?
  □ Yes □ No

• Are there any data items that you would like to see modified or refined?
  □ Yes □ No

Reasons for your response: (free text)

29. Are there any other areas of work, individuals or organisations that you feel should be consulted regarding this project? Please include contact details below.

  □ Yes □ No

Reasons for your response: (free text)

30. Would you like to receive further information about the project as it progresses?

  □ Yes □ No
31. Would you be interested in attending a stakeholder consultation event to discuss the data set with the project team?

☐ Yes – Leeds, 18th June
☐ Yes – London, 26th June
☐ Yes – EDIS vendor event, 7th July
☐ No