National Radiology Information & Intelligence Platform (NRIIP)

Radiology Dataset

February 2019

Definitions & Recording Guidance
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Revision History:

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<th>Change made by</th>
<th>Change Marked</th>
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<td>Update to match File Spec</td>
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<td>V1.0</td>
<td>04/03/2019</td>
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<td>25/09/2019</td>
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INTRODUCTION

The demand for radiology services has increased significantly over time and there are now considerable workforce challenges. The current model for delivering these services is not considered sustainable. To try and address this, a National Model for Radiology has been developed which will provide the ability for radiology staff to work across Scotland.

To support the National Model for Radiology it is essential that there are consistent and comparable radiology data with common definitions and variables used across radiology services within NHSScotland.

The purpose of this document is to set out the nationally agreed dataset and definitions along with recording guidance.

DATASET

This dataset is designed so that it is flexible and can support a national approach to the recording of radiology activity data.

The dataset has 6 sections:

- Section 1 – Patient Demographics
- Section 2 – Request Details
- Section 3 – Justification/Authorisation
- Section 4 – Appointment
- Section 5 – Exam
- Section 6 – Reporting

The national data collected from this dataset will be used to support strategic planning at national, regional and local levels.

Where codes and values held on local systems differ from those within the national dataset, these local codes can be mapped to the national codes. Public Health & Intelligence (PHI) will develop and hold the mapping as a reference table. It is the responsibility of NHS Boards to notify PHI of any changes in the mapped data. NHS Boards are not expected to record data on every code and value included in each data item.
The NRIIP project adheres to Information Governance and Information Security safeguards. Approval to collect the data items specified in this dataset was granted by the Public Benefit & Privacy Panel (PBPP) on 30 August 2017.

**SCOPE**

Data are requested for all patients who have had an interaction with radiology services. This includes both diagnostic, including obstetric ultrasound, and interventional radiology. Screening is not included.

The emphasis of this project is to develop a new national radiology dataset which will be used for national analysis. The requirements necessary to support a national radiology shared service are part of a separate project under the Scottish Radiology Transformation Programme.

**MAPPINGS AND FUTURE SUBMISSIONS**

This document includes multiple data items which will be mapped using reference information that NHS Boards will need to provide to the National Radiology Information & Intelligence Platform (NRIIP) team via email to nss.phinriip@nhs.net. For these data items, the information in this document includes the values which will be present in the datamart and dashboard.

Should NHS Boards implement any changes to their local Radiology Information System (RIS) it is requested that values are updated to match those within this document.

**SUBMISSION**

Full details on the file submission and processing rules can be found in the National Dataset File Specification document.
# RADIOLOGY DATA SUMMARY

<table>
<thead>
<tr>
<th><strong>Section 1: Patient Demographics</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 CHI Number</td>
</tr>
<tr>
<td>1.3 Surname</td>
</tr>
<tr>
<td>1.5 Date of Birth</td>
</tr>
<tr>
<td>1.7 Gender</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th><strong>Section 2: Request Details</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Request ID</td>
</tr>
<tr>
<td>2.3 Requesting Clinician Surname</td>
</tr>
<tr>
<td>2.5 Requesting Source Code</td>
</tr>
<tr>
<td>2.7 Requesting NHS Board Code</td>
</tr>
<tr>
<td>2.9 Requesting Location Code</td>
</tr>
<tr>
<td>2.11 Requesting Clinician Specialty Code</td>
</tr>
<tr>
<td>2.13 Request Received Date</td>
</tr>
<tr>
<td>2.15 Patient Type Code</td>
</tr>
<tr>
<td>2.17 Clinician Indication</td>
</tr>
<tr>
<td>2.19 Request Status Description</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th><strong>Section 3: Justification/Authorisation</strong></th>
</tr>
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<tr>
<td>3.1 Justification/Authorisation Date</td>
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<td>3.3 Justification/Authorisation Clinician ID</td>
</tr>
<tr>
<td>3.5 Justification/Authorisation NHS Board Description</td>
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<tr>
<td>3.7 Justification/Authorisation Insourced Flag</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Section 4: Booking &amp; Appointment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Unavailability Start Date</td>
</tr>
<tr>
<td>4.3 Unavailability Reason Code</td>
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<tr>
<td>4.5 Appointment Date</td>
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<td>4.7 Booking Date</td>
</tr>
<tr>
<td>4.9 Cancellation Date</td>
</tr>
<tr>
<td>4.11 Booked Status Code</td>
</tr>
<tr>
<td>4.13 Planned Exam Flag</td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td><strong>Section 5: Exam</strong></td>
</tr>
<tr>
<td>5.1 Master/Exam ID</td>
</tr>
<tr>
<td>5.3 Urgency Code</td>
</tr>
<tr>
<td>5.5 Special Pathway Code</td>
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<td>5.7 Modality Code</td>
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<tr>
<td>5.9 Exam Outsourced Flag</td>
</tr>
<tr>
<td>5.11 Exam NHS Board Code</td>
</tr>
<tr>
<td>5.13 Exam Location Code</td>
</tr>
<tr>
<td>5.15 Exam Start Date</td>
</tr>
<tr>
<td>5.17 Exam Start Time</td>
</tr>
<tr>
<td>5.19 Operator 1 Clinician ID</td>
</tr>
<tr>
<td>5.21 Room/Equipment Code</td>
</tr>
<tr>
<td>5.23 Exam Description</td>
</tr>
<tr>
<td>5.25 Dose Unit Code</td>
</tr>
</tbody>
</table>

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| 6.1 No Report Required Flag | 6.2 Report ID |
| 6.3 Report Outsourced Flag | 6.4 Report Insourced Flag |
| 6.5 Reporting NHS Board Code | 6.6 Reporting NHS Board Description |
| 6.7 Report Date             | 6.8 Report Time |
| 6.9 Reporting Clinician ID  | 6.10 Verifying Clinician ID |
| 6.11 Verification Outsourced Flag | 6.12 Verification Insourced Flag |
| 6.13 Verification NHS Board Code | 6.14 Verification NHS Board Description |
| 6.15 Verified Date          | 6.16 Verified Time |

**Appendix – Clinician Reference File**

| A.1 Sending Location      | A.2 Local Clinician ID     |
| A.3 Clinician Professional Code | A.4 Clinician Surname |
| A.5 Clinician Forename    | A.6 Clinician Date of Birth|
| A.7 Clinician Gender      | A.8 Designation Code       |
| A.9 Start Date            | A.10 End Date              |

**Appendix – NHS Board Codes and Description**
SECTION 1: PATIENT DEMOGRAPHICS

General Guidance for Section 1:

- Record demographic data for all patients who have had a request received by or submitted to the radiology service.
- The patient is the person receiving care or a diagnostic service.
- The CHI number is required for all patients. Where CHI is not available surname, forename, date of birth, postcode and gender must be provided to allow CHI seeding to take place.
- Should the contact relate to a fetus, please include the mother’s details.

1.1 CHI NUMBER

Definition: The Community Health Index (CHI) is a population register which is used in Scotland for health care purposes. The CHI number uniquely identifies a patient within Scotland.

Format: Alpha Numeric (10)

Recording Guidance:

- CHI is a mandatory field when CHI is known.
- Temporary CHI numbers and other unique identifiers should not be recorded. Where CHI number is not available a temporary CHI number or other unique identifier can be recorded in data item 1.2 - Patient ID

Supplementary Information:

- The CHI number is a unique numeric identifier allocated to each patient on first registration with the health service.
- The CHI number is a 10-character code consisting of the 6-digit date of birth (DDMMYY), two digits, a 9th digit which is always even for females and odd for males and an arithmetical check digit.
- Records will be CHI seeded.
### 1.2 PATIENT ID

**Definition:** A unique identifier allocated to a patient on a local Radiology Information System (RIS).

**Format:** Alpha Numeric (15)

**Recording Guidance:**
- This can be the CHI number.

### 1.3 PATIENT SURNAME

**Definition:** The surname of a person represents that part of the name of a person which indicates the family group of which the person is part.

**Common Names:** Family Name; Last Name.

**Format:** Alpha Numeric (35)

**Recording Guidance:**
- This is a mandatory field if CHI is not provided.
- Double-barreled surnames should be entered with a hyphen between the two parts of the surname.
  
  Example: DURHAM-JONES
- Where a patient should remain anonymous, a pseudo-name, such as A N Other, should be used.
- Must be a minimum of 2 characters.
1.4 PATIENT FORENAME

**Definition:** The first forename of a person represents that part of the name of a person which after the surname is the principal identifier of a person.

**Common Names:** First Name; Given Name.

**Format:** Alpha Numeric (35)

**Recording Guidance:**

- This is a mandatory field if CHI is not provided.
- Hyphens occurring within a forename should be entered as a separate character (but not as a first character).

  Example: ANNE-MARIE

- Must be a minimum of 2 characters.

1.5 PATIENT DATE OF BIRTH

**Definition:** The date on which a person was born or is officially deemed to have been born as recorded on their birth certificate.

**Format:** Date - YYYYMMDD

**Recording Guidance:**

- This is a mandatory field if CHI is not provided.
- Date of birth should be entered thus: 9th February 1942
  - 19420209
1.6 PATIENT POSTCODE

**Definition:** The postcode is a basic unit for identifying geographic locations. A postcode is associated with each address in the UK.

**Common Name:** Postal Code

**Format:** Alpha Numeric (8)

**Recording Guidance:**
- This is a mandatory field if CHI is not provided.
- The postcode for the patient’s main place of residence should be recorded.
- If postcode is not available please use NK010AA.

1.7 PATIENT GENDER

**Definition:** A statement by the individual about the gender they currently identify themselves to be. This will be the gender at point of contact.

**Common Name:** Sex

**Format:** Integer (1)

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not Known</td>
<td>The gender of the person cannot be determined or identified at present.</td>
</tr>
<tr>
<td>1</td>
<td>Male</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Not Specified</td>
<td>The gender of the person is not provided in the personal details i.e. the data provided has not been supplied and sex cannot be ascertained from the data provided.</td>
</tr>
</tbody>
</table>

**Recording Guidance:**
- This is a mandatory field if CHI is not provided.
- If a client/service user is undergoing or has undergone gender reassignment/transgender they may record “1 Male” or “2 Female” if they wish to indicate their perceived gender at that time.
## SECTION 2: REQUEST DETAILS

**General Guidance for Section 2:**
- Data should be recorded for all requests received by the radiology service within the reporting period.

### 2.1 REQUEST ID

**Definition:** A unique identifier in the local Radiological Information System (RIS) for the exam request

**Format:** Alpha Numeric (20)

**Recording Guidance:**
- Request ID may be the same as the Master ID where the request is for a single exam.
- This field will be submitted in both Request and Master files and will be used to join the data.
- This is a mandatory field.

### 2.2 REQUESTING CLINICIAN ID

**Definition:** A unique identifier for the clinician who made the request.

**Format:** Alpha Numeric (15)

**Recording Guidance:**
- Uniquely identifies the clinician for the sending location.
- For data collection purposes clinician is not restricted to individuals who are clinically skilled but is used to identify anyone involved in delivering the patient’s diagnostic/interventional pathway.
2.3 REQUESTING CLINICIAN Surname

**Definition:** The surname of the individual clinician, care professional or other individual requesting the patient has a radiology exam.

**Format:** Alpha Numeric (35)

**Recording Guidance:**
- Double-barreled surnames should be entered with a hyphen between the two parts of the surname.
  
  Example: DURHAM-JONES.
- Must be a minimum of 2 characters.

2.4 REQUESTING CLINICIAN Forename

**Definition:** The forename of the individual clinician, care professional or other individual requesting the patient has a radiology exam.

**Format:** Alpha Numeric (35)

**Recording Guidance:**
- Hyphens occurring within a forename should be entered as a separate character (but not as a first character).
  
  Example: ANNE-MARIE.
- Must be a minimum of 2 characters.
### 2.5 REQUESTING SOURCE CODE

**Definition:** The Requesting Source Code is a broad category of organisation and/or professionals who may make a request.

**Format:** Alpha Numeric (10)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>GP</td>
</tr>
<tr>
<td>2</td>
<td>Consultant at this NHS Board/Health Care Provider</td>
</tr>
<tr>
<td>4</td>
<td>Consultant from a NHS Board/Health Care Provider out with this NHS Board area</td>
</tr>
<tr>
<td>5</td>
<td>Self Request</td>
</tr>
<tr>
<td>6</td>
<td>Prison/Penal Establishments</td>
</tr>
<tr>
<td>7</td>
<td>Judicial</td>
</tr>
<tr>
<td>8</td>
<td>Local Authority/Voluntary Agency</td>
</tr>
<tr>
<td>9</td>
<td>Other (includes Armed Forces)</td>
</tr>
<tr>
<td>A</td>
<td>Accident and Emergency Department</td>
</tr>
<tr>
<td>B</td>
<td>Optometrist/Optician</td>
</tr>
<tr>
<td>C</td>
<td>Allied Health Professional (AHP)</td>
</tr>
<tr>
<td>D</td>
<td>Dental Practitioner</td>
</tr>
<tr>
<td>E</td>
<td>Community Health Service (excluding Optometrist/Optician and Allied Health Professional (AHP))</td>
</tr>
</tbody>
</table>

**Recording Guidance**

- Local values will be mapped centrally for national analysis.
2.6 REQUESTING SOURCE DESCRIPTION

**Definition:** A description of the source of request which is a broad category of organisation and/or professionals who may make a request.

**Format:** Alpha Numeric (100)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:**

(See table in 2.5 Requesting Source Code)

**Recording Guidance**

- Local values will be mapped centrally for national analysis.

2.7 REQUESTING NHS BOARD CODE

**Definition:** The code for the NHS Board from which the radiology exam(s) request originated from.

**Format:** Alpha Numeric (10)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:** See Appendix – NHS Board Codes

**Recording Guidance:**

- Where a request comes from a GP Practice the NHS Board area where the practice is located should be recorded.
- Local values will be mapped centrally for national analysis.

2.8 REQUESTING NHS BOARD NAME

**Definition:** The NHS Board’s name/description from which the radiology exam(s) request was originated from.

**Format:** Alpha Numeric (100)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:** See Appendix – NHS Board Codes

**Recording Guidance**

- Local values will be mapped centrally for national analysis.
2.9 REQUESTING LOCATION CODE

**Definition:** The requesters base of employment. This may be a hospital, GP practice, research facility or other type of facility.

**Format:** Alpha Numeric (10)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:** National Location Codes – available upon request.

**Recording Guidance:**
- Local values will be mapped centrally for national analysis.

2.10 REQUESTING LOCATION NAME

**Definition:** A description of the requester’s base of employment. This may be a hospital, GP Practice, research facility or another type of facility.

**Format:** Alpha Numeric (100)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:** National Location Codes – available upon request.

**Recording Guidance**
- Local values will be mapped centrally for national analysis.

2.11 REQUESTING CLINICIAN SPECIALTY CODE

**Definition:** The specialty code of the clinician who made the request for the patient.

**Format:** Alpha Numeric (3)

**Codes and Values:** National Specialty Codes – available upon request.

**Recording Guidance:**
- This field should be coded to the specialty of the consultant, GP or Health Care Professional who has made the patient request. If the consultant is formally recognized and contracted to work in more than one specialty then the patient’s requirements should dictate the specialty.
2.12 REQUESTING DEPARTMENT

**Definition:** The department, ward or unit that made the request - e.g. out-patient department, ward 1, GP Practice name etc.

**Common Name:** Request Unit

**Format:** Characters – Free Text (100)

**Recording Guidance:**

- This is an optional field.

2.13 REQUEST RECEIVED DATE

**Definition:** The date on which the exam request was received in the radiology department.

**Format:** Date – YYYYMMD

**Recording Guidance:**

- This should be the date that the exam request (request letter, telephone call or electronic request) is received within the radiology department; it is not the date that the request has been sent or the date that it is entered onto the local RIS system.
- Where a request has been made by telephone and is then followed by written confirmation the date of the telephone call takes precedence and should be recorded as the request received date.
- This is a mandatory field.
2.14 REQUEST RECEIVED TIME

**Definition:** The time at which the exam request was received in the radiology department.

**Format:** hh:mm - 24hr clock (5)

**Recording Guidance:**

- This should be the time that the exam request (request letter, telephone call or electronic request) is received within the radiology department; it is not the time that the request has been sent or the time that it is entered onto the local RIS system.
- All times must be expressed in the 24 hour clock format, e.g. one minute past midnight is 00:01.
- This is a mandatory field.

2.15 PATIENT TYPE CODE

**Definition:** The administrative category of the patient being referred.

**Format:** Alpha Numeric (10)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>A&amp;E</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Clinical Trials</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Day Care</td>
<td>A patient who has an elective admission and requires supervised recovery in place of treatment but does not remain overnight.</td>
</tr>
<tr>
<td>D</td>
<td>Day Patient</td>
<td>A patient who attends a day hospital on a regular basis.</td>
</tr>
<tr>
<td>E</td>
<td>GP</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>GP Direct Access/Walk In</td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>Inpatient</td>
<td></td>
</tr>
<tr>
<td>Code</td>
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<td>H</td>
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<tr>
<td>J</td>
<td>Research</td>
<td></td>
</tr>
<tr>
<td>K</td>
<td>Volunteer</td>
<td></td>
</tr>
<tr>
<td>L</td>
<td>Ward Attender</td>
<td>A patient from out with the hospital or an inpatient from another specialty who</td>
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<td></td>
<td>attends a ward on an individual basis. Can be distinguished from outpatients by</td>
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<td></td>
<td>the fact that they are out with clinic sessions and the patients are usually</td>
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<td>seen by a junior doctor rather than by a consultant or a senior member of his/</td>
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<td></td>
<td></td>
<td>her team.</td>
</tr>
<tr>
<td>M</td>
<td>Outpatient</td>
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<tr>
<td>P</td>
<td>Dental</td>
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</tr>
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</table>

**Recording Guidance:**

- The patient type at point of request should be recorded.
- Local values will be mapped centrally for national analysis.

### 2.16 PATIENT TYPE DESCRIPTION

**Definition:** The description of patient type of the requesting patient.

**Format:** Alpha Numeric (100)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:** (See table in 2.15 Patient Type Code)

**Recording Guidance:**

- The patient type at point of request should be recorded.
- Local values will be mapped centrally for national analysis.
2.17 CLINICAL INDICATION

**Definition:** The requester’s clinical reason for the exam(s).

**Format:** Characters – Free Text (200)

**Recording Guidance:**

- This should be the reason given by the requester for why the patient requires the radiology exam(s) requested.

2.18 REQUEST STATUS CODE

**Definition:** The code which defines the current status of the exam requested.

**Format:** Alpha Numeric (10)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Awaiting Justification/Authorisation</td>
</tr>
<tr>
<td>2</td>
<td>Justified/Authorised</td>
</tr>
<tr>
<td>3</td>
<td>Rejected</td>
</tr>
</tbody>
</table>

**Recording Guidance:**

- Local values will be mapped centrally for national analysis.

2.19 REQUEST STATUS DESCRIPTION

**Definition:** The description of the current status of the exam requested.

**Format:** Alpha Numeric (100)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:** (See table in 2.20 Request Status Code)

**Recording Guidance:**

- Local values will be mapped centrally for national analysis.
SECTION 3: JUSTIFICATION/AUTHORISATION

General Guidance for Section 3:

Data will be recorded for all requests that have been Justified/Authorised in the radiology service.

3.1 JUSTIFICATION/AUTHORISATION DATE

Definition: Date the decision was made to reject/accept the exam request.

Format: Date – YYYYMMDD

Recording Guidance:

- This will be the last justification date if more then one justification occurred.

3.2 JUSTIFICATION/AUTHORISATION TIME

Definition: Time the decision was made to reject/accept the exam request.

Format: hh:mm - 24hr clock (5)

Recording Guidance:

- All times must be expressed in the 24 hour clock format, e.g. one minute past midnight is 00:01.

3.3 JUSTIFICATION/AUTHORISATION CLINICIAN ID

Definition: A unique identifier of the individual clinician authorizing the exam(s). This will normally be the ID of the Clinician in the local RIS.

Format: Alpha Numeric (15)

Recording Guidance:

- Must have matching details in Clinician Reference File. See Appendix.
3.4 JUSTIFICATION/AUTHORISATION NHS BOARD CODE

Definition: The NHS Board’s code for the Person who Justified/Authorised the request.

Format: Alpha Numeric (10)

Submission: Local values will be submitted and mapped centrally to National values.

National Codes and Values: See Appendix – NHS Board Codes

Recording Guidance:
- Local values will be mapped centrally for national analysis.

3.5 JUSTIFICATION/AUTHORISATION NHS BOARD NAME

Definition: The NHS Board’s description for the Person who Justified/Authorised the request.

Format: Alpha Numeric (100)

Submission: Local values will be submitted and mapped centrally to National values.

National Codes and Values: See Appendix – NHS Board Codes

Recording Guidance
- Local values will be mapped centrally for national analysis.

3.6 JUSTIFICATION/AUTHORISATION OUTSOURCED FLAG

Definition: A code which indicates if a company external to the NHS undertook the Justification/Authorisation and was therefore Outsourced.

Format: Integer (1)

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Definition: A code which indicates that the Justification/Authorisation was undertaken by a member of NHS staff who is working in their non-contracted hours and was therefore Insourced.

Format: Integer (1)

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
</tbody>
</table>
SECTION 4: BOOKING & APPOINTMENT

General Guidance for Section 4:

Date will be recorded for all appointments and bookings made with the radiology service. Appointments and bookings that have been and later cancelled should also be recorded.

4.1 UNAVAILABILITY START DATE

Definition: Start date of a period of patient unavailability for a radiology appointment.

Format: Date – YYYYMMDD

Recording Guidance:

- The systems do not capture multiple periods of unavailability therefore the longest period of unavailability which affects the diagnostic pathway should be recorded.

4.2 UNAVAILABILITY END DATE

Definition: End date of a period of patient unavailability for a radiology appointment.

Format: Date – YYYYMMDD

Recording Guidance:

- The systems do not capture multiple periods of unavailability therefore the longest period of unavailability which affects the diagnostic pathway should be recorded.
- The unavailability end date must be supplied for all periods of definite unavailability.
- For periods of indefinite unavailability the unavailability end date may be left blank.
4.3 UNAVAILABILITY REASON CODE

**Definition:** The reason code given by the patient for the period of unavailability.

**Format:** Alpha Numeric (10)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A</td>
<td>Patient Advised – on holiday</td>
</tr>
<tr>
<td>1B</td>
<td>Patient Advised - personal commitment</td>
</tr>
<tr>
<td>1C</td>
<td>Patient Advised - work commitment</td>
</tr>
<tr>
<td>1D</td>
<td>Patient Advised - carer commitment</td>
</tr>
<tr>
<td>1E</td>
<td>Patient Advised - academic commitment</td>
</tr>
<tr>
<td>1F</td>
<td>Patient Advised - jury duty</td>
</tr>
<tr>
<td>1G</td>
<td>Patient Request - wishes named consultant</td>
</tr>
<tr>
<td>1H</td>
<td>Patient Request - wishes to be treated within NHS Board</td>
</tr>
<tr>
<td>1I</td>
<td>Patient Advised - Visiting Consultant Service</td>
</tr>
<tr>
<td>1J</td>
<td>Patient Advised - severe Weather - cancellation of Visiting Consultant Service</td>
</tr>
<tr>
<td>1K</td>
<td>Patient Advised - indefinitely unavailable</td>
</tr>
</tbody>
</table>

**Recording Guidance:**

- Unavailability reason code should be recorded when it is known that the patient is unavailable for a known period of time or are indefinitely unavailable.
4.4 UNAVAILABILITY REASON DESCRIPTION

**Definition:** The description of the reason given by the patient for the period of unavailability.

**Format:** Alpha Numeric (100)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:** (See table for 4.3 Unavailability Reason Code)

4.5 APPOINTMENT DATE

**Definition:** The date on which the radiology department have scheduled the exam to take place.

**Common Names:** Date of proposed appointment.

**Format:** Date – YYYYMMDD

**Recording Guidance:**
- The appointment date should not be within any period of patient unavailability.

4.6 APPOINTMENT TIME

**Definition:** The time at which the radiology department have scheduled the exam to take place.

**Format:** hh:mm – 24hr clock (5)

**Recording Guidance:**
- All times must be expressed in the 24 hour clock format, e.g. one minute past midnight is 00:01.
4.7 BOOKING DATE

**Definition:** Date the patient was contacted or the patient contacted the department regarding making an appointment.

**Format:** Date – YYYYMMDD

**Recording Guidance:**
- This is not the date the exam was scheduled to take place.

4.8 BOOKING TIME

**Definition:** Time the patient was contacted or the patient contacted the department regarding making an appointment.

**Format:** hh:mm – 24hr clock (5)

**Recording Guidance:**
- This is not the time the exam was scheduled to take place.
- All times must be expressed in the 24 hour clock format, e.g. one minute past midnight is 00:01.

4.9 CANCELLATION DATE

**Definition:** The date the exam was cancelled by the hospital, radiology department or patient.

**Format:** Date – YYYYMMDD

**Recording Guidance:**
- Only to be populated when the Justified/Authorised exam has not gone ahead.
4.10 CANCELLATION TIME

**Definition:** The time the exam was cancelled by the hospital, radiology department or patient.

**Format:** hh:mm – 24hr clock (5)

**Recording Guidance:**

- All times must be expressed in the 24 hour clock format, e.g. one minute past midnight is 00:01.

4.11 BOOK STATUS CODE

**Definition:** A code which dictates the status of the patients booking.

**Format:** Alpha Numeric (10)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Attended</td>
</tr>
<tr>
<td>2</td>
<td>Could Not Attend</td>
</tr>
<tr>
<td>3</td>
<td>Did Not Attend</td>
</tr>
<tr>
<td>5</td>
<td>Cancelled by Hospital</td>
</tr>
</tbody>
</table>

**Recording Guidance:**

- Local values will be mapped centrally for national analysis of attendance status.
4.12 BOOK STATUS DESCRIPTION

**Definition:** The description which shows the latest status of the patients booking.

**Format:** Alpha Numeric (100)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:** (see table in 4.10 Booked Status Code)

**Recording Guidance:**

- Local values will be mapped centrally for national analysis of attendance status.

4.13 PLANNED EXAM FLAG

**Definition:** An indicator for whether the exam had been planned as part of an ongoing course of treatment.

**Format:** Integer (1)

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Recording Guidance:**

- This indicates that this exam should not be included in normal request to exam turnaround time calculations.

4.14 PLANNED EXAM DATE

**Definition:** The date of any future exam planned for this course of treatment.

**Format:** Date – YYYYMMDD
SECTION 5: EXAM

General Guidance for Section 5:

Data will be recorded for all exams carried out by the radiology service.

5.1 MASTER/EXAM ID

Definition: A unique record identifier for the exam performed.

Format: Alpha Numeric (20)

Recording Guidance:

- Must uniquely identify the exam record for the sending location.
- Master/Exam ID may be the accession number if the number is used locally to identify an exam or created from a combination of data items, e.g. accession number + study sequence number.
- This is a mandatory field.

5.2 ATTENDANCE ID

Definition: A unique identifier in the local Radiological Information System (RIS) for the attendance at the Radiology centre.

Format: Alpha Numeric (20)

Recording Guidance:

- Attendance ID may be the accession number if the number is used locally to identify an attendance.
- One Attendance ID may include multiple exams.
- This is a mandatory field.
5.3 URGENCY CODE

Definition: The urgency code of the clinical urgency allocated by the radiologist.

Format: Alpha Numeric (10)

Submission: Local values will be submitted and mapped centrally to National values.

National Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Emergency</td>
<td>Less than 1 hour</td>
</tr>
<tr>
<td>2</td>
<td>Urgent</td>
<td>More than 1 hour and within 14 days</td>
</tr>
<tr>
<td>3</td>
<td>Routine</td>
<td>More than 14 days</td>
</tr>
</tbody>
</table>

Recording Guidance:

- Local values will be mapped centrally for national analysis.
- Urgency can be updated throughout the patient’s diagnostic pathway and will reflect the clinical urgency at the latest time reviewed which may not be the urgency at request.

5.4 URGENCY DESCRIPTION

Definition: The description of urgency of the exam requested. These will match the corresponding Urgency Code.

Format: Alpha Numeric (100)

Submission: Local values will be submitted and mapped centrally to National values.

National Codes and Values: (See table in 2.18 Urgency Code)

Recording Guidance:

- Local values will be mapped centrally for national analysis.
- Urgency can be updated throughout the patient’s diagnostic pathway and will reflect the clinical urgency at the latest time reviewed which may not be the urgency at request.
5.5 SPECIAL PATHWAY TYPE CODE

Definition: A code to indicate and describe that the patient was on a Special Pathway.

Format: Alpha Numeric (10)

5.6 SPECIAL PATHWAY TYPE DESCRIPTION

Definition: A description to indicate and describe that the patient was on a Special Pathway.

Format: Alpha Numeric (100)

5.7 MODALITY CODE

Definition: A code used to define the imaging modality that was involved in the exam(s).

Format: Alpha Numeric (10)

Submission: Local values will be submitted and mapped centrally to National values.

National Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>CT</td>
</tr>
<tr>
<td>E</td>
<td>Endoscopy</td>
</tr>
<tr>
<td>F</td>
<td>Fluoroscopy</td>
</tr>
<tr>
<td>I</td>
<td>Interventional</td>
</tr>
<tr>
<td>K</td>
<td>Cone Beam CT</td>
</tr>
<tr>
<td>M</td>
<td>MRI/MRA/MRV</td>
</tr>
<tr>
<td>N</td>
<td>NM/RNI</td>
</tr>
<tr>
<td>U</td>
<td>Ultrasound</td>
</tr>
</tbody>
</table>
**5.8 MODALITY DESCRIPTION**

**Definition:** The description of imaging modality that was involved in the exam(s).

**Format:** Alpha Numeric (100)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:** (see table in 5.5 Modality Code)

---

**5.9 EXAM OUTSOURCED FLAG**

**Definition:** A code which indicates if a company external to the NHS undertook the exam and was therefore outsourced.

**Format:** Integer (1)

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
</tbody>
</table>
5.10 EXAM INSOURCED FLAG

**Definition:** A code which indicates that the exam was undertaken by a member of NHS staff who is working in their non-contracted hours and was therefore insourced.

**Format:** Integer (1)

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
</tbody>
</table>

5.11 EXAM NHS BOARD CODE

**Definition:** The NHS Board’s code where the radiology exam was performed

**Format:** Alpha Numeric (10)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:** See [Appendix – NHS Board Codes](#)

5.12 EXAM NHS BOARD NAME

**Definition:** The NHS Board’s name/description from which the radiology exam request was carried out

**Format:** Alpha Numeric (100)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:** See [Appendix – NHS Board Codes](#)
5.13 EXAM LOCATION CODE

**Definition:** The code of the location which performed the exam. This must be a hospital or GP Practice.

**Format:** Alpha Numeric (10)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:** National Location Codes – available upon request.

**Recording Guidance:**
- Local values will be mapped centrally for national analysis.
- All domiciliary visits will be mapped to D299N – Domiciliary location.
- Mobile units should be coded as the hospital location.
- Any community location should be coded as D299N – Domiciliary location.

5.14 EXAM LOCATION NAME

**Definition:** A description of the location which performed the exam. This may be a hospital, research facility, training facility, or another type of facility.

**Format:** Alpha Numeric (100)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:** National Location Codes – available upon request.

**Recording Guidance**
- Local values will be mapped centrally for national analysis.

5.15 EXAM START DATE

**Definition:** The actual date the exam was performed, which may not be the date the exam was scheduled for.

**Format:** Date – YYYYMMDD

**Recording Guidance:**
- This can be the start of an attendance and not the exam.
• If start and end dates not collected, please submit date used locally for exam.

5.16 EXAM END DATE

Definition: The actual date the exam ended, which may not be the date the exam was scheduled for.

Format: Date – YYYYMMDD

Recording Guidance:

• This can be the end of an attendance and not the exam.
• If start and end dates not collected, please submit date used locally for exam.

5.17 EXAM START TIME

Definition: The time when the exam(s) began, including any time required to prepare the patient.

Format: hh:mm – 24hr clock (5)

Recording Guidance:

• All times must be expressed in the 24 hour clock format, e.g. one minute past midnight is 00:01.
• This can be the start/end of an attendance and not the exam.
• If start and end times not collected, please submit date used locally for exam.

5.18 EXAM END TIME

Definition: The time when the exam(s) was completed, including any time to care for the patient and validate the image(s) taken.

Format: hh:mm – 24hr clock (5)

Recording Guidance:

• All times must be expressed in the 24 hour clock format, e.g. one minute past midnight is 00:01. All times are assumed to be GMT.
• If start and end times not collected, please submit date used locally for exam.

This can be the start/end of an attendance and not the exam.
5.19 OPERATOR 1 CLINICIAN ID

**Definition:** The staff login or PIN of the clinician, care professional or other individual who performed the radiology exam(s). This will normally be the ID of the Clinician in the local RIS.

**Format:** Alpha Numeric (15)

**Recording Guidance:**
- Must have matching details in Clinician Reference File. [See Appendix.](#)

5.20 OPERATOR 2 CLINICIAN ID

**Definition:** The staff login or PIN of the clinician, care professional or other individual who supported the radiology exam(s). This will normally be the ID of the Clinician in the local RIS.

**Format:** Alpha Numeric (15)

**Recording Guidance:**
- Must have matching details in Clinician Reference File. [See Appendix.](#)

5.21 ROOM/EQUIPMENT ID

**Definition:** Unique identifier code for the room where the exam was performed or piece of equipment used for the exam.

**Format:** Alpha Numeric (20)

**Recording Guidance:**
- If you have equipment identifiers this can also be submitted.
### 5.22 EXAM CODE

**Definition:** The code which depicts the type of exam that is performed on the patient.

**Format:** Alpha Numeric (10)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:** National Interim Clinical Imaging Procedure (NICIP) Codes - available upon request.

**Recording Guidance:**
- Different versions of NICIP codes are used + local codes therefore, local values will be mapped centrally for national analysis.
- Additional details such as NICIP modality, interventional/diagnostic and body part will be mapped as part of the NICIP reference file.

### 5.23 EXAM DESCRIPTION

**Definition:** The exam(s) which is performed on the patient.

**Format:** Alpha Numeric (100)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:** National Interim Clinical Imaging Procedure (NICIP) Codes - available upon request.

### 5.24 DOSE AMOUNT

**Definition:** The amount of radiation administered during the exam(s)

**Format:** Number

### 5.25 DOSE UNIT CODE
**SECTION 6: REPORTING**

**General guidance for section 6:**

Data will be recorded for all reporting on radiology exams by the radiology service.

**6.1 NO REPORT REQUIRED FLAG**

**Definition:** A flag to indicate that no report was required for this record.

**Format:** Integer (1)

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>A report is required.</td>
</tr>
<tr>
<td>1</td>
<td>No report is required.</td>
</tr>
</tbody>
</table>

**6.2 REPORT ID**

**Definition:** A unique identifier for the report

**Format:** Alpha Numeric (20)

**Recording Guidance:**

- Where a report refers to multiple exams, the report ID should be recorded with each Exam ID.
- Will be null until the exam has been reported on.
6.3 REPORT OUTSOURCED FLAG

**Definition:** A code which indicates if a company external to the NHS undertook the report and was therefore Outsourced.

**Format:** Numeric (1)

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
</tbody>
</table>

6.4 REPORT INSOURCED FLAG

**Definition:** A code which indicates that the report was undertaken by a member of NHS staff who is working in their non-contracted hours and was therefore Insourced.

**Format:** Numeric (1)

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
</tbody>
</table>

6.5 REPORT NHS BOARD CODE

**Definition:** The NHS Board's code from which the report was completed

**Format:** Alpha Numeric (10)

**Submission:** Local values will be submitted and mapped centrally to National values.
6.6 REPORT NHS BOARD NAME

**Definition:** The NHS Board’s name(description) from which the report was completed.

**Format:** Alpha Numeric (100)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:** See Appendix – NHS Board Codes

6.7 REPORT DATE

**Definition:** The date the report was completed.

**Format:** Date – YYYYMMDD

**Recording Guidance:**

6.8 REPORT TIME

**Definition:** The time the report was completed.

**Format:** hh:mm – 24hr clock (5)

**Recording Guidance:**

- All times must be expressed in the 24 hour clock format, e.g. one minute past midnight is 00:01.

6.9 REPORTING CLINICIAN ID

**Definition:** The staff login or PIN of the individual clinician who completes the report of the radiology exam. This will normally be the ID of the Clinician in the local RIS.

**Format:** Alpha Numeric (20)

**Recording Guidance:**

- If national identifiers are not used the clinician may have multiple IDs if they work in different NHS Boards.
• Must have matching details in Clinician Reference File. See Appendix.

6.10 VERIFYING CLINICIAN ID

**Definition:** The staff login or PIN of the individual clinician who verified the report of the radiology exam. This will normally be the ID of the Clinician in the local RIS.

**Format:** Alpha Numeric (15)

**Recording Guidance:**

- If national identifiers are not used the clinician may have multiple IDs if they work in different NHS Boards.
- Must have matching details in Clinician Reference File. See Appendix.

6.11 VERIFICATION OUTSOURCED FLAG

**Definition:** A code which indicates if a company external to the NHS undertook the verification and was therefore Outsourced.

**Format:** Integer (1)

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
</tbody>
</table>

6.12 VERIFICATION INSOURCED FLAG

**Definition:** A code which indicates that the verification was undertaken by a member of NHS staff who is working in their non-contracted hours and was therefore Insourced.

**Format:** Integer (1)

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 6.13 VERIFICATION NHS BOARD CODE

**Definition:** The NHS Board’s code from which the report was verified.

**Format:** Alpha Numeric (10)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:** See [Appendix – NHS Board Codes](#).

### 6.14 VERIFICATION NHS BOARD NAME

**Definition:** The NHS Board’s name/description from which the report was verified.

**Format:** Alpha Numeric (100)

**Submission:** Local values will be submitted and mapped centrally to National values.

**National Codes and Values:** See [Appendix – NHS Board Codes](#).

### 6.15 VERIFIED DATE

**Definition:** The latest date the report was verified or subsequently updated.

**Format:** Date – YYYYMMDD

**Recording Guidance:**

- Latest date the report was verified or subsequently updated.

### 6.16 VERIFIED TIME

**Definition:** The Latest time the report was verified or subsequently updated.

**Format:** hh:mm – 24hr clock (5)

**Recording Guidance:**
• This may be the time that the exam report is verified and printed (if the report is printed).
• All times must be expressed in the 24 hour clock format, e.g. one minute past midnight is 00:01.

**APPENDIX – CLINICIAN REFERENCE FILE**

Another clinician reference file will be submitted in order to for the clinician ID to be mapped to additional information – National Clinician ID will not be submitted by boards in this reference file. These are outlined in the following Section.

For data collection purposes clinician is not restricted to individuals who are clinically skilled but is used to identify anyone involved in delivering the patient’s diagnostic/interventional pathway.

**A.1 SENDING LOCATION**

**Definition:** This is a single digit cipher code used to dictate the board which send the clinician reference file.

**Format:** Text (1)

**Codes and Values:**

<table>
<thead>
<tr>
<th>Sending Location Code</th>
<th>Sending Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>NHS AYRSHIRE &amp; ARRAN</td>
</tr>
<tr>
<td>B</td>
<td>NHS BORDERS</td>
</tr>
<tr>
<td>Y</td>
<td>NHS DUMFRIES &amp; GALLOWAY</td>
</tr>
<tr>
<td>F</td>
<td>NHS FIFE</td>
</tr>
<tr>
<td>V</td>
<td>NHS FORTH VALLEY</td>
</tr>
<tr>
<td>N</td>
<td>NHS GRAMPIAN</td>
</tr>
<tr>
<td>G</td>
<td>NHS GREATER GLASGOW &amp; CLYDE</td>
</tr>
<tr>
<td>H</td>
<td>NHS HIGHLAND</td>
</tr>
<tr>
<td>C</td>
<td>NHS HIGHLAND – ARGYLL &amp; BUTE</td>
</tr>
<tr>
<td>L</td>
<td>NHS LANARKSHIRE</td>
</tr>
<tr>
<td>S</td>
<td>NHS LOTHIAN</td>
</tr>
<tr>
<td>T</td>
<td>NHS TAYSIDE</td>
</tr>
<tr>
<td>W</td>
<td>NHS WESTERN ISLES</td>
</tr>
<tr>
<td>K</td>
<td>GOLDEN JUBILEE</td>
</tr>
</tbody>
</table>
A.2 LOCAL CLINICIAN ID

**Definition:** The local code of the clinician used by the health-board. This will normally be the login, PIN or local code of the Clinician in the local RIS.

**Format:** Alpha Numeric (15)

**Recording Guidance:**
- This is the ID to identify the staff ID used in any of the following data items. 3.3 Justifying Clinician ID, 5.10 Operator 1 Clinician ID, 5.11 Operator 2 Clinician ID, 6.4 Reporting Clinician ID, or 6.8 Verifying Clinician ID.

A.3 CLINICIAN PROFESSIONAL CODE

**Definition:** The professional ID used by the Clinician. This could be GMC Number or any other professional ID.

**Format:** Alpha Numeric (15)

**Recording Guidance:**
- This item is not included in the reference file submission.
- This ID will be used in order to differentiate staff which may work across multiple boards.

A.4 CLINICIAN SURNAME

**Definition:** The surname of a person represents that part of the name of a person which indicates the family group of which the person is part.
**Common Names:** Family Name; Last Name.

**Format:** Alpha Numeric (100)

**Recording Guidance:**

- This is a mandatory field if CHI is not provided.
- Double-barreled surnames should be entered with a hyphen between the two parts of the surname.
  
  Example: DURHAM-JONES

- Where a patient should remain anonymous, a pseudo-name, such as A N Other, should be used.
- Must be a minimum of 2 characters.

### A.5 CLINICIAN FORENAME

**Definition:** The first forename of a person represents that part of the name of a person which after the surname is the principal identifier of a person.

**Common Names:** First Name; Given Name.

**Format:** Alpha Numeric (100)

**Recording Guidance:**

- This is a mandatory field if CHI is not provided.
- Hyphens occurring within a forename should be entered as a separate character (but not as a first character).

  Example: ANNE-MARIE

- Must be a minimum of 2 characters.

### A.6 CLINICIAN DATE OF BIRTH

**Definition:** The date of the birth of the clinician.

**Format:** YYYYMMDD
A.7 CLINICIAN GENDER

Definition: A statement by the individual about the gender they currently identify themselves to be. This will be the gender at point of contact.

Common Name: Sex

Format: Integer (1)

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not Known</td>
<td>The gender of the person cannot be determined or identified at present.</td>
</tr>
<tr>
<td>1</td>
<td>Male</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Not Specified</td>
<td>The gender of the person is not provided in the personal details i.e. the data provided has not been supplied and sex cannot be ascertained from the data provided.</td>
</tr>
</tbody>
</table>

Recording Guidance:

- This is a mandatory field if CHI is not provided.

If a client/service user is undergoing or has undergone gender reassignment/transgender they may record “1 Male” or “2 Female” if they wish to indicate their perceived gender at that time.
**A.8 DESIGNATION CODE**

**Definition:** A code used to establish the designation of the clinician

**Format:** Integer (1)

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Radiologist</td>
</tr>
<tr>
<td>2</td>
<td>Radiographer</td>
</tr>
<tr>
<td>3</td>
<td>Sonographer</td>
</tr>
<tr>
<td>6</td>
<td>Other</td>
</tr>
</tbody>
</table>

**A.9 START DATE**

**Definition:** The date of when the clinician started their designation

**Format:** YYYYMMDD

**A.10 END DATE**

**Definition:** The date of when the clinician ended their designation

**Format:** YYYYMMDD
## APPENDIX – NHS BOARD CODES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S08000015</td>
<td>NHS Ayrshire &amp; Arran</td>
</tr>
<tr>
<td>S08000016</td>
<td>NHS Borders</td>
</tr>
<tr>
<td>S08000017</td>
<td>NHS Dumfries &amp; Galloway</td>
</tr>
<tr>
<td>S08000018</td>
<td>NHS Fife</td>
</tr>
<tr>
<td>S08000019</td>
<td>NHS Forth Valley</td>
</tr>
<tr>
<td>S08000020</td>
<td>NHS Grampian</td>
</tr>
<tr>
<td>S08000021</td>
<td>NHS Greater Glasgow &amp; Clyde</td>
</tr>
<tr>
<td>S08000022</td>
<td>NHS Highland</td>
</tr>
<tr>
<td>S08000023</td>
<td>NHS Lanarkshire</td>
</tr>
<tr>
<td>S08000024</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>S08000025</td>
<td>NHS Orkney</td>
</tr>
<tr>
<td>S08000026</td>
<td>NHS Shetland</td>
</tr>
<tr>
<td>S08000027</td>
<td>NHS Tayside</td>
</tr>
<tr>
<td>S08000028</td>
<td>NHS Western Isles</td>
</tr>
<tr>
<td>S08100001</td>
<td>National Facility/Golden Jubilee</td>
</tr>
<tr>
<td>S08200001</td>
<td>England/Wales/Northern Ireland</td>
</tr>
<tr>
<td>S27000001</td>
<td>Non-NHS Provider</td>
</tr>
</tbody>
</table>