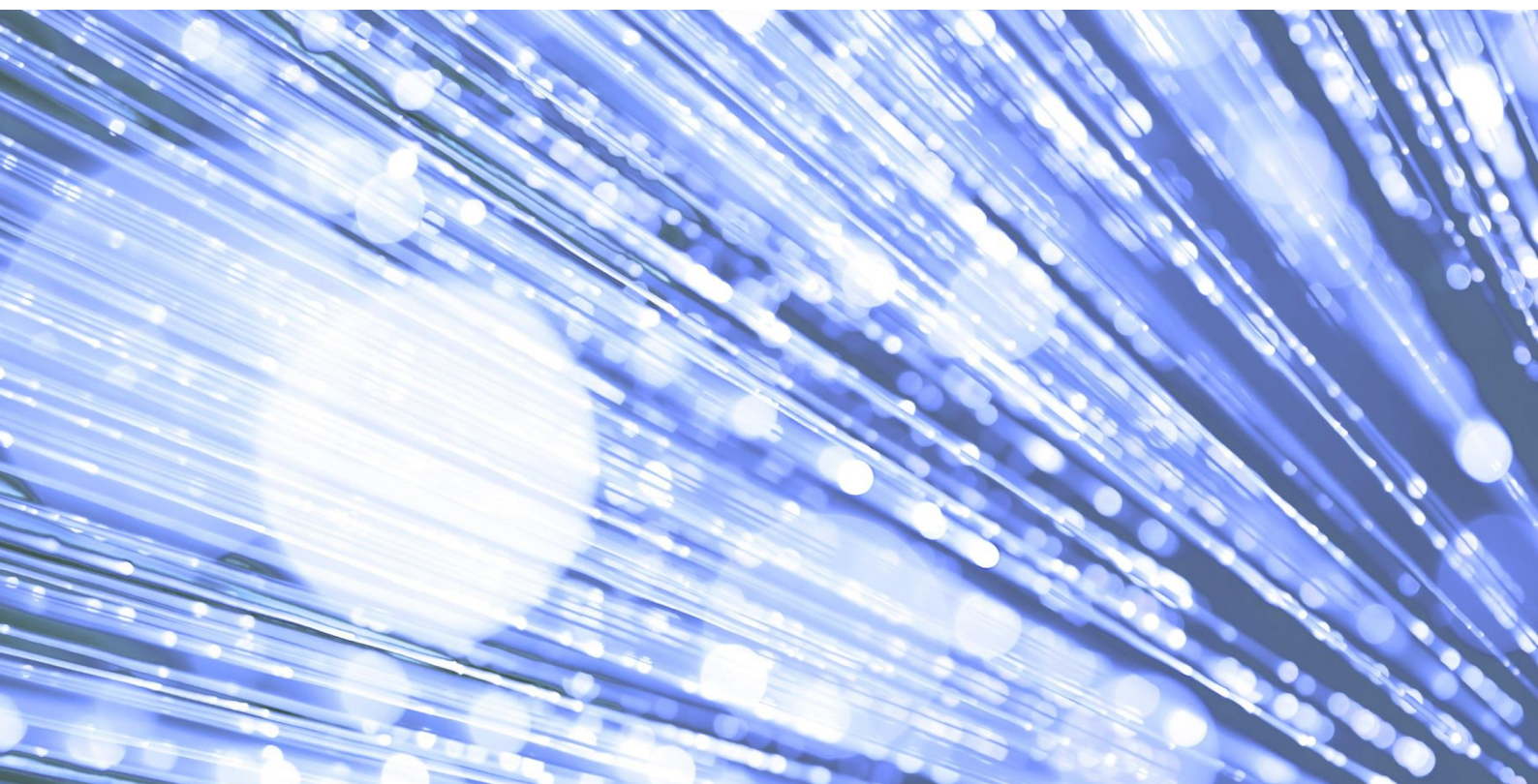


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# Commissioning Data Sets v6.3 User Guidance



**Information and technology**  
**for better health and care**

# Document Management

## Revision History

Version	Date	Summary of Changes
6.3.01	22/09/2021	First draft version of the v6.3 User Guidance
6.3.02	13/12/2021	Minor additions for first published version

## Reviewers

This document must be reviewed by the following people:

Reviewer name	Title / Responsibility	Date	Version
Tom Latham	DSDS Technical Manager	13/12/2021	6.3.02

## Approved by

This document must be approved by the following people:

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Tom Latham	DSDS Technical Manager	13/12/2021	6.3.02

## Glossary of Terms

A full Glossary of Terms for the CDS Information Standard can be found within the [CDS v6.3 Requirements Specification](#).

### Document Control:

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# 1 About this Document

## 1.1 Purpose of the Document

The purpose of this document is to outline how the Commissioning Data Sets (CDS) v6.3 should be used and interpreted by care providers, system suppliers, data submitters and other stakeholders by providing information on each individual data group and its constituent data items.

## 1.2 Scope of the Document

This document provides guidance for:

- Managers and clinical leads of organisations providing secondary care, including foundation and non-foundation Trusts. This also includes services commissioned by the NHS but provided by independent organisations.
- Information management departments within data provider organisations
- Suppliers of secondary care systems, including Patient Administration Systems (PAS), Clinical Care Records systems and other operational systems such as Maternity and Critical Care
- Other organisations that use the CDS Information Standard
- CDS XML/middleware suppliers

The following areas are out of scope of this document:

- Detailed justification for the development of the Information Standard.
- Data submission framework (i.e. how data is submitted by data providers to the Secondary Uses Service (SUS)).

This document should be read in conjunction with the following documents:

- CDS v6.3 Requirements Specification
- CDS v6.3 Technical Output Specification
- CDS v6.3 Implementation Guidance
- NHS Data Model and Dictionary
- [SUS guidance and supporting documents](#)

## 1.3 Document design approach

### 1.3.1 DATA GROUP / MASTER DATA GROUP Headers

The design approach applied in this document aims to represent the structure of individual CDS data groups, as described in other CDS information sources such as the XML schema, NHS Data Model and Dictionary and the Technical Output Specification.

It is however important to note that while the technical details included in these documents are expected to be consistent, there might be differences in how the same information is presented resulting from the different formats utilised within these documents.

While the DATA GROUP heading is the most common concept used in this document to group individual data items, in selected cases the MASTER DATA GROUP header is used instead, in line with the TOS.

This concept aims to show closely related data groups (and in some cases ungrouped data items, e.g. DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET)) combined into an overarching master group, containing separate 'Status' and 'Repeats' details, as defined in the Data Dictionary.

The MASTER DATA GROUP concept in the CDS User Guidance is currently applied to:

- PATIENT PATHWAY
- PATIENT IDENTITY
- PERSON IDENTITY
- CLINICAL DIAGNOSIS GROUP (ICD)
- PROCEDURE GROUP (OPCS)
- NEONATAL CRITICAL CARE PERIOD
- PAEDIATRIC CRITICAL CARE PERIOD
- ADULT CRITICAL CARE PERIOD

### 1.3.2 Common DATA GROUP approach

In order to optimise the size of this document, while ensuring it remains fit for purpose, the design focuses on eliminating repeating elements common across multiple CDS types. A single reference is provided for each individual data group used across the various CDS types, with clearly defined information and guidance specific to individual CDS types where required. This includes the following:

- Where group names vary between CDS types, a generic Data Group name is used in the group header (for example, 'EPISODE – ACTIVITY CHARACTERISTICS') with the individual Data Group names used in each CDS type and shown in the Data Dictionary listed within the table header (for example, 'BIRTH EPISODE - ACTIVITY CHARACTERISTICS', 'DELIVERY EPISODE - ACTIVITY CHARACTERISTICS', 'CARE EPISODE - ACTIVITY CHARACTERISTICS')
- Generic Data Group descriptions are used for common groups that appear across multiple CDS types, with references to (for example) Care/ Birth/Delivery and Finished/Unfinished episodes removed.
- Relevant CDS types are listed against each Data Group, as well as the individual data items within each group
- The full list of data items relevant to the Data Group is included for all CDS types the group is applicable to (example: NHS NUMBER STATUS INDICATOR CODE (MOTHER) and NHS NUMBER STATUS INDICATOR CODE (BABY) are both included in the WITHHELD IDENTITY STRUCTURE of the PERSON IDENTITY group)

## 1.4 Schedule for Updating this Document

Please note this guidance document is considered to be a live document and NHS Digital reserves the right to review and update when necessary, for example in response to stakeholder feedback. Changes to this document will not necessitate further acceptance from the Data Alliance Partnership Board (DAPB), however this is on the understanding that the changes do not affect the scope of the Information Standard.

## 2 Background Information

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

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

These include:

- Monitoring and managing NHS service agreements
- Developing commissioning plans
- Supporting the National Tariff Payment System
- Enabling the calculation of Healthcare Resource Groups (HRGs)
- Monitoring Health Improvement Programmes
- Underpinning clinical governance
- Understanding the health needs of the population
- Enabling reporting against referral to treatment (RTT) targets

The Department of Health and Social Care requires accurate data for the types of patient activity covering Outpatient Appointments (including Did Not Attends) and Admitted Patient Care (Hospital Admissions).

This includes all secondary care activity of this nature undertaken by NHS Hospital Providers in England, including patients receiving private treatment within an NHS Trust (i.e. within a Private Patient Unit (PPU)), and NHS commissioned elective activity carried out elsewhere, including in the independent sector (including Any Qualified Providers) and overseas.

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

As a secondary uses data set, CDS re-uses clinical and operational data for purposes other than direct patient care. It defines the data items, definitions, and associated value sets to be extracted or derived from local information systems.

### 2.1 Summary of Changes in CDS v6.3

CDS v6.3 is an interim update to the existing CDS v6.2. The 'tactical release' of CDS v6.3 is designed to rapidly introduce a number of high priority changes so that SNOMED CT codes (including recently authored codes that relate to COVID-19) can be submitted to CDS as soon as possible. In order to expedite this, requirements that involve major structural changes or large numbers of additional data items have been deferred to a future version.

The CDS v6.3 changes are mainly designed to update CDS in line with current clinical and data recording practices, as well as to support recent policy initiatives and enable conformance with other information standards and legislation introduced since CDS v6.2 went live in 2012.

Changes introduced into CDS v6.3 are explicitly stated in the *Change Specification*, *Detailed Change Specification* and *Technical Output Specification* documents, but in summary the high-level changes include:

- Introduction of SNOMED CT, as per the SCCI0034 information standard
- Removal of Read/CTV-3 structures

- Changes to conform with other information standards, such as:
  - DCB0028 Treatment Function and Main Specialty Standard
  - DCB3017 Overseas Visitor Charging Category (OVCC)
  - DCB0090 Health and Social Care Organisation Reference Data
  - DCB2094 Sexual Orientation Monitoring Standard
- Removal of enumerated value lists from XML schema for some data items
- Various updates to NHS Data Model and Dictionary pages and data items to reflect changes since the CDS was last updated
- Retirement of redundant CDS types which are no longer utilised or represent duplication
- Introduction of the ability to submit multiple commissioners and SPECIALISED SERVICE CODE data item, to support specialised commissioning requirements
- Minor changes to support NHS England and NHS Improvement Outpatient Transformation Programme requirements
- Acute Data Alignment Programme (ADAPt) changes to support alignment with the Private Healthcare Information Network (PHIN) submissions of data for private patients
- Additional data items to match and enable linkage with new Ambulance Data Set
- Changes to enable the capture of risk assessments completed for ophthalmology patients and an associated 'latest clinically appropriate date' for treatment
- Enabling the reporting of digitalised fit notes issued in secondary care within CDS, in support of the forthcoming DAPB4011 eMED3 Fit Notes in Secondary Care information standard

CDS v6.3 will ultimately replace CDS v6.2 (ISB 0092 Amd 16/2010), which was published in September 2012.

## 2.2 Introduction of Clinical Terminologies within CDS

### 2.2.1 What is SNOMED CT?

SNOMED CT is the standard clinical terminology for the NHS to support recording of clinical information in a way that supports data management and analysis to assist patient care, while enabling data extraction and data exchange.

SNOMED CT provides a comprehensive set of clinical phrases or terms; this is called a terminology. SNOMED CT is much more than just a set of clinical phrases, for example it also includes groups with relationships between terms. It is the most comprehensive international terminology currently available and can be used across all care settings and all clinical domains.

SNOMED CT is managed and maintained internationally by [SNOMED International](#) and in the UK by the [UK National Release Centre \(part of NHS Digital\)](#).

SNOMED CT was specified as the single terminology to be used across the health system in ['Personalised Health and Care 2020: A Framework for Action'](#) and the [SCCI0034 SNOMED CT information standard](#).

### 2.2.2 What are the benefits of using SNOMED CT?

As the NHS moves to paperless records, and the aspiration to exchange data electronically across the NHS, it is critical that all systems share the same clinical vocabulary. If every

system uses its own vocabulary, then interoperability is reduced to simply moving readable documents around the system and clinicians having to repeatedly transcribe data they need to be within their system, thus introducing errors.

The use of an international terminology enables system suppliers to design their system to a common terminology that can be implemented with less country specialisation across a number of countries. The last few years has seen a shift by suppliers from developing country specific solutions to global solutions with local configuration.

The data set can also benefit significantly from implementing clinical terminologies within the data model by responding more quickly to changes in clinical practice and information requirements. Terminology is updated at regular intervals and the data set automatically can capture the latest terms without the need for changing the data set through the DAPB process.

### 2.2.3 SNOMED CT in CDS v6.3

CDS v6.3 enables the ability for data submitters to flow SNOMED CT codes. Diagnoses and Procedures can be recorded using existing ICD-10 and OPCS-4 clinical classifications, as well as newly introduced SNOMED CT data groups. We expect data submitters to continue sending ICD-10 and OPCS-4 codes, as these are required for payment purposes. In the short term, this may mean some duplication between ICD-10/OCPS-4 and SNOMED CT codes, where the same procedure or diagnosis is recorded in each.

Additional data groups have also been introduced in CDS v6.3 in order to allow data to be recorded using SNOMED CT terminology exclusively.

These include:

- COMORBIDITY (SNOMED CT) – to record patient’s previous diagnoses
- OBSERVATION GROUP (SNOMED CT) – to record patient’s coded observations
- FINDING GROUP (SNOMED CT) – to record patient’s coded findings
- ASSESSMENT TOOL GROUP (SNOMED CT) – this group will allow recording CDS specific Assessment Tools data once such tools are developed in the future.
- SOCIAL AND PERSONAL CIRCUMSTANCES (SNOMED CT) – to record patient’s social and personal circumstances (e.g. religion, sexual orientation)

All SNOMED CT data groups introduced in CDS v6.3 have their status set to ‘Required’, meaning that while it is generally expected for data to be submitted if it is available, in line with the Department of Health and Social Care requirement, not submitting these groups will not result in a submission being rejected.

In addition, the optional DATA ABSENT REASON (FHIR R4) data item has been introduced in order to provide information on why the SNOMED CT data is missing and cannot be submitted.

Unlike the Emergency Care Data Set (ECDS), CDS v6.3 will accept the submission of any valid SNOMED CT code, except for any codes that are legally restricted, A list of legally restricted codes, including those related to the Human Fertilisation and Embryology Act and Gender Recognition Act, will be published prior to CDS v6.3 going live.

CDS v6.3 also allows the submission of post-coordinated SNOMED CT expressions. Post-coordinated expressions combine concepts and allow more detail to be added to the meaning

represented by a single concept. The use of post-coordination in CDS v6.3 is optional and single, pre-coordinated SNOMED CT expressions can also be submitted. More information about SNOMED CT expressions is available from the [SNOMED International SNOMED CT Starter Guide](#).

## 2.2.4 Further Resources for SNOMED CT

More information about SNOMED CT can be found on the [NHS Digital SNOMED CT](#) pages, including information about:

- **Licensing**

The UK is a SNOMED International member country. Use of SNOMED CT in the UK is free, however the use of SNOMED CT does require a license. All SNOMED CT licensing enquiries can be sent to [information.standards@nhs.net](mailto:information.standards@nhs.net)

- **Training**

NHS Digital offer a range of ways for individuals to learn more about SNOMED CT and its uses. For those who feel they need more understanding of SNOMED CT, NHS Digital provide a number of [training and education resources](#).

## 3 Configuration of local systems

The Technical Output Specification fully defines the data items within the CDS. Separate tabs within the Technical Output Specification represent specific CDS types and split individual types into a number of tables, each containing related data items.

The CDS is an output data set. An output data set is a description of the data that needs to be extracted or derived from an existing patient administration system (PAS) or clinical system and does not directly support patient care. In many cases, the output data item will be identical to the input definition. However, the two may differ both in terms of the format of the data item and the range of values presented. The data collection system may represent the data in a different manner or in more granularity; however, providing the input data items can be mapped to the output data set, the input source will not require any modification.

This can be illustrated in the following table:

Provider System (Input system)		National Data Set	
Data item name	Format/Values	Data item name	Format/values
Date of Birth	DD/MM/YY	<a href="#">Person Birth Date</a>	CCYY-MM-DD
Type of Consultation	A - First B - Follow Up	<a href="#">Consultation Type</a>	01 - Initial Consultation 02 - Follow-up Consultation

The CDS is not a specification for the standardisation of a patient care record. Service Providers have the flexibility to adopt any local data collection process or system as long as the local data collection frameworks can output and submit data, as per the data set specification, to the Secondary Uses Service (SUS). The data set is not a patient care record but is based on clinical and operational information. Providers should therefore look to re-use their clinical and operational systems to extract CDS data.

## 4 Data Item Guidance

### 4.1 Notation

The information below outlines the status notation and definitions which apply to the data groups throughout this document.

In addition, the CDS Technical Output Specification fully defines the data items within the output data set for individual CDS Types and splits the data sets into a number of groups, each containing related data items.

The requirements for each group and data item are outlined in the original levels of mandation as described to DAPB (as outlined in the mandatory/required/optional/pilot (M/R/O/X) columns in the Technical Output Specification):

**Mandatory:** This signifies that the collection and submission of this Commissioning Data Set data is deemed MANDATORY and its presence is necessary for the CDS Type to be correctly validated and accepted for processing by the Secondary Uses Service.

If a data item is shown as MANDATORY, this should also be regarded as REQUIRED by the Department of Health and Social Care.

In most instances, data marked as MANDATORY in a Sub Group will result in its parent Data Group also being marked as mandatory, but this is not always the case.

For instance, although the Care Episode - Clinical Diagnosis Group (ICD) is marked as R=REQUIRED (and therefore need not actually be populated), if it is used then both the DIAGNOSIS SCHEME IN USE and the PRIMARY DIAGNOSIS (ICD) are marked as M=MANDATORY and must both be present.

Failure to submit these items will result in the rejection of the submission file.

**Required:** This signifies that the collection and submission of this Commissioning Data Set data is deemed REQUIRED by the Department of Health and Social Care to comply with authorised NHS Standards, Policies and Directives. Therefore whenever a Commissioning Data Set is collected and subsequently submitted to the Secondary Uses Service, this data must be supported and populated into the relevant data sets if the data is available.

Note that "temporal" conditions may mean that there are instances where this directive cannot be fulfilled.

For instance in a CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set, ICD and OPCS data groups are marked as "Required" indicating that this data should be included. However, if at the time of submission to the Secondary Uses Service this data remains incomplete (perhaps awaiting coding in the ORGANISATION), the remaining data in the CDS record should still be submitted. Once the ORGANISATION has updated its systems with the data, the CDS Type relating to that ACTIVITY should then be resubmitted to the Secondary Uses Service.

Failure to submit these items will not result in the rejection of the submission file but may affect the derivation of national indicators or national analysis. (Please note that the purpose of the data set is not to change clinical practice.)

**Optional:** This signifies that the collection and submission of this Commissioning Data Set data is OPTIONAL. Its inclusion in the Commissioning Data Set is therefore determined by "local agreement" between the ORGANISATIONS exchanging the data.

Note that even if marked O=OPTIONAL, any data included in a Commissioning Data Set submission to the Secondary Uses Service must comply with its specification published in the NHS Data Model and Dictionary otherwise the data may be deemed invalid and rejected.

**Pilot:** This is used where the Data Element name has been included in the Commissioning Data Set design, usually for pilot use, but is not yet authorised for transmission by the wider NHS.

These data items have been included within the specification for piloting purposes only to support future implementation. These data items have not been approved and/or mandated and SHOULD NOT be submitted unless specifically requested by NHS Digital.

## 4.2 Data Group: CDS V6-3 Type 001 - Commissioning Data Set Interchange Header

CDS V6-3 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER		
<b>Description</b>		
To carry the details of the mandatory identity and addressing information for the Commissioning Data Set submission. One per Interchange submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.		
<b>Group Status</b>		
Mandatory		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
CDS INTERCHANGE SENDER IDENTITY	001	The assigned Electronic Data Interchange (EDI) address of the physical Organisation or site responsible for sending Commissioning data.
CDS INTERCHANGE RECEIVER IDENTITY	001	The address of the physical site receiving a Commissioning Data Set interchange.
CDS INTERCHANGE CONTROL REFERENCE	001	This provides a unique number (per sender identity) to identify every Commissioning Data Set Interchange submission.
CDS INTERCHANGE DATE OF PREPARATION	001	This is the date when the Commissioning Data Set Interchange data was created.

CDS INTERCHANGE TIME OF PREPARATION	001	This is the time when the Commissioning Data Set Interchange data was created.
CDS INTERCHANGE APPLICATION REFERENCE	001	This data element identifies the application content of the Interchange where the Interchange contains only one type of Message.
CDS INTERCHANGE TEST INDICATOR	001	An indication of whether the Commissioning Data Set Interchange is a production or test Interchange.

### 4.3 Data Group: CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer

CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER		
<b>Description</b>		
<p>To carry the details of the mandatory identity and addressing information for the Commissioning Data Set submission.            One per Interchange submitted to the Secondary Uses Service.            Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.</p>		
<b>Group Status</b>		
Mandatory		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
CDS INTERCHANGE CONTROL REFERENCE	002	This provides a unique number (per sender identity) to identify every Commissioning Data Set Interchange submission.
CDS INTERCHANGE CONTROL COUNT	002	This is a mandatory data element and is a count of CDS Messages contained in the CDS Interchange.
CDS INTERCHANGE SENDER IDENTITY	002	The assigned Electronic Data Interchange (EDI) address of the physical Organisation or site responsible for sending Commissioning data.
CDS INTERCHANGE RECEIVER IDENTITY	002	The address of the physical site receiving a Commissioning Data Set interchange.

## 4.4 Data Group: CDS V6-3 Type 003 - Commissioning Data Set Message Header

CDS V6-3 TYPE 003 - COMMISSIONING DATA SET MESSAGE HEADER		
<b>Description</b>		
To carry the details of the mandatory identity controls for each Commissioning Data Set Message. One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.		
<b>Group Status</b>		
Mandatory		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
CDS MESSAGE TYPE	003	The type of message within a Commissioning Data Set Interchange.
CDS MESSAGE VERSION NUMBER	003	The version number of the Commissioning Data Set XML Schema in use.
CDS MESSAGE REFERENCE	003	This is a mandatory data element and is a sequentially incremented number for each message within an interchange.
CDS RECORD IDENTIFIER	003	When exchanging Commissioning Data Set data, CDS RECORD IDENTIFIER is an optional data element and when used is a unique number generated by the sender and inserted into the Commissioning Data Set data to enable senders and recipients to be able to cross-match and uniquely identify each and every Commissioning Data Set record.

## 4.5 Data Group: CDS V6-3 Type 004 - Commissioning Data Set Message Trailer

CDS V6-3 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER		
<b>Description</b>		
To carry the details of the mandatory identity controls for each Commissioning Data Set Message. One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.		
<b>Group Status</b>		

Mandatory		
Additional Notes on Data Items		
Data Item Name	Relevant CDS Types	Additional Notes
CDS MESSAGE REFERENCE	004	This is a mandatory data element and is a sequentially incremented number for each message within an interchange.

## 4.6 Data Group: CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol

CDS V6-3 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL		
Description		
<p>To carry the details of the mandatory Commissioning Data Set Submission Protocol controls for when using the Bulk Update mechanism.</p> <p>One per Commissioning Data Set Message submitted to the Secondary Uses Service.</p> <p>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.</p>		
Group Status		
Mandatory		
Additional Notes on Data Items		
Data Item Name	Relevant CDS Types	Additional Notes
CDS TYPE CODE	005B	A code to identify the specific type of Commissioning Data Set data.
CDS PROTOCOL IDENTIFIER CODE	005B	A code to identify the Commissioning Data Set Submission Protocol associated with the transaction.
CDS UNIQUE IDENTIFIER	005B	<p>See the supporting information in the Commissioning Data Set Submission Protocol.</p> <p>A Commissioning Data Set data element providing a unique identity for the life-time of an episode carried in a Commissioning Data Set message.</p> <p>Once assigned, a Commissioning Data Set record must retain its CDS UNIQUE IDENTIFIER otherwise duplicate Commissioning Data Set records may be generated and stored in the Secondary Uses Service database.</p>
CDS BULK REPLACEMENT GROUP CODE	005B	The Commissioning Data Set Group into which CDS Types must be grouped when using the Commissioning Data Set Bulk Replacement Update Mechanism.

CDS EXTRACT DATE	005B	The DATE (with an associated CDS EXTRACT TIME ) of the update event (or the nearest equivalent) that resulted in the need to exchange this Commissioning Data Set.
CDS EXTRACT TIME	005B	The TIME at which the Commissioning data extract was undertaken.
CDS REPORT PERIOD START DATE	005B	This defines the start date (for the date range of the data being exchanged) for the Bulk Replacement Update time period.
CDS REPORT PERIOD END DATE	005B	This data item defines the end date (for the date range of the data being exchanged) for the Commissioning Data Set Bulk Replacement Update time period.
CDS ACTIVITY DATE	005B	For Commissioning data, every CDS Type has a "CDS Originating Date" contained within the Commissioning Data Set data that must be used to populate the CDS ACTIVITY DATE.
ORGANISATION IDENTIFIER (CDS SENDER)	005B	ORGANISATION IDENTIFIER (CDS SENDER) is the mandatory NHS ORGANISATION IDENTIFIER of the Organisation acting as the physical Sender of Commissioning Data Set submissions.
ORGANISATION IDENTIFIER (CDS RECIPIENT)	005B	ORGANISATION IDENTIFIER (CDS RECIPIENT) is the mandatory NHS ORGANISATION IDENTIFIER (or valid Organisation Data Service Default Code) representing the Organisation determined to be the Commissioning Data Set Recipient of the Commissioning Data Set Message as indicated in the Commissioning Data Set Addressing Grid.

## 4.7 Data Group: CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol

### CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL

#### Description

To carry the details of the mandatory Commissioning Data Set Submission Protocol controls for when using the Net Change mechanism.  
One per Commissioning Data Set Message submitted to the Secondary Uses Service.  
Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

#### Group Status

Mandatory

#### Additional Notes on Data Items

Data Item Name	Relevant CDS Types	Additional Notes
CDS TYPE CODE	005N	A code to identify the specific type of Commissioning Data Set data.
CDS PROTOCOL IDENTIFIER CODE	005N	A code to identify the Commissioning Data Set Submission Protocol associated with the transaction.
CDS UNIQUE IDENTIFIER	005N	See the supporting information in the Commissioning Data Set Submission Protocol.  A Commissioning Data Set data element providing a unique identity for the life-time of an episode carried in a Commissioning Data Set message.  Once assigned, a Commissioning Data Set record must retain its CDS UNIQUE IDENTIFIER otherwise duplicate Commissioning Data Set records may be generated and stored in the Secondary Uses Service database.
CDS UPDATE TYPE	005N	A code to indicate the required database update process for the submitted CDS Message.
CDS APPLICABLE DATE	005N	The date (with an associated CDS APPLICABLE TIME) of the update event (or the nearest equivalent) that resulted in the need to exchange this Commissioning Data Set.
CDS APPLICABLE TIME	005N	The time (with an associated CDS APPLICABLE DATE) of the update event (or the nearest equivalent) that resulted in the need to exchange this Commissioning data.
CDS ACTIVITY DATE	005N	For Commissioning data, every CDS Type has a "CDS Originating Date" contained within the Commissioning Data Set data that must be used to populate the CDS ACTIVITY DATE.
ORGANISATION IDENTIFIER (CDS SENDER)	005N	ORGANISATION IDENTIFIER (CDS SENDER) is the mandatory NHS ORGANISATION IDENTIFIER of the Organisation acting as the physical Sender of Commissioning Data Set submissions.
ORGANISATION IDENTIFIER (CDS RECIPIENT)	005N	ORGANISATION IDENTIFIER (CDS RECIPIENT) is the mandatory NHS ORGANISATION IDENTIFIER (or valid Organisation Data Service Default Code) representing the Organisation determined to be the Commissioning Data Set Recipient of the Commissioning Data Set Message as indicated in the Commissioning Data Set Addressing Grid.

## 4.8 Master Data Group: Patient Pathway

<b>PATIENT PATHWAY</b>		
<b>Description</b>		
To carry the details of the Patient Pathway. This Group must be present if the record relates to a Referral To Treatment Period Included In 18 Weeks Target or is subject to Allied Health Professional Referral To Treatment Measurement.		
<b>Master Group Status</b>		
Required for CDS Types: 020, 130, 190 Optional for CDS Types: 120, 140, 150, 160, 180, 200		
<b>CDS Types</b>		
020, 120, 130, 140, 150, 160, 180, 190, 200		
<b>PATIENT PATHWAY IDENTITY</b>		
<b>Description</b>		
To carry the details of the Patient Pathway Identity.		
<b>Group Status</b>		
Mandatory		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	020, 120, 130, 140, 150, 160, 180, 190, 200	<p>The unique booking reference number assigned by the Choose and Book system when a PATIENT accepts an APPOINTMENT DATE OFFERED of an APPOINTMENT OFFER where the offer was made via the Choose and Book system.</p> <p>When a PATIENT accepts an APPOINTMENT DATE OFFERED, the unique booking reference number issued and used during the booking process is considered to be 'converted' i.e. an APPOINTMENT has been created and recorded; and the PATIENT has been placed on an Out-Patient Waiting List even if subsequently the PATIENT does not attend or cancels the APPOINTMENT.</p>
Or		
PATIENT PATHWAY IDENTIFIER	020, 120, 130, 140, 150, 160, 180, 190, 200	<p>An identifier, which together with the ORGANISATION CODE / ORGANISATION IDENTIFIER of the issuer, uniquely identifies a PATIENT PATHWAY. This is a specific type of the attribute ACTIVITY IDENTIFIER.</p> <p>Where a pathway is initiated by a SERVICE REQUEST using the Choose and Book system, the PATIENT PATHWAY will be uniquely identified by the Unique Booking Reference Number (UBRN) of the first referral and the ORGANISATION CODE of Choose and Book which is X09.</p> <p>Where the pathway is initiated by some other method, the PATIENT PATHWAY IDENTIFIER will be allocated by the ORGANISATION receiving the SERVICE REQUEST which together with that ORGANISATION's ORGANISATION CODE / ORGANISATION IDENTIFIER will uniquely identify the PATIENT PATHWAY.</p>

ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	020, 120, 130, 140, 150, 160, 180, 190, 200	This is the ORGANISATION IDENTIFIER of the ORGANISATION issuing the PATIENT PATHWAY IDENTIFIER.  Where Choose and Book has been used, the ORGANISATION IDENTIFIER X09 should be used.
<b>REFERRAL TO TREATMENT PERIOD CHARACTERISTICS</b>		
<b>Description</b>		
To carry the details of the Referral To Treatment Period.		
<b>Group Status</b>		
Mandatory		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
REFERRAL TO TREATMENT PERIOD STATUS	020, 120, 130, 140, 150, 160, 180, 190, 200	The status of an ACTIVITY (or anticipated ACTIVITY) for the REFERRAL TO TREATMENT PERIOD decided by the lead CARE PROFESSIONAL.
WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)	020, 120, 130, 140, 150, 160, 180, 190, 200	The type of waiting time measurement methodology which may be applied during a PATIENT PATHWAY. The methodology applied may be for one part of a PATIENT PATHWAY, such as the measurement of a REFERRAL TO TREATMENT PERIOD, or other parts of the PATIENT PATHWAY according to Department of Health and Social Care policy.
REFERRAL TO TREATMENT PERIOD START DATE	020, 120, 130, 140, 150, 160, 180, 190, 200	The start date of a REFERRAL TO TREATMENT PERIOD.
REFERRAL TO TREATMENT PERIOD END DATE	020, 120, 130, 140, 150, 160, 180, 190, 200	The end date of a REFERRAL TO TREATMENT PERIOD.

## 4.9 Master Data Group: Patient Identity

PATIENT IDENTITY PATIENT IDENTITY (BABY) PATIENT IDENTITY (MOTHER)		
<b>Description</b>		
To carry the Identity details of the main Patient. One of the following DATA GROUPS must be used:  WITHHELD IDENTITY STRUCTURE VERIFIED IDENTITY STRUCTURE UNVERIFIED IDENTITY STRUCTURE		
<b>Master Group Status</b>		
Mandatory		
<b>CDS Types</b>		
020, 120, 130, 140, 150, 160, 180, 190, 200		
WITHHELD IDENTITY STRUCTURE		
<b>Description</b>		
Must be used where the Commissioning Data Set record has been anonymised.		
<b>Group Status</b>		
Mandatory		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
NHS NUMBER STATUS INDICATOR CODE	020, 120, 130, 140, 150, 160, 180, 190, 200	NHS NUMBER STATUS INDICATOR CODE is the trace status of the NHS NUMBER.
PERSON BIRTH DATE	120, 150, 180	The date on which a PERSON was born or is officially deemed to have been born.

<b>ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)</b>	020, 130, 140, 160, 190, 200	<p>ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) is the ORGANISATION IDENTIFIER derived from the PATIENT's POSTCODE OF USUAL ADDRESS, where they reside within the boundary of a:</p> <ul style="list-style-type: none"> <li>•Clinical Commissioning Group</li> <li>•Care Trust</li> <li>•Local Health Board (Wales)</li> <li>•Scottish Health Board</li> <li>•Northern Ireland Local Commissioning Group</li> <li>•Primary Healthcare Directorate (Isle of Man)</li> <li>•Local Authority.</li> </ul>
<b>WITHHELD IDENTITY REASON</b>	020, 120, 130, 140, 150, 160, 180, 190, 200	A code allowing suppliers of Commissioning Data Set records to indicate to recipients of the record (for example, the Commissioner of the ACTIVITY) that the record has been purposely anonymised for a valid reason.
<b>Or</b>		
<b>VERIFIED IDENTITY STRUCTURE</b>		
<b>Description</b>		
Must be used where the NHS NUMBER STATUS INDICATOR CODE National Code = 01 (Number present and verified).		
<b>Group Status</b>		
Mandatory		
<b>Additional Notes on Data Items</b>		
<b>Data Item Name</b>	<b>Relevant CDS Types</b>	<b>Additional Notes</b>
<b>LOCAL PATIENT IDENTIFIER (EXTENDED)</b>	020, 120, 130, 140, 150, 160, 180, 190, 200	<p>This is a number used to identify a PATIENT uniquely within a Health Care Provider. It may be different from the PATIENT's casenote number and may be assigned automatically by the computer system.</p> <p>LOCAL PATIENT IDENTIFIER (EXTENDED) is used where IT systems have a LOCAL PATIENT IDENTIFIER which is longer than 10 characters and LOCAL PATIENT IDENTIFIER cannot be used for data submission.</p>
<b>ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)</b>	020, 120, 130, 140, 150, 160, 180, 190, 200	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) is the ORGANISATION IDENTIFIER of the Organisation that assigned the LOCAL PATIENT IDENTIFIER.

NHS NUMBER	020, 120, 130, 140, 150, 160, 180, 190, 200	<p>The NHS NUMBER, the primary identifier of a PERSON, is a unique identifier for a PATIENT within the NHS in England and Wales.</p> <p>This will not vary by any ORGANISATION of which a PERSON is a PATIENT.</p> <p>It is mandatory to record the NHS NUMBER. There are exceptions, such as Accident and Emergency care, sexual health and major incidents, as defined in existing national policies.</p> <p>The NHS NUMBER is 10 numeric digits in length. The tenth digit is a check digit used to confirm its validity. The check digit is validated using the Modulus 11 algorithm and the use of this algorithm is mandatory.</p>
NHS NUMBER STATUS INDICATOR CODE	020, 120, 130, 140, 150, 160, 180, 190, 200	NHS NUMBER STATUS INDICATOR CODE is the trace status of the NHS NUMBER.
POSTCODE OF USUAL ADDRESS	020, 130, 140, 160, 190, 200	The POSTCODE of the ADDRESS nominated by the PATIENT with ADDRESS ASSOCIATION TYPE 'Main Permanent Residence' or 'Other Permanent Residence'.
ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	020, 130, 140, 160, 190, 200	<p>ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) is the ORGANISATION IDENTIFIER derived from the PATIENT's POSTCODE OF USUAL ADDRESS, where they reside within the boundary of a:</p> <ul style="list-style-type: none"> <li>•Clinical Commissioning Group</li> <li>•Care Trust</li> <li>•Local Health Board (Wales)</li> <li>•Scottish Health Board</li> <li>•Northern Ireland Local Commissioning Group</li> <li>•Primary Healthcare Directorate (Isle of Man)</li> <li>•Local Authority.</li> </ul>
PERSON BIRTH DATE	020, 120, 130, 140, 150, 160, 180, 190, 200	The date on which a PERSON was born or is officially deemed to have been born.
<b>Or</b>		
<b>UNVERIFIED IDENTITY STRUCTURE</b>		
<b>Description</b>		
Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE NOT included in the above.		
<b>Group Status</b>		
Mandatory		
<b>Additional Notes on Data Items</b>		

Data Item Name	Relevant CDS Types	Additional Notes
LOCAL PATIENT IDENTIFIER (EXTENDED)	020, 120, 130, 140, 150, 160, 180, 190, 200	<p>This is a number used to identify a PATIENT uniquely within a Health Care Provider. It may be different from the PATIENT's casenote number and may be assigned automatically by the computer system.</p> <p>LOCAL PATIENT IDENTIFIER (EXTENDED) is used where IT systems have a LOCAL PATIENT IDENTIFIER which is longer than 10 characters and LOCAL PATIENT IDENTIFIER cannot be used for data submission.</p>
ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	020, 120, 130, 140, 150, 160, 180, 190, 200	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) is the ORGANISATION IDENTIFIER of the Organisation that assigned the LOCAL PATIENT IDENTIFIER.
NHS NUMBER	020, 120, 130, 140, 150, 160, 180, 190, 200	<p>The NHS NUMBER, the primary identifier of a PERSON, is a unique identifier for a PATIENT within the NHS in England and Wales.</p> <p>This will not vary by any ORGANISATION of which a PERSON is a PATIENT.</p> <p>It is mandatory to record the NHS NUMBER. There are exceptions, such as Accident and Emergency care, sexual health and major incidents, as defined in existing national policies.</p> <p>The NHS NUMBER is 10 numeric digits in length. The tenth digit is a check digit used to confirm its validity. The check digit is validated using the Modulus 11 algorithm and the use of this algorithm is mandatory.</p>
NHS NUMBER STATUS INDICATOR CODE	020, 120, 130, 140, 150, 160, 180, 190, 200	NHS NUMBER STATUS INDICATOR CODE is the trace status of the NHS NUMBER.
PATIENT FULL NAME	020, 120, 130, 140, 150, 160, 180, 190, 200	<p>PATIENT FULL NAME is the same as attribute PERSON NAME WORD TEXT.</p> <p>PATIENT FULL NAME is the preferred PERSON FULL NAME of the PATIENT.</p> <p>PERSON FULL NAME is an unstructured concatenation of some or all of the PERSON TITLE, PERSON GIVEN NAME, PERSON FAMILY NAME and PERSON NAME SUFFIX elements, or other elements that make up a PERSON's full name.</p>
Or		
PATIENT TITLE	020, 120, 130, 140, 150, 160, 180, 190, 200	PATIENT TITLE is the PERSON TITLE of the PATIENT.
And		

PATIENT GIVEN NAME	020, 120, 130, 140, 150, 160, 180, 190, 200	PATIENT GIVEN NAME is the PERSON GIVEN NAME of the PATIENT.
And		
PATIENT FAMILY NAME	020, 120, 130, 140, 150, 160, 180, 190, 200	PATIENT FAMILY NAME is the PERSON FAMILY NAME of the PATIENT.
And		
PATIENT NAME SUFFIX	020, 120, 130, 140, 150, 160, 180, 190, 200	PATIENT NAME SUFFIX is the PERSON NAME SUFFIX of the PATIENT.
And		
PATIENT INITIALS	020, 120, 130, 140, 150, 160, 180, 190, 200	PATIENT INITIALS is the PERSON INITIALS of the PATIENT.
PATIENT USUAL ADDRESS (UNSTRUCTURED)	020, 130, 140, 160, 190, 200	<p>PATIENT USUAL ADDRESS (UNSTRUCTURED) is the usual ADDRESS nominated by the PATIENT, where the ADDRESS ASSOCIATION TYPE is 'Main Permanent Residence' or 'Other Permanent Residence'.</p> <p>To denote an unstructured ADDRESS, i.e. an ADDRESS consisting of up to five contiguous data elements of 35 characters representing a 175 character string.</p>
Or		
PATIENT USUAL ADDRESS (STRUCTURED)	020, 130, 140, 160, 190, 200	<p>PATIENT USUAL ADDRESS (STRUCTURED) consists of up to five address lines of 35 characters where each line is left justified as a specific data element.</p> <p>The format of 5 lines of an35 conforms to ADDRESS FORMAT TYPE 'Unstructured Format'. The format refers to the physical layout of the ADDRESS, not the logical layout, and does not require intelligent intervention when splitting the text string into lines.</p>
POSTCODE OF USUAL ADDRESS	020, 130, 140, 160, 190, 200	The POSTCODE of the ADDRESS nominated by the PATIENT with ADDRESS ASSOCIATION TYPE 'Main Permanent Residence' or 'Other Permanent Residence'.

<p>ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)</p>	<p>020, 130, 140, 160, 190, 200</p>	<p>ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) is the ORGANISATION IDENTIFIER derived from the PATIENT's POSTCODE OF USUAL ADDRESS, where they reside within the boundary of a:</p> <ul style="list-style-type: none"> <li>•Clinical Commissioning Group</li> <li>•Care Trust</li> <li>•Local Health Board (Wales)</li> <li>•Scottish Health Board</li> <li>•Northern Ireland Local Commissioning Group</li> <li>•Primary Healthcare Directorate (Isle of Man)</li> <li>•Local Authority.</li> </ul>
<p>PERSON BIRTH DATE</p>	<p>020, 120, 130, 140, 150, 160, 180, 190, 200</p>	<p>The date on which a PERSON was born or is officially deemed to have been born.</p>

## 4.10 Master Data Group: Person Identity

PATIENT IDENTITY (BABY) PATIENT IDENTITY (MOTHER)		
<b>Description</b>		
To carry the Identity details of the main Patient's Baby / Mother. One of the following DATA GROUPS must be used:  WITHHELD IDENTITY STRUCTURE VERIFIED IDENTITY STRUCTURE UNVERIFIED IDENTITY STRUCTURE		
<b>Master Group Status</b>		
Mandatory		
<b>CDS Types</b>		
120, 140, 150, 160, 180, 200		
WITHHELD IDENTITY STRUCTURE		
<b>Description</b>		
Must be used where the Commissioning Data Set record has been anonymised.		
<b>Group Status</b>		
Mandatory		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
NHS NUMBER STATUS INDICATOR CODE (MOTHER)	120, 150, 180	NHS NUMBER STATUS INDICATOR CODE (MOTHER) is the trace status of the NHS NUMBER (MOTHER).
NHS NUMBER STATUS INDICATOR CODE (BABY)	140, 160, 200	NHS NUMBER STATUS INDICATOR CODE (BABY) is the trace status of the NHS NUMBER (BABY).
PERSON BIRTH DATE (BABY)	140, 160, 200	PERSON BIRTH DATE (BABY) is the same as data element PERSON BIRTH DATE for the baby.

ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	120, 150, 180	<p>ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) is the ORGANISATION IDENTIFIER derived from the PATIENT's POSTCODE OF USUAL ADDRESS, where they reside within the boundary of a:</p> <ul style="list-style-type: none"> <li>•Clinical Commissioning Group</li> <li>•Care Trust</li> <li>•Local Health Board (Wales)</li> <li>•Scottish Health Board</li> <li>•Northern Ireland Local Commissioning Group</li> <li>•Primary Healthcare Directorate (Isle of Man)</li> <li>•Local Authority.</li> </ul>
WITHHELD IDENTITY REASON	020, 120, 130, 140, 150, 160, 180, 190, 200	A code allowing suppliers of Commissioning Data Set records to indicate to recipients of the record (for example, the Commissioner of the ACTIVITY) that the record has been purposely anonymised for a valid reason.
<b>Or</b>		
<b>VERIFIED IDENTITY STRUCTURE</b>		
<b>Description</b>		
Must be used where the NHS NUMBER STATUS INDICATOR CODE National Code = 01 (Number present and verified).		
<b>Group Status</b>		
Mandatory		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER))	120, 150, 180	This is a number used to identify a PATIENT uniquely within a Health Care Provider. It may be different from the PATIENT's casenote number and may be assigned automatically by the computer system.
LOCAL PATIENT IDENTIFIER (EXTENDED (BABY))	140, 160, 200	This is a number used to identify a PATIENT uniquely within a Health Care Provider. It may be different from the PATIENT's casenote number and may be assigned automatically by the computer system.
ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER))	120, 150, 180	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER)) is the ORGANISATION IDENTIFIER of the Organisation that assigned the LOCAL PATIENT IDENTIFIER (MOTHER).

ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (BABY))	140, 160, 200	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (BABY)) is the ORGANISATION IDENTIFIER of the Organisation that assigned the LOCAL PATIENT IDENTIFIER for the baby.
NHS NUMBER (MOTHER)	120, 150, 180	NHS NUMBER (MOTHER) is the NHS NUMBER of the mother within the Commissioning Data Set Birth Episode and Commissioning Data Set Home Birth where the baby is recorded by use of NHS NUMBER.
NHS NUMBER (BABY)	140, 160, 200	NHS NUMBER (BABY) is the NHS NUMBER of the baby within the Commissioning Data Set Delivery Episode and Commissioning Data Set Home Delivery where the mother is recorded by use of NHS NUMBER. NHS NUMBER (BABY) is a segment content data item for a Data Set Segment Row in the Baby Data Segment Groups for the Maternity Services Secondary Uses Data Set.
NHS NUMBER STATUS INDICATOR CODE (MOTHER)	120, 150, 180	NHS NUMBER STATUS INDICATOR CODE (MOTHER) is the trace status of the NHS NUMBER (MOTHER).
NHS NUMBER STATUS INDICATOR CODE (BABY)	140, 160, 200	NHS NUMBER STATUS INDICATOR CODE (BABY) is the trace status of the NHS NUMBER (BABY).
POSTCODE OF USUAL ADDRESS (MOTHER)	120, 150, 180	POSTCODE OF USUAL ADDRESS (MOTHER) is the same as data element POSTCODE OF USUAL ADDRESS. POSTCODE OF USUAL ADDRESS (MOTHER) is the POSTCODE OF USUAL ADDRESS where it relates to the mother of the PATIENT.
ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	120, 150, 180	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) is the ORGANISATION IDENTIFIER derived from the PATIENT's POSTCODE OF USUAL ADDRESS, where they reside within the boundary of a: <ul style="list-style-type: none"> <li>•Clinical Commissioning Group</li> <li>•Care Trust</li> <li>•Local Health Board (Wales)</li> <li>•Scottish Health Board</li> <li>•Northern Ireland Local Commissioning Group</li> <li>•Primary Healthcare Directorate (Isle of Man)</li> <li>•Local Authority.</li> </ul>
PERSON BIRTH DATE (MOTHER)	120, 150, 180	PERSON BIRTH DATE (MOTHER) is the same as data element PERSON BIRTH DATE for the mother.

PERSON BIRTH DATE (BABY)	140, 160, 200	PERSON BIRTH DATE (BABY) is the same as data element PERSON BIRTH DATE for the baby.
<b>Or</b>		
<b>UNVERIFIED IDENTITY STRUCTURE</b>		
<b>Description</b>		
Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE NOT included in the above.		
<b>Group Status</b>		
Mandatory		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER))	120, 150, 180	This is a number used to identify a PATIENT uniquely within a Health Care Provider. It may be different from the PATIENT's casenote number and may be assigned automatically by the computer system.
LOCAL PATIENT IDENTIFIER (EXTENDED (BABY))	140, 160, 200	This is a number used to identify a PATIENT uniquely within a Health Care Provider. It may be different from the PATIENT's casenote number and may be assigned automatically by the computer system.
ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER))	120, 150, 180	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER)) is the ORGANISATION IDENTIFIER of the Organisation that assigned the LOCAL PATIENT IDENTIFIER (MOTHER).
ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (BABY))	140, 160, 200	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (BABY)) is the ORGANISATION IDENTIFIER of the Organisation that assigned the LOCAL PATIENT IDENTIFIER for the baby.
NHS NUMBER (MOTHER)	120, 150, 180	NHS NUMBER (MOTHER) is the NHS NUMBER of the mother within the Commissioning Data Set Birth Episode and Commissioning Data Set Home Birth where the baby is recorded by use of NHS NUMBER.

NHS NUMBER (BABY)	140, 160, 200	NHS NUMBER (BABY) is the NHS NUMBER of the baby within the Commissioning Data Set Delivery Episode and Commissioning Data Set Home Delivery where the mother is recorded by use of NHS NUMBER. NHS NUMBER (BABY) is a segment content data item for a Data Set Segment Row in the Baby Data Segment Groups for the Maternity Services Secondary Uses Data Set.
NHS NUMBER STATUS INDICATOR CODE (MOTHER)	120, 150, 180	NHS NUMBER STATUS INDICATOR CODE (MOTHER) is the trace status of the NHS NUMBER (MOTHER).
NHS NUMBER STATUS INDICATOR CODE (BABY)	140, 160, 200	NHS NUMBER STATUS INDICATOR CODE (BABY) is the trace status of the NHS NUMBER (BABY).
PATIENT USUAL ADDRESS (UNSTRUCTURED (MOTHER))	120, 150, 180	PATIENT USUAL ADDRESS (UNSTRUCTURED (MOTHER)) is the usual ADDRESS nominated by the mother, where the ADDRESS ASSOCIATION TYPE is 'Main Permanent Residence' or 'Other Permanent Residence'.  To denote an unstructured ADDRESS, i.e. an ADDRESS consisting of up to five contiguous data elements of 35 characters representing a 175 character string.
Or		
PATIENT USUAL ADDRESS (STRUCTURED (MOTHER))	120, 150, 180	PATIENT USUAL ADDRESS (STRUCTURED (MOTHER)) is the usual ADDRESS STRUCTURED nominated by the PATIENT (mother), where the ADDRESS ASSOCIATION TYPE is National Code 'Main Permanent Residence' or 'Other Permanent Residence'.  The format of 5 lines of an35 conforms to ADDRESS FORMAT TYPE 'Unstructured Format'. The format refers to the physical layout of the ADDRESS, not the logical layout, and does not require intelligent intervention when splitting the text string into lines.
POSTCODE OF USUAL ADDRESS (MOTHER)	120, 150, 180	POSTCODE OF USUAL ADDRESS (MOTHER) is the same as data element POSTCODE OF USUAL ADDRESS. POSTCODE OF USUAL ADDRESS (MOTHER) is the POSTCODE OF USUAL ADDRESS where it relates to the mother of the PATIENT.

ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	120, 150, 180	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) is the ORGANISATION IDENTIFIER derived from the PATIENT's POSTCODE OF USUAL ADDRESS, where they reside within the boundary of a: <ul style="list-style-type: none"> <li>•Clinical Commissioning Group</li> <li>•Care Trust</li> <li>•Local Health Board (Wales)</li> <li>•Scottish Health Board</li> <li>•Northern Ireland Local Commissioning Group</li> <li>•Primary Healthcare Directorate (Isle of Man)</li> <li>•Local Authority.</li> </ul>
PERSON BIRTH DATE (MOTHER)	120, 150, 180	PERSON BIRTH DATE (MOTHER) is the same as data element PERSON BIRTH DATE for the mother.
PERSON BIRTH DATE (BABY)	140, 160, 200	PERSON BIRTH DATE (BABY) is the same as data element PERSON BIRTH DATE for the baby.

## 4.11 Data Group: Patient Characteristics

PATIENT CHARACTERISTICS		
<b>Description</b>		
To carry the characteristics of the Patient.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
020, 120, 130, 140, 150, 160, 180, 190, 200		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
PERSON STATED GENDER CODE	020, 130, 140, 160, 190, 200	The gender of a PERSON. PERSON STATED GENDER CODE is self declared or inferred by observation for those unable to declare their PERSON STATED GENDER.
PERSON PHENOTYPIC SEX	120, 180, 150	A classification of PERSON PHENOTYPIC SEX.

CARER SUPPORT INDICATOR	020, 130, 140, 160, 190, 200	An indication of whether or not carer support is available to the PATIENT at their normal residence. This does not include any paid support or support from a voluntary organisation, unless the PATIENT is normally resident in a Care Home.
ETHNIC CATEGORY	020, 120, 180, 130, 140, 160, 150, 190, 200	The ethnicity of a PERSON, as specified by the PERSON.  Note: ETHNIC CATEGORY is the classification used for the 2001 census.
ETHNIC CATEGORY 2021	020, 120, 180, 130, 140, 160, 150, 190, 200	The ethnicity of a PERSON, as specified by the PERSON.  ETHNIC CATEGORY 2021 is the classification used for the 2021 census.  Note: This item has not been approved by the Data Alliance Partnership Board. It has been introduced to provide advance notice to data providers and system suppliers of the intention to report this item at a later date. This item should not be submitted until further development by NHS Digital has been undertaken.
LIVE OR STILL BIRTH CODE	120, 180, 140, 160, 150, 200	An indication of whether the birth was a live or stillbirth.
BIRTH WEIGHT	120, 180, 150	BIRTH WEIGHT is the Birth Weight, where the UNIT OF MEASUREMENT is 'Grams (g)'.  The range is 0001 to 9998.
PERSON MARITAL STATUS	130, 140, 160, 190, 200	An indicator to identify the legal marital status of a PERSON.
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)	130, 140, 190, 200	A code which identifies the MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION.

## 4.12 Data Group: Delivery Characteristics

DELIVERY CHARACTERISTICS
<b>Description</b>
To carry the delivery characteristics of the Patient (the Mother).
<b>Group Status</b>
Required

CDS Types		
140, 160, 200		
Additional Notes on Data Items		
Data Item Name	Relevant CDS Types	Additional Notes
NUMBER OF PREVIOUS PREGNANCIES RESULTING IN REGISTRABLE BIRTH	140, 160, 200	NUMBER OF PREVIOUS PREGNANCIES RESULTING IN REGISTRABLE BIRTH is the number of previous pregnancies resulting in one or more REGISTRABLE BIRTHS.

## 4.13 Data Group: Patient Characteristics – Social and Personal Circumstances (SNOMED CT)

PATIENT CHARACTERISTICS - SOCIAL AND PERSONAL CIRCUMSTANCES (SNOMED CT)		
Description		
To carry the details of the SNOMED CT coded Social and Personal Circumstances for the Patient.		
Group Status		
Required		
CDS Types		
140, 160, 200		
Additional Notes on Data Items		
Data Item Name	Relevant CDS Types	Additional Notes
SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION)	020, 120, 180, 130, 140, 160, 150, 190, 200	SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION) is a structured combination of one or more SNOMED CT® concept identifiers which are used to describe a social and personal circumstance for a PERSON.
SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP	020, 120, 180, 130, 140, 160, 150, 190, 200	SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP is the date, time and time zone when the SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT) was recorded.
Or		
DATA ABSENT REASON (FHIR R4)	020, 120, 180, 130, 140, 160, 150, 190, 200	DATA ABSENT REASON (FHIR R4) is the concept from the FHIR Release 4 Value Set 'data-absent-reason' which identifies the reason that a CODED CLINICAL ENTRY data item in an ELECTRONIC HEALTH RECORD is missing.

## 4.14 Data Group: Hospital Provider Spell - Admission Characteristics

<b>HOSPITAL PROVIDER SPELL - ADMISSION CHARACTERISTICS</b>		
<b>Description</b>		
To carry the admission details of the Hospital Provider Spell containing the Finished Birth Care Professional Admitted Care Episode.		
<b>Group Status</b>		
Mandatory		
<b>CDS Types</b>		
120, 180, 130, 140, 190, 200		
<b>Additional Notes on Data Items</b>		
<b>Data Item Name</b>	<b>Relevant CDS Types</b>	<b>Additional Notes</b>
HOSPITAL PROVIDER SPELL IDENTIFIER	120, 180, 130, 140, 190, 200	A unique identifier for each Hospital Provider Spell for a Health Care Provider.
ADMINISTRATIVE CATEGORY CODE (ON ADMISSION)	120, 180, 130, 140, 190, 200	ADMINISTRATIVE CATEGORY CODE (ON ADMISSION) is used to record the ADMINISTRATIVE CATEGORY CODE at the start of the Hospital Provider Spell.
PATIENT CLASSIFICATION CODE	120, 180, 130, 140, 190, 200	A coded classification of PATIENTS who have been admitted to a Hospital Provider Spell.
METHOD OF ADMISSION (HOSPITAL PROVIDER SPELL)	120, 180, 130, 140, 190, 200	The method of admission to a Hospital Provider Spell.
ADMISSION SOURCE (HOSPITAL PROVIDER SPELL)	120, 180, 130, 140, 190, 200	The source of admission to a Hospital Provider Spell or a Nursing Episode when the PATIENT is in a Hospital Site or a Care Home.
START DATE (HOSPITAL PROVIDER SPELL)	120, 180, 130, 140, 190, 200	The start date of a Hospital Provider Spell.

START TIME (HOSPITAL PROVIDER SPELL)	120, 180, 130, 140, 190, 200	The start time of a Hospital Provider Spell.
AGE ON ADMISSION	120, 180, 130, 140, 190, 200	AGE ON ADMISSION is derived as the number of completed years between the PERSON BIRTH DATE of the PATIENT and the START DATE (HOSPITAL PROVIDER SPELL).
AMBULANCE CALL IDENTIFIER	130, 140, 190, 200	A unique identifier for each AMBULANCE CALL.
ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST)	130, 140, 190, 200	ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST) is the ORGANISATION IDENTIFIER of an Ambulance Service which conveys a PATIENT.
CARE CONTACT IDENTIFIER (AMBULANCE SERVICE)	130, 140, 190, 200	CARE CONTACT IDENTIFIER (AMBULANCE SERVICE) is an identifier allocated to each Ambulance Incident for each PATIENT. CARE CONTACT IDENTIFIER (AMBULANCE SERVICE) is the ACTIVITY IDENTIFIER for a CARE CONTACT allocated by the Ambulance Service. The PATIENT can have more than one CARE CONTACT IDENTIFIER (AMBULANCE SERVICE) if the PATIENT is treated more than once in separate Ambulance Incidents.

## 4.15 Data Group: Hospital Provider Spell - Discharge Characteristics

HOSPITAL PROVIDER SPELL - DISCHARGE CHARACTERISTICS		
<b>Description</b>		
To carry the discharge details of the Hospital Provider Spell containing the Finished Birth Care Professional Admitted Care Episode.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
120, 180, 130, 140, 190, 200		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
DESTINATION OF DISCHARGE (HOSPITAL PROVIDER SPELL)	120, 180, 130, 140, 190, 200	The destination of a PATIENT on completion of a Hospital Provider Spell. This includes a National Code to indicate a PATIENT death or a stillbirth.

METHOD OF DISCHARGE (HOSPITAL PROVIDER SPELL)	120, 180, 130, 140, 190, 200	The method of discharge from a Hospital Provider Spell.
DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL)	120, 180, 130, 140, 190, 200	Discharge Ready Date is the date that a PATIENT was medically ready for discharge from a Hospital Bed but could not be discharged, thereby qualifying for Delayed Discharge Payments under the provisions of the Community Care (Delayed Discharges etc) Act 2003.
DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	120, 180, 130, 140, 190, 200	Discharge Date is the date of discharge from a Hospital Provider Spell.
DISCHARGE TIME (HOSPITAL PROVIDER SPELL)	120, 180, 130, 140, 190, 200	The time that a PATIENT was discharged from a Hospital Provider Spell.
DISCHARGED TO NHS AT HOME SERVICE INDICATOR	120, 180, 130, 140, 190, 200	An indication of whether a PATIENT was discharged from a Hospital Provider Spell to an NHS At Home Service.

## 4.16 Data Group: Episode - Activity Characteristics

BIRTH EPISODE - ACTIVITY CHARACTERISTICS DELIVERY EPISODE - ACTIVITY CHARACTERISTICS CARE EPISODE - ACTIVITY CHARACTERISTICS		
Description		
To carry the details of the Care Professional Admitted Care Episode.		
Group Status		
Mandatory		
CDS Types		
120, 130, 140, 180, 190, 200		
Additional Notes on Data Items		
Data Item Name	Relevant CDS Types	Additional Notes
EPISODE NUMBER	120, 130, 140, 180, 190, 200	EPISODE NUMBER is used to uniquely identify episodes and is a sequence number for each Consultant Episode (Hospital Provider) in a Hospital Provider Spell.  A known EPISODE NUMBER can be between 01 to 87.
LAST EPISODE IN SPELL INDICATOR CODE	120, 130, 140, 180, 190, 200	An indication of whether the consultant episode is the final episode in the Hospital Provider Spell.
NEONATAL LEVEL OF CARE CODE	120, 130, 140, 180, 190, 200	The level of care received by a Neonate during a Neonatal Level Of Care Period.
FIRST REGULAR DAY OR NIGHT ADMISSION CODE	130, 190	The first admission in a series of regular day/night admissions for a course of treatment.
PSYCHIATRIC PATIENT STATUS CODE	130, 140, 190, 200	An indication of whether the PATIENT has been admitted or transferred to a CONSULTANT in one of the psychiatric specialties within a Hospital Provider Spell.
START DATE (EPISODE)	120, 130, 140, 180, 190, 200	The start of an episode covered by a plan or other time period.
START TIME (EPISODE)	120, 130, 140, 180, 190, 200	Start Time is the start time of episode covered by a plan, or other period of time. The time should be recorded using the 24 hour clock.
END DATE (EPISODE)	120, 130, 140, 180, 190, 200	The end of an episode covered by a plan or other time period.

<b>END TIME (EPISODE)</b>	120, 130, 140, 180, 190, 200	End Time is the end time of episode covered by a plan, or other period of time. The time should be recorded using the 24 hour clock.
<b>AGE AT CDS ACTIVITY DATE</b>	120, 130, 140, 180, 190, 200	AGE AT CDS ACTIVITY DATE is derived as the number of completed years between the PERSON BIRTH DATE of the PATIENT and the CDS ACTIVITY DATE.

## 4.17 Data Group: Overseas Visitor Charging Category

<b>BIRTH EPISODE - OVERSEAS VISITOR CHARGING CATEGORY DELIVERY EPISODE - OVERSEAS VISITOR CHARGING CATEGORY CARE EPISODE - OVERSEAS VISITOR CHARGING CATEGORY</b>		
<b>Description</b>		
To carry the details of the Overseas Visitor Charging Categories of the Patient during Care Professional Admitted Care Episode.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
120, 180, 130, 140, 190, 200		
<b>Additional Notes on Data Items</b>		
<b>Data Item Name</b>	<b>Relevant CDS Types</b>	<b>Additional Notes</b>
<b>OVERSEAS VISITOR CHARGING CATEGORY</b>	120, 180, 130, 140, 190, 200	The charging category relating to an OVERSEAS VISITOR STATUS.
<b>OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE FROM DATE</b>	120, 180, 130, 140, 190, 200	OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE FROM DATE is the date when the OVERSEAS VISITOR CHARGING CATEGORY was applicable from.
<b>OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE END DATE</b>	120, 180, 130, 140, 190, 200	OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE END DATE is the date when the OVERSEAS VISITOR CHARGING CATEGORY was applicable until.

## 4.18 Data Group: Service Agreement Details

CARE ATTENDANCE - SERVICE AGREEMENT DETAILS BIRTH EPISODE - SERVICE AGREEMENT DETAILS DELIVERY EPISODE - SERVICE AGREEMENT DETAILS CARE EPISODE - SERVICE AGREEMENT DETAILS		
<b>Description</b>		
To carry the details of the Provider, Commissioners and Service Agreements.		
Please note that CDS v6.3 allows multiple commissioners to be recorded against a single hospital provider spell or outpatient attendance. This is designed to support specific scenarios where more than one commissioner is responsible for the patient's care, for example a locally-commissioned service and a directly-commissioned service. This could include:		
<ul style="list-style-type: none"> <li>scenarios whereby NHS England and NHS Improvement commission part of a hospital spell. For example, NHS England and NHS Improvement commission the bed days associated with young babies being cared for in neonatal intensive care but they only commission the hospital spell for that patient if the surgical intervention relates to a specialised surgery. Otherwise, the hospital spell would be locally commissioned.</li> <li>scenarios where other unbundled activities occur; these may be commissioned by different commissioners.</li> <li>scenarios whereby the duration of care determines commissioner. For example NHS England and NHS Improvement is responsible for the commissioning of Bone and Marrow transplantation care up to 100 days post transplantation. Thereafter, the commissioning responsibility sits with the CCG.</li> </ul>		
Further examples will be added to this User Guidance prior to CDS v6.3 go-live.		
<b>Group Status</b>		
Mandatory		
<b>CDS Types</b>		
020, 120, 180, 130, 140, 160, 150, 190, 200		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
ORGANISATION IDENTIFIER (CODE OF PROVIDER)	020, 120, 180, 130, 140, 160, 150, 190, 200	ORGANISATION IDENTIFIER (CODE OF PROVIDER) is the ORGANISATION IDENTIFIER of the Organisation acting as a Health Care Provider.
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	020, 120, 180, 130, 140, 160, 150, 190, 200	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) is the ORGANISATION IDENTIFIER of the Organisation commissioning health care.
START DATE (COMMISSIONER ASSIGNMENT PERIOD)	020, 120, 180, 130, 140, 160, 150, 190, 200	The Start Date of the Commissioner Assignment Period.

END DATE (COMMISSIONER ASSIGNMENT PERIOD)	020, 120, 180, 130, 140, 160, 150, 190, 200	The End Date of the Commissioner Assignment Period.
NHS SERVICE AGREEMENT IDENTIFIER	020, 120, 180, 130, 140, 160, 150, 190, 200	The unique identifier of an NHS SERVICE AGREEMENT.  The NHS SERVICE AGREEMENT IDENTIFIER is issued by the ORGANISATION acting as commissioner of a SERVICE.
NHS SERVICE AGREEMENT LINE IDENTIFIER	020, 120, 180, 130, 140, 160, 150, 190, 200	A number (alphanumeric) to provide a unique identifier for a line within a NHS SERVICE AGREEMENT.
PROVIDER REFERENCE IDENTIFIER	020, 120, 180, 130, 140, 160, 150, 190, 200	The reference identifier agreed locally between a Health Care Provider and the Commissioner of a SERVICE PROVIDED UNDER AGREEMENT.
COMMISSIONER REFERENCE IDENTIFIER	020, 120, 180, 130, 140, 160, 150, 190, 200	The identifier of a SERVICE REQUEST allocated by the commissioner of a SERVICE.
SPECIALISED SERVICE CODE	020, 120, 180, 130, 140, 160, 150, 190, 200	The type of Specialised Service provided in a SERVICE PROVIDED UNDER AGREEMENT.  This allows directly-commissioned services (including NHS England and NHS Improvement-funded specialised services) to be recorded.  The SPECIALISED SERVICE CODE National Codes are published by NHS England and NHS Improvement, and can be accessed on <a href="#">the NHS England and NHS Improvement website</a> .

## 4.19 Data Group: Person Group (Care Professional)

CARE EPISODE - PERSON GROUP (CARE PROFESSIONAL) BIRTH EPISODE - PERSON GROUP (CARE PROFESSIONAL) DELIVERY EPISODE - PERSON GROUP (CARE PROFESSIONAL)		
<b>Description</b>		
To carry the details of the Care Professionals active during the Care Professional Admitted Care Episode. In CDS v6.3, this is not limited to consultants.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
020, 120, 180, 130, 140, 190, 200		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes

PROFESSIONAL REGISTRATION ISSUER CODE	020, 120, 180, 130, 140, 190, 200	A code which identifies the PROFESSIONAL REGISTRATION BODY.
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER	020, 120, 180, 130, 140, 190, 200	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER is the registration identifier allocated by an ORGANISATION.
CARE PROFESSIONAL MAIN SPECIALTY CODE	020, 120, 180, 130, 140, 190, 200	CARE PROFESSIONAL MAIN SPECIALTY CODE is the specialty in which the CONSULTANT is contracted or recognised. MAIN SPECIALTY classifies clinical work divisions more precisely for a limited number of specialties.  Pseudo/default codes can be used to record non-consultant activity, for example '560 - Midwife'.
ACTIVITY TREATMENT FUNCTION CODE	020, 120, 180, 130, 140, 190, 200	ACTIVITY TREATMENT FUNCTION CODE is a unique identifier for a TREATMENT FUNCTION. It is recorded to report the service within which the PATIENT is treated.
LOCAL SUB-SPECIALTY CODE	020, 120, 180, 130, 140, 190, 200	A unique identifier for a LOCAL SUB-SPECIALTY.
RESPONSIBLE CARE PROFESSIONAL INDICATOR	020, 120, 180, 130, 140, 190, 200	An indication of whether a CARE PROFESSIONAL belonging to a CARE PROFESSIONAL TEAM delivering a Consultant Led Service or Non-Consultant Led Service has overall clinical responsibility for the care of the PATIENT during an ACTIVITY GROUP.

## 4.20 Master Data Group: Clinical Diagnosis Group (ICD)

### CARE EPISODE - CLINICAL DIAGNOSIS GROUP (ICD) BIRTH EPISODE - CLINICAL DIAGNOSIS GROUP (ICD) DELIVERY EPISODE - CLINICAL DIAGNOSIS GROUP (ICD)

#### Description

To carry the details of the ICD coded Clinical Diagnoses for the Patient.

#### Master Group Status

Required

#### CDS Types

020, 120, 180, 130, 140, 190, 200

#### Additional Notes on Data Items

Data Item Name	Relevant CDS Types	Additional Notes
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DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET)	020, 120, 180, 130, 140, 190, 200	<p>DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET) is the same as attribute DIAGNOSIS SCHEME IN USE for the Commissioning Data Sets.</p> <p>DIAGNOSIS SCHEME IN USE is used in the Clinical Information Group of the Commissioning Data Set to denote the code scheme basis of the Diagnosis.</p>
<b>PRIMARY DIAGNOSIS</b>		
<b>Description</b>		
To carry the details of the ICD coded Primary Diagnosis for the Patient.		
<b>Group Status</b>		
Mandatory		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
PRIMARY DIAGNOSIS (ICD)	020, 120, 180, 130, 140, 190, 200	PRIMARY DIAGNOSIS (ICD) is the International Classification of Diseases (ICD) code used to identify the PRIMARY DIAGNOSIS.
PRESENT ON ADMISSION INDICATOR	130, 190	<p>An indication of whether a PATIENT DIAGNOSIS was already present when the PATIENT started a Hospital Provider Spell.</p> <p>Note: PRESENT ON ADMISSION INDICATOR is only required for patients with a diagnosis relating to a pre-existing pressure ulcer before admission to a Health Care Provider, recorded as an ICD-10 code. This is to allow sufficient time for Health Care Providers to move to using the 'Comorbidity (SNOMED CT)' data structure to submit this data in Types 130 and 190, which is the preferred mechanism of data submission.</p>
<b>SECONDARY DIAGNOSES</b>		
<b>Description</b>		
To carry the details of the ICD coded Secondary Diagnoses for the Patient.		
<b>Group Status</b>		
Required		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
SECONDARY DIAGNOSIS (ICD)	020, 120, 180, 130, 140, 190, 200	SECONDARY DIAGNOSIS (ICD) is the International Classification of Diseases (ICD) code used to identify the secondary PATIENT DIAGNOSIS.

PRESENT ON ADMISSION INDICATOR	130, 190	<p>An indication of whether a PATIENT DIAGNOSIS was already present when the PATIENT started a Hospital Provider Spell.</p> <p>Note: PRESENT ON ADMISSION INDICATOR is only required for patients with a diagnosis relating to a pre-existing pressure ulcer before admission to a Health Care Provider, recorded as an ICD-10 code. This is to allow sufficient time for Health Care Providers to move to using the 'Comorbidity (SNOMED CT)' data structure to submit this data in Types 130 and 190, which is the preferred mechanism of data submission.</p>
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## 4.21 Data Group: Clinical Diagnosis Group (SNOMED CT)

<b>CARE EPISODE - CLINICAL DIAGNOSIS GROUP (SNOMED CT)</b> <b>BIRTH EPISODE - CLINICAL DIAGNOSIS GROUP (SNOMED CT)</b> <b>DELIVERY EPISODE - CLINICAL DIAGNOSIS GROUP (SNOMED CT)</b>		
<b>Description</b>		
To carry the details of the SNOMED CT coded Clinical Diagnoses for the Patient.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
020, 120, 180, 130, 140, 190, 200		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
DIAGNOSIS (SNOMED CT EXPRESSION)	120, 180, 130, 140, 190, 200	DIAGNOSIS (SNOMED CT EXPRESSION) is a structured combination of one or more SNOMED CT® concept identifiers which are used to describe a PATIENT DIAGNOSIS.
CODED CLINICAL ENTRY SEQUENCE NUMBER	120, 180, 130, 140, 190, 200	The sequence number of a CODED CLINICAL ENTRY, recorded to enable correct sequential processing of data.
CODED DIAGNOSIS TIMESTAMP	120, 180, 130, 140, 190, 200	CODED DIAGNOSIS TIMESTAMP is the date, time and time zone that the DIAGNOSIS was recorded by a CARE PROFESSIONAL.
Or		
DATA ABSENT REASON (FHIR R4)	120, 180, 130, 140, 190, 200	DATA ABSENT REASON (FHIR R4) is the concept from the FHIR Release 4 Value Set 'data-absent-reason' which identifies the reason that a CODED CLINICAL ENTRY data item in an ELECTRONIC HEALTH RECORD is missing.

## 4.22 Data Group: Comorbidity (SNOMED CT)

CARE EPISODE - COMORBIDITY (SNOMED CT) BIRTH EPISODE - COMORBIDITY (SNOMED CT) DELIVERY EPISODE - COMORBIDITY (SNOMED CT)		
<b>Description</b>		
To carry the details of the SNOMED CT coded Comorbidities for the Patient.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
020, 120, 180, 130, 140, 190, 200		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
COMORBIDITY (SNOMED CT EXPRESSION)	020, 120, 180, 130, 140, 190, 200	COMORBIDITY (SNOMED CT EXPRESSION) is a structured combination of one or more SNOMED CT® concept identifiers which are used to describe a comorbid conditions for a PERSON.
Or		
DATA ABSENT REASON (FHIR R4)	020, 120, 180, 130, 140, 190, 200	DATA ABSENT REASON (FHIR R4) is the concept from the FHIR Release 4 Value Set 'data-absent-reason' which identifies the reason that a CODED CLINICAL ENTRY data item in an ELECTRONIC HEALTH RECORD is missing.

## 4.23 Master Data Group: Procedure Group (OPCS)

CARE ATTENDANCE - PROCEDURE GROUP (OPCS) BIRTH EPISODE - PROCEDURE GROUP (OPCS) DELIVERY EPISODE - PROCEDURE GROUP (OPCS) CARE EPISODE - PROCEDURE GROUP (OPCS)		
<b>Description</b>		
To carry the details of the OPCS coded Procedures for the Patient.		
<b>Master Group Status</b>		
Required		
<b>CDS Types</b>		
020, 120, 180, 130, 140, 190, 200		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes

PROCEDURE SCHEME IN USE (COMMISSIONING DATA SET)	020, 120, 180, 130, 140, 190, 200	The type of CODED CLINICAL ENTRY used for the CLINICAL INTERVENTION.
PRIMARY PROCEDURE		
Description		
To carry the details of the OPCS coded Primary Procedure for the Patient.		
Group Status		
Mandatory		
Additional Notes on Data Items		
Data Item Name	Relevant CDS Types	Additional Notes
PRIMARY PROCEDURE (OPCS)	020, 120, 180, 130, 140, 190, 200	PRIMARY PROCEDURE (OPCS) is the OPCS Classification of Interventions and Procedures code which is used to identify the primary Patient Procedure carried out.
PROCEDURE DATE	020, 120, 180, 130, 140, 190, 200	Procedure Date is the date of the Patient Procedure.
PROFESSIONAL REGISTRATION ISSUER CODE	020, 120, 180, 130, 140, 190, 200	A code which identifies the PROFESSIONAL REGISTRATION BODY.
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)	020, 120, 180, 130, 140, 190, 200	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) is the PROFESSIONAL REGISTRATION ENTRY IDENTIFIER of the CARE PROFESSIONAL carrying out a Patient Procedure.  Where more than one CARE PROFESSIONAL is involved in the Patient Procedure, the PROFESSIONAL REGISTRATION ENTRY IDENTIFIER of the main/lead CARE PROFESSIONAL should be recorded.
PROFESSIONAL REGISTRATION ISSUER CODE	020, 120, 180, 130, 140, 190, 200	A code which identifies the PROFESSIONAL REGISTRATION BODY.
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)	020, 120, 180, 130, 140, 190, 200	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) is the PROFESSIONAL REGISTRATION ENTRY IDENTIFIER of the CARE PROFESSIONAL providing anaesthesia during a Patient Procedure. Where more than one CARE PROFESSIONAL is involved in providing anaesthesia during the Patient Procedure, the PROFESSIONAL REGISTRATION ENTRY IDENTIFIER of the main/lead anaesthetist should be recorded.

<b>SECONDARY PROCEDURES</b>		
<b>Description</b>		
To carry the details of the OPCS coded Secondary Procedures for the Patient.		
<b>Group Status</b>		
Required		
<b>Additional Notes on Data Items</b>		
<b>Data Item Name</b>	<b>Relevant CDS Types</b>	<b>Additional Notes</b>
PROCEDURE (OPCS)	020, 120, 180, 130, 140, 190, 200	PROCEDURE (OPCS) is a Patient Procedure other than the PRIMARY PROCEDURE (OPCS).
PROCEDURE DATE	020, 120, 180, 130, 140, 190, 200	Procedure Date is the date of the Patient Procedure.
PROFESSIONAL REGISTRATION ISSUER CODE	020, 120, 180, 130, 140, 190, 200	A code which identifies the PROFESSIONAL REGISTRATION BODY.
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)	020, 120, 180, 130, 140, 190, 200	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) is the PROFESSIONAL REGISTRATION ENTRY IDENTIFIER of the CARE PROFESSIONAL carrying out a Patient Procedure.  Where more than one CARE PROFESSIONAL is involved in the Patient Procedure, the PROFESSIONAL REGISTRATION ENTRY IDENTIFIER of the main/lead CARE PROFESSIONAL should be recorded.
PROFESSIONAL REGISTRATION ISSUER CODE	020, 120, 180, 130, 140, 190, 200	A code which identifies the PROFESSIONAL REGISTRATION BODY.
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)	020, 120, 180, 130, 140, 190, 200	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) is the PROFESSIONAL REGISTRATION ENTRY IDENTIFIER of the CARE PROFESSIONAL providing anaesthesia during a Patient Procedure. Where more than one CARE PROFESSIONAL is involved in providing anaesthesia during the Patient Procedure, the PROFESSIONAL REGISTRATION ENTRY IDENTIFIER of the main/lead anaesthetist should be recorded.

## 4.24 Data Group: Procedure Group (SNOMED CT)

**CARE ATTENDANCE - PROCEDURE GROUP (SNOMED CT)**  
**BIRTH EPISODE - PROCEDURE GROUP (SNOMED CT)**

<b>DELIVERY EPISODE - PROCEDURE GROUP (SNOMED CT) CARE EPISODE - PROCEDURE GROUP (SNOMED CT)</b>		
<b>Description</b>		
To carry the details of the SNOMED CT coded Procedures for the Patient.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
020, 120, 180, 130, 140, 190, 200		
<b>Additional Notes on Data Items</b>		
<b>Data Item Name</b>	<b>Relevant CDS Types</b>	<b>Additional Notes</b>
PROCEDURE (SNOMED CT EXPRESSION)	020, 120, 180, 130, 140, 190, 200	PROCEDURE (SNOMED CT EXPRESSION) is a structured combination of one or more SNOMED CT® concept identifiers which are used to describe a Patient Procedure.
CODED CLINICAL ENTRY SEQUENCE NUMBER	020, 120, 180, 130, 140, 190, 200	The sequence number of a CODED CLINICAL ENTRY, recorded to enable correct sequential processing of data.
CODED PROCEDURE TIMESTAMP	020, 120, 180, 130, 140, 190, 200	CODED PROCEDURE TIMESTAMP is the date, time and time zone that the Patient Procedure was performed by a CARE PROFESSIONAL.
PROFESSIONAL REGISTRATION ISSUER CODE	020, 120, 180, 130, 140, 190, 200	A code which identifies the PROFESSIONAL REGISTRATION BODY.
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)	020, 120, 180, 130, 140, 190, 200	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) is the PROFESSIONAL REGISTRATION ENTRY IDENTIFIER of the CARE PROFESSIONAL carrying out a Patient Procedure.  Where more than one CARE PROFESSIONAL is involved in the Patient Procedure, the PROFESSIONAL REGISTRATION ENTRY IDENTIFIER of the main/lead CARE PROFESSIONAL should be recorded.
PROFESSIONAL REGISTRATION ISSUER CODE	020, 120, 180, 130, 140, 190, 200	A code which identifies the PROFESSIONAL REGISTRATION BODY.

PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)	020, 120, 180, 130, 140, 190, 200	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) is the PROFESSIONAL REGISTRATION ENTRY IDENTIFIER of the CARE PROFESSIONAL providing anaesthesia during a Patient Procedure. Where more than one CARE PROFESSIONAL is involved in providing anaesthesia during the Patient Procedure, the PROFESSIONAL REGISTRATION ENTRY IDENTIFIER of the main/lead anaesthetist should be recorded.
Or		
DATA ABSENT REASON (FHIR R4)	020, 120, 180, 130, 140, 190, 200	DATA ABSENT REASON (FHIR R4) is the concept from the FHIR Release 4 Value Set 'data-absent-reason' which identifies the reason that a CODED CLINICAL ENTRY data item in an ELECTRONIC HEALTH RECORD is missing.

## 4.25 Data Group: Observation Group (SNOMED CT)

<b>CARE ATTENDANCE - OBSERVATION GROUP (SNOMED CT)</b>		
<b>BIRTH EPISODE - OBSERVATION GROUP (SNOMED CT)</b>		
<b>DELIVERY EPISODE - OBSERVATION GROUP (SNOMED CT)</b>		
<b>CARE EPISODE - OBSERVATION GROUP (SNOMED CT)</b>		
<b>Description</b>		
To carry the details of the SNOMED CT coded Clinical Observations for the Patient.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
020, 120, 180, 130, 140, 190, 200		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
OBSERVATION (SNOMED CT EXPRESSION)	020, 120, 180, 130, 140, 190, 200	OBSERVATION (SNOMED CT EXPRESSION) is a structured combination of one or more SNOMED CT® concept identifiers which are used to describe an Observable Entity.
OBSERVATION VALUE	020, 120, 180, 130, 140, 190, 200	The numeric value resulting from a clinical OBSERVATION.
UCUM UNIT OF MEASUREMENT	020, 120, 180, 130, 140, 190, 200	The unit of measurement used to measure the result of a clinical OBSERVATION. See <a href="http://unitsofmeasure.org/trac/">http://unitsofmeasure.org/trac/</a> .

<b>CODED OBSERVATION TIMESTAMP</b>	020, 120, 180, 130, 140, 190, 200	CODED OBSERVATION TIMESTAMP is the date, time and time zone that the Observable Entity was recorded by a CARE PROFESSIONAL.
Or		
<b>DATA ABSENT REASON (FHIR R4)</b>	020, 120, 180, 130, 140, 190, 200	DATA ABSENT REASON (FHIR R4) is the concept from the FHIR Release 4 Value Set 'data-absent-reason' which identifies the reason that a CODED CLINICAL ENTRY data item in an ELECTRONIC HEALTH RECORD is missing.

## 4.26 Data Group: Finding Group (SNOMED CT)

<b>CARE ATTENDANCE - FINDING GROUP (SNOMED CT)</b>		
<b>BIRTH EPISODE - FINDING GROUP (SNOMED CT)</b>		
<b>DELIVERY EPISODE - FINDING GROUP (SNOMED CT)</b>		
<b>CARE EPISODE - FINDING GROUP (SNOMED CT)</b>		
<b>Description</b>		
To carry the details of the SNOMED CT coded Clinical Findings for the Patient.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
020, 120, 180, 130, 140, 190, 200		
<b>Additional Notes on Data Items</b>		
<b>Data Item Name</b>	<b>Relevant CDS Types</b>	<b>Additional Notes</b>
<b>FINDING (SNOMED CT EXPRESSION)</b>	020, 120, 180, 130, 140, 190, 200	FINDING (SNOMED CT EXPRESSION) is a structured combination of one or more SNOMED CT® concept identifiers which are used to describe a Finding.
<b>CODED FINDING TIMESTAMP</b>	020, 120, 180, 130, 140, 190, 200	CODED FINDING TIMESTAMP is the date, time and time zone that the Clinical Finding was recorded by a CARE PROFESSIONAL.
Or		
<b>DATA ABSENT REASON (FHIR R4)</b>	020, 120, 180, 130, 140, 190, 200	DATA ABSENT REASON (FHIR R4) is the concept from the FHIR Release 4 Value Set 'data-absent-reason' which identifies the reason that a CODED CLINICAL ENTRY data item in an ELECTRONIC HEALTH RECORD is missing.

## 4.27 Data Group: Assessment Tool Group (SNOMED CT)

CARE ATTENDANCE - ASSESSMENT TOOL GROUP (SNOMED CT) BIRTH EPISODE - ASSESSMENT TOOL GROUP (SNOMED CT) DELIVERY EPISODE - ASSESSMENT TOOL GROUP (SNOMED CT) CARE EPISODE - ASSESSMENT TOOL GROUP (SNOMED CT)		
<b>Description</b>		
To carry the details of the SNOMED CT coded Assessment Tools for the Patient.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
020, 120, 180, 130, 140, 190, 200		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
ASSESSMENT TOOL (SNOMED CT EXPRESSION)	020, 120, 180, 130, 140, 190, 200	ASSESSMENT TOOL (SNOMED CT EXPRESSION) is a structured combination of one or more SNOMED CT® concept identifiers which are used to describe an Observable Entity.
PERSON SCORE	020, 120, 180, 130, 140, 190, 200	The score taken from an ASSESSMENT TOOL.
ASSESSMENT TOOL COMPLETION TIMESTAMP	020, 120, 180, 130, 140, 190, 200	The date, time and time zone on which the assessment took place.
Or		
DATA ABSENT REASON (FHIR R4)	020, 120, 180, 130, 140, 190, 200	DATA ABSENT REASON (FHIR R4) is the concept from the FHIR Release 4 Value Set 'data-absent-reason' which identifies the reason that a CODED CLINICAL ENTRY data item in an ELECTRONIC HEALTH RECORD is missing.

## 4.28 Data Group: Location Group - Attendance

LOCATION GROUP - ATTENDANCE
<b>Description</b>
To carry the details of the Location and Site Code Of Treatment.
<b>Group Status</b>

Required		
<b>CDS Types</b>		
020		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
ORGANISATION SITE IDENTIFIER (OF TREATMENT)	020	ORGANISATION SITE IDENTIFIER (OF TREATMENT) is the ORGANISATION IDENTIFIER of the Organisation Site where the PATIENT was treated, i.e. it should enable the treating Organisation to be identified.
ACTIVITY LOCATION TYPE CODE	020	The type of LOCATION for an ACTIVITY: - where PATIENTS are seen - where SERVICES are provided or - from which requests for SERVICES are sent
CLINIC CODE	020	CLINIC CODE identifies the CLINIC OR FACILITY where an Out-Patient Appointment took place.

## 4.29 Data Group: Location Group (At Start Of Episode)

<b>LOCATION GROUP (AT START OF BIRTH EPISODE)</b>		
<b>LOCATION GROUP (AT START OF DELIVERY EPISODE)</b>		
<b>LOCATION GROUP (AT START OF CARE EPISODE)</b>		
<b>Description</b>		
To carry the details of the Location at the Start of the Professional Admitted Care Episode.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
120, 180, 130, 140, 190, 200		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
ORGANISATION SITE IDENTIFIER (OF TREATMENT)	120, 180, 130, 140, 190, 200	ORGANISATION SITE IDENTIFIER (OF TREATMENT) is the ORGANISATION IDENTIFIER of the Organisation Site where the PATIENT was treated, i.e. it should enable the treating Organisation to be identified.
ACTIVITY LOCATION TYPE CODE	120, 180, 130, 140, 190, 200	The type of LOCATION for an ACTIVITY: - where PATIENTS are seen - where SERVICES are provided or - from which requests for SERVICES are sent

WARD INTENDED CLINICAL CARE INTENSITY	120, 180, 130, 140, 190, 200	The level of resources and intensity of care which is intended to be provided in a WARD.
WARD INTENDED AGE GROUP	120, 180, 130, 140, 190, 200	The age group of PATIENTS intended to use a WARD, as indicated in the WARD OPERATIONAL PLAN.
WARD INTENDED SEX OF PATIENTS	120, 180, 130, 140, 190, 200	The sex of PATIENTS intended to use a WARD, as indicated in the WARD OPERATIONAL PLAN.
WARD INTENDED DAY PERIOD AVAILABILITY	120, 180, 130, 140, 190, 200	The number of day periods in a week that it is intended that a WARD should be available, as indicated in the WARD OPERATIONAL PLAN.  Where a WARD is closed, the WARD INTENDED DAY PERIOD AVAILABILITY will be National Code 'Zero days'.
WARD INTENDED NIGHT PERIOD AVAILABILITY	120, 180, 130, 140, 190, 200	The number of night periods in a week that it is intended that a WARD should be available, as indicated in the WARD OPERATIONAL PLAN.  Where a WARD is closed, the WARD INTENDED NIGHT PERIOD AVAILABILITY will be National Code 'Zero days'.
WARD SECURITY LEVEL	120, 180, 130, 140, 190, 200	The level of security for a ward.
WARD CODE	120, 180, 130, 140, 190, 200	A unique identification of a WARD within a Health Care Provider.

## 4.30 Data Group: Location Group (At Ward Stay)

LOCATION GROUP (AT WARD STAY)		
<b>Description</b>		
To carry the details of one or more Ward Stays during Care Professional Admitted Care Episode.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
120, 180, 130, 140, 190, 200		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes

ORGANISATION SITE IDENTIFIER (OF TREATMENT)	120, 180, 130, 140, 190, 200	ORGANISATION SITE IDENTIFIER (OF TREATMENT) is the ORGANISATION IDENTIFIER of the Organisation Site where the PATIENT was treated, i.e. it should enable the treating Organisation to be identified.
ACTIVITY LOCATION TYPE CODE	120, 180, 130, 140, 190, 200	The type of LOCATION for an ACTIVITY: - where PATIENTS are seen - where SERVICES are provided or - from which requests for SERVICES are sent
WARD INTENDED CLINICAL CARE INTENSITY	120, 180, 130, 140, 190, 200	The level of resources and intensity of care which is intended to be provided in a WARD.
WARD INTENDED AGE GROUP	120, 180, 130, 140, 190, 200	The age group of PATIENTS intended to use a WARD, as indicated in the WARD OPERATIONAL PLAN.
WARD INTENDED SEX OF PATIENTS	120, 180, 130, 140, 190, 200	The sex of PATIENTS intended to use a WARD, as indicated in the WARD OPERATIONAL PLAN.
WARD INTENDED DAY PERIOD AVAILABILITY	120, 180, 130, 140, 190, 200	The number of day periods in a week that it is intended that a WARD should be available, as indicated in the WARD OPERATIONAL PLAN.  Where a WARD is closed, the WARD INTENDED DAY PERIOD AVAILABILITY will be National Code 'Zero days'.
WARD INTENDED NIGHT PERIOD AVAILABILITY	120, 180, 130, 140, 190, 200	The number of night periods in a week that it is intended that a WARD should be available, as indicated in the WARD OPERATIONAL PLAN.  Where a WARD is closed, the WARD INTENDED NIGHT PERIOD AVAILABILITY will be National Code 'Zero days'.
START DATE (WARD STAY)	120, 180, 130, 140, 190, 200	The start date of a ward stay.
START TIME (WARD STAY)	120, 180, 130, 140, 190, 200	The start time of a ward stay.
END DATE (WARD STAY)	120, 180, 130, 140, 190, 200	The end date of a ward stay.
END TIME (WARD STAY)	120, 180, 130, 140, 190, 200	The end time of a ward stay.
WARD SECURITY LEVEL	120, 180, 130, 140, 190, 200	The level of security for a ward.

WARD CODE	120, 180, 130, 140, 190, 200	A unique identification of a WARD within a Health Care Provider.
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## 4.31 Data Group: Location Group (At End Of Episode)

LOCATION GROUP (AT END OF BIRTH EPISODE) LOCATION GROUP (AT END OF DELIVERY EPISODE) LOCATION GROUP (AT END OF CARE EPISODE)		
<b>Description</b>		
To carry the details of the Location at the End of the Professional Admitted Care Episode.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
120, 180, 130, 140, 190, 200		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
ORGANISATION SITE IDENTIFIER (OF TREATMENT)	120, 180, 130, 140, 190, 200	ORGANISATION SITE IDENTIFIER (OF TREATMENT) is the ORGANISATION IDENTIFIER of the Organisation Site where the PATIENT was treated, i.e. it should enable the treating Organisation to be identified.
ACTIVITY LOCATION TYPE CODE	120, 180, 130, 140, 190, 200	The type of LOCATION for an ACTIVITY: - where PATIENTS are seen - where SERVICES are provided or - from which requests for SERVICES are sent
WARD INTENDED CLINICAL CARE INTENSITY	120, 180, 130, 140, 190, 200	The level of resources and intensity of care which is intended to be provided in a WARD.
WARD INTENDED AGE GROUP	120, 180, 130, 140, 190, 200	The age group of PATIENTS intended to use a WARD, as indicated in the WARD OPERATIONAL PLAN.
WARD INTENDED SEX OF PATIENTS	120, 180, 130, 140, 190, 200	The sex of PATIENTS intended to use a WARD, as indicated in the WARD OPERATIONAL PLAN.

WARD INTENDED DAY PERIOD AVAILABILITY	120, 180, 130, 140, 190, 200	The number of day periods in a week that it is intended that a WARD should be available, as indicated in the WARD OPERATIONAL PLAN.  Where a WARD is closed, the WARD INTENDED DAY PERIOD AVAILABILITY will be National Code 'Zero days'.
WARD INTENDED NIGHT PERIOD AVAILABILITY	120, 180, 130, 140, 190, 200	The number of night periods in a week that it is intended that a WARD should be available, as indicated in the WARD OPERATIONAL PLAN.  Where a WARD is closed, the WARD INTENDED NIGHT PERIOD AVAILABILITY will be National Code 'Zero days'.
WARD SECURITY LEVEL	120, 180, 130, 140, 190, 200	The level of security for a ward.
WARD CODE	120, 180, 130, 140, 190, 200	A unique identification of a WARD within a Health Care Provider.

## 4.32 Data Group: Location Group - Home Leave

LOCATION GROUP - HOME LEAVE		
<b>Description</b>		
To carry the details of each separate period of Home Leave within the Care Professional Admitted Care Episode.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
120, 180, 130, 140, 190, 200		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
START DATE (HOME LEAVE)	120, 180, 130, 140, 190, 200	The start date for a period of Home Leave for patients NOT liable for detention under the Mental Health Act 1983.
START TIME (HOME LEAVE)	120, 180, 130, 140, 190, 200	The start time for a period of Home Leave for patients NOT liable for detention under the Mental Health Act 1983.
END DATE (HOME LEAVE)	120, 180, 130, 140, 190, 200	The end date for a period of Home Leave for patients NOT liable for detention under the Mental Health Act 1983.

<b>END TIME (HOME LEAVE)</b>	120, 180, 130, 140, 190, 200	The end time for a period of Home Leave for patients NOT liable for detention under the Mental Health Act 1983.
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## 4.33 Master Data Group: Neonatal Critical Care Period

<b>BIRTH EPISODE - NEONATAL CRITICAL CARE PERIOD DELIVERY EPISODE - NEONATAL CRITICAL CARE PERIOD CARE EPISODE - NEONATAL CRITICAL CARE PERIOD</b>		
<b>Description</b>		
To carry the details of the first 9 Critical Care Periods for care provided using Neonatal Care facilities.		
<b>Master Group Status</b>		
Required		
<b>CDS Types</b>		
120, 180, 130, 190		
<b>NEONATAL CARE - ADMISSION CHARACTERISTICS</b>		
<b>Description</b>		
To carry the admission details of the first 9 Critical Care Periods for care provided using Neonatal Care facilities.		
<b>Group Status</b>		
Mandatory		
<b>Additional Notes on Data Items</b>		
<b>Data Item Name</b>	<b>Relevant CDS Types</b>	<b>Additional Notes</b>
<b>CRITICAL CARE LOCAL IDENTIFIER</b>	120, 180, 130, 190	This is a unique local ACTIVITY IDENTIFIER used to identify the start of CARE ACTIVITY within a CRITICAL CARE PERIOD. This locally defined variable should as a minimum include a sequential numerical component that can discriminate two or more CRITICAL CARE PERIODS occurring on the same calendar day for the same patient.
<b>CRITICAL CARE START DATE</b>	120, 180, 130, 190	Start date of a CRITICAL CARE activity.
<b>CRITICAL CARE START TIME</b>	120, 180, 130, 190	Start time of a CRITICAL CARE activity.
<b>CRITICAL CARE UNIT FUNCTION</b>	120, 180, 130, 190	The type of area to which the PATIENT was admitted during a CRITICAL CARE PERIOD. This is the principal clinical service provided within the WARD.

<b>GESTATION LENGTH (AT DELIVERY)</b>	120, 180, 130, 190	GESTATION LENGTH (AT DELIVERY) records a period of between 10 to 49 weeks in completed weeks that is a clinical assessment of GESTATION LENGTH IN WEEKS.
<b>NEONATAL DAILY CARE - ACTIVITY CHARACTERISTICS</b>		
<b>Description</b>		
To carry the activity details of the first 9 Critical Care Periods for care provided using Neonatal Care facilities.		
<b>Group Status</b>		
Mandatory		
<b>Additional Notes on Data Items</b>		
<b>Data Item Name</b>	<b>Relevant CDS Types</b>	<b>Additional Notes</b>
<b>ACTIVITY DATE (CRITICAL CARE)</b>	120, 180, 130, 190	ACTIVITY DATE (CRITICAL CARE) is the date the PATIENT receives care which is a CRITICAL CARE ACTIVITY. ACTIVITY DATE (CRITICAL CARE) is the ACTIVITY DATE where the CARE ACTIVITY is during a CRITICAL CARE PERIOD.
<b>PERSON WEIGHT</b>	120, 180, 130, 190	PERSON WEIGHT is the result of the Clinical Investigation which measures the PATIENT's Weight, where the UCUM UNIT OF MEASUREMENT is 'Kilograms (kg)'.
<b>CRITICAL CARE ACTIVITY CODE</b>	120, 180, 130, 190	A type of CRITICAL CARE ACTIVITY provided to a PATIENT during a CRITICAL CARE PERIOD.
<b>HIGH COST DRUGS (OPCS)</b>	120, 180, 130, 190	This is the use of high cost drugs as per OPCS-4 definitions provided as a CARE ACTIVITY.
<b>NEONATAL CARE - DISCHARGE CHARACTERISTICS</b>		
<b>Description</b>		
To carry the discharge details of the first 9 Critical Care Periods for care provided using Neonatal Care facilities.		
<b>Group Status</b>		
Required		
<b>Additional Notes on Data Items</b>		
<b>Data Item Name</b>	<b>Relevant CDS Types</b>	<b>Additional Notes</b>
<b>CRITICAL CARE DISCHARGE DATE</b>	120, 180, 130, 190	The end date of a CRITICAL CARE PERIOD. This may be the date the PATIENT is discharged from the critical care unit, the date the PATIENT died or the date of declaration of brainstem death. This is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TIME TYPE is National Code 11 'End Date' for the CRITICAL CARE PERIOD.

CRITICAL CARE DISCHARGE TIME	120, 180, 130, 190	CRITICAL CARE DISCHARGE TIME is CRITICAL CARE PERIOD end time.
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## 4.34 Master Data Group: Paediatric Daily Care - Activity Characteristics

BIRTH EPISODE - PAEDIATRIC CRITICAL CARE PERIOD DELIVERY EPISODE - PAEDIATRIC CRITICAL CARE PERIOD CARE EPISODE - PAEDIATRIC CRITICAL CARE PERIOD		
<b>Description</b>		
To carry the details of the first 9 Critical Care Periods for care provided using Paediatric Care facilities.		
<b>Master Group Status</b>		
Required		
<b>CDS Types</b>		
120, 130, 140, 180, 190, 200		
PAEDIATRIC CRITICAL CARE - ADMISSION CHARACTERISTICS		
<b>Description</b>		
To carry the admission details of the first 9 Critical Care Periods for care provided using Paediatric Care facilities.		
<b>Group Status</b>		
Mandatory		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
CRITICAL CARE LOCAL IDENTIFIER	120, 130, 140, 180, 190, 200	This is a unique local ACTIVITY IDENTIFIER used to identify the start of CARE ACTIVITY within a CRITICAL CARE PERIOD. This locally defined variable should as a minimum include a sequential numerical component that can discriminate two or more CRITICAL CARE PERIODS occurring on the same calendar day for the same patient.
CRITICAL CARE START DATE	120, 130, 140, 180, 190, 200	Start date of a CRITICAL CARE activity.
CRITICAL CARE START TIME	120, 130, 140, 180, 190, 200	Start time of a CRITICAL CARE activity.

<b>CRITICAL CARE UNIT FUNCTION</b>	120, 130, 140, 180, 190, 200	The type of area to which the PATIENT was admitted during a CRITICAL CARE PERIOD. This is the principal clinical service provided within the WARD.
<b>PAEDIATRIC DAILY CARE - ACTIVITY CHARACTERISTICS</b>		
<b>Description</b>		
To carry the activity details of the first 9 Critical Care Periods for care provided using Paediatric Care facilities.		
<b>Group Status</b>		
Mandatory		
<b>Additional Notes on Data Items</b>		
<b>Data Item Name</b>	<b>Relevant CDS Types</b>	<b>Additional Notes</b>
<b>ACTIVITY DATE (CRITICAL CARE)</b>	120, 130, 140, 180, 190, 200	ACTIVITY DATE (CRITICAL CARE) is the date the PATIENT receives care which is a CRITICAL CARE ACTIVITY. ACTIVITY DATE (CRITICAL CARE) is the ACTIVITY DATE where the CARE ACTIVITY is during a CRITICAL CARE PERIOD.
<b>CRITICAL CARE ACTIVITY CODE</b>	120, 130, 140, 180, 190, 200	A type of CRITICAL CARE ACTIVITY provided to a PATIENT during a CRITICAL CARE PERIOD.
<b>HIGH COST DRUGS (OPCS)</b>	120, 130, 140, 180, 190, 200	This is the use of high cost drugs as per OPCS-4 definitions provided as a CARE ACTIVITY.
<b>PAEDIATRIC CRITICAL CARE - DISCHARGE CHARACTERISTICS</b>		
<b>Description</b>		
To carry the discharge details of the first 9 Critical Care Periods for care provided using Paediatric Care facilities.		
<b>Group Status</b>		
Required		
<b>Additional Notes on Data Items</b>		
<b>Data Item Name</b>	<b>Relevant CDS Types</b>	<b>Additional Notes</b>
<b>CRITICAL CARE DISCHARGE DATE</b>	120, 130, 140, 180, 190, 200	The end date of a CRITICAL CARE PERIOD. This may be the date the PATIENT is discharged from the critical care unit, the date the PATIENT died or the date of declaration of brainstem death. This is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TIME TYPE is National Code 11 'End Date' for the CRITICAL CARE PERIOD.
<b>CRITICAL CARE DISCHARGE TIME</b>	120, 130, 140, 180, 190, 200	CRITICAL CARE DISCHARGE TIME is CRITICAL CARE PERIOD end time.

## 4.35 Master Data Group: Adult Critical Care Period

BIRTH EPISODE - ADULT CRITICAL CARE PERIOD DELIVERY EPISODE - ADULT CRITICAL CARE PERIOD CARE EPISODE - ADULT CRITICAL CARE PERIOD		
<b>Description</b>		
To carry the details of the first 9 Critical Care Periods for care provided using Adult Care facilities.		
<b>Master Group Status</b>		
Required		
<b>CDS Types</b>		
120, 130, 140, 180, 190, 200		
ADULT CRITICAL CARE - ADMISSION CHARACTERISTICS		
<b>Description</b>		
To carry the admission details of the first 9 Critical Care Periods for care provided using Adult Care facilities.		
<b>Group Status</b>		
Mandatory		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
CRITICAL CARE LOCAL IDENTIFIER	120, 130, 140, 180, 190, 200	This is a unique local ACTIVITY IDENTIFIER used to identify the start of CARE ACTIVITY within a CRITICAL CARE PERIOD. This locally defined variable should as a minimum include a sequential numerical component that can discriminate two or more CRITICAL CARE PERIODS occurring on the same calendar day for the same patient.
CRITICAL CARE START DATE	120, 130, 140, 180, 190, 200	Start date of a CRITICAL CARE activity.
CRITICAL CARE START TIME	120, 130, 140, 180, 190, 200	Start time of a CRITICAL CARE activity.
CRITICAL CARE UNIT FUNCTION	120, 130, 140, 180, 190, 200	The type of area to which the PATIENT was admitted during a CRITICAL CARE PERIOD. This is the principal clinical service provided within the WARD.
CRITICAL CARE UNIT BED CONFIGURATION	120, 130, 140, 180, 190, 200	The main composition of critical care bed types for the WARD.

CRITICAL CARE ADMISSION SOURCE	120, 130, 140, 180, 190, 200	The primary Organisation type that the PATIENT has been admitted from prior to the start of the CRITICAL CARE PERIOD.
CRITICAL CARE SOURCE LOCATION	120, 130, 140, 180, 190, 200	The type of LOCATION the PATIENT was in prior to the start of the CRITICAL CARE PERIOD.
CRITICAL CARE ADMISSION TYPE	120, 130, 140, 180, 190, 200	An indication of whether a CRITICAL CARE PERIOD was initiated as a result of a non-emergency treatment plan, for example, for elective major surgery. This relates only to the period of critical care and not to the nature of the hospital admission. For example, a planned hospital admission may unexpectedly require an emergency intensive care unit admission, in which case the classification will be National Code '01'.

## ADULT CRITICAL CARE - ACTIVITY CHARACTERISTICS

### Description

To carry the activity details of the first 9 Critical Care Periods for care provided using Adult Care facilities.

### Group Status

Mandatory

### Additional Notes on Data Items

Data Item Name	Relevant CDS Types	Additional Notes
ADVANCED RESPIRATORY SUPPORT DAYS	120, 130, 140, 180, 190, 200	The total number of days that the PATIENT received advanced respiratory support during a CRITICAL CARE PERIOD, ranging from 000 to 997 days. This is derived from the difference between the ACTIVITY PROPERTY EFFECTIVE DATE and the ACTIVITY PROPERTY END DATE for all ACTIVITY PROPERTIES where the ORGAN SYSTEM SUPPORTED is National Code 02 'Advanced Respiratory Support' within the CRITICAL CARE PERIOD.
BASIC RESPIRATORY SUPPORT DAYS	120, 130, 140, 180, 190, 200	The total number of days that the PATIENT received basic respiratory support during a CRITICAL CARE PERIOD, ranging from 000 to 997 days. This is derived from the difference between the ACTIVITY PROPERTY EFFECTIVE DATE and the ACTIVITY PROPERTY END DATE for all ACTIVITY PROPERTIES where the ORGAN SYSTEM SUPPORTED is National Code 01 'Basic Respiratory Support' within the CRITICAL CARE PERIOD.

ADVANCED CARDIOVASCULAR SUPPORT DAYS	120, 130, 140, 180, 190, 200	The total number of days that the PATIENT received advanced cardiovascular support during a CRITICAL CARE PERIOD, ranging from 000 to 997 days. This is derived from the difference between the ACTIVITY PROPERTY EFFECTIVE DATE and the ACTIVITY PROPERTY END DATE for all ACTIVITY PROPERTIES where the ORGAN SYSTEM SUPPORTED is National Code 04 'Advanced Cardiovascular Support' within the CRITICAL CARE PERIOD.
BASIC CARDIOVASCULAR SUPPORT DAYS	120, 130, 140, 180, 190, 200	The total number of days that the PATIENT received basic cardiovascular support during a CRITICAL CARE PERIOD, ranging from 000 to 997 days. This is derived from the difference between the ACTIVITY PROPERTY EFFECTIVE DATE and the ACTIVITY PROPERTY END DATE for all ACTIVITY PROPERTIES where the ORGAN SYSTEM SUPPORTED is National Code 03 'Basic Cardiovascular Support' within the CRITICAL CARE PERIOD.
RENAL SUPPORT DAYS	120, 130, 140, 180, 190, 200	RENAL SUPPORT DAYS is the total number of days that the PATIENT received renal system support during a CRITICAL CARE PERIOD.
NEUROLOGICAL SUPPORT DAYS	120, 130, 140, 180, 190, 200	NEUROLOGICAL SUPPORT DAYS is the total number of days that the PATIENT received neurological system support during a CRITICAL CARE PERIOD.
GASTRO- INTESTINAL SUPPORT DAYS	120, 130, 140, 180, 190, 200	The total number of days that the PATIENT received gastro-intestinal system support during a CRITICAL CARE PERIOD.
DERMATOLOGICAL SUPPORT DAYS	120, 130, 140, 180, 190, 200	The total number of days that the PATIENT received dermatological system support during a CRITICAL CARE PERIOD.
LIVER SUPPORT DAYS	120, 130, 140, 180, 190, 200	LIVER SUPPORT DAYS is the total number of days that the PATIENT received liver support during a CRITICAL CARE PERIOD.
ORGAN SUPPORT MAXIMUM	120, 130, 140, 180, 190, 200	The maximum number of ORGAN SYSTEMS SUPPORTED on any one day during a CRITICAL CARE PERIOD.  Each organ system can only be counted once on any calendar day. Both basic and advanced categories cannot be counted at the same time. The number of organ systems supported can be between 00 to 07, although for the purposes of recording on the Commissioning Data Set messages Gastro-intestinal support days are not recorded so the maximum is effectively 06.

CRITICAL CARE LEVEL 2 DAYS	120, 130, 140, 180, 190, 200	<p>The total number of days a PATIENT received level 2 care during a CRITICAL CARE PERIOD. From 000 to 997 days can be recorded; if 998 or more days have occurred the default code should be used.</p> <p>This is derived from the difference between the ACTIVITY PROPERTY EFFECTIVE DATE and the ACTIVITY PROPERTY END DATE for all ACTIVITY PROPERTIES where the CRITICAL CARE LEVEL is National Code 02 'Level 2' within the CRITICAL CARE PERIOD.</p>
CRITICAL CARE LEVEL 3 DAYS	120, 130, 140, 180, 190, 200	<p>The total number of days a PATIENT received level 3 care during a CRITICAL CARE PERIOD. From 000 to 997 days can be recorded; if 998 or more days have occurred the default code should be used.</p> <p>This is derived from the difference between the ACTIVITY PROPERTY EFFECTIVE DATE and the ACTIVITY PROPERTY END DATE for all ACTIVITY PROPERTIES where the CRITICAL CARE LEVEL is National Code 03 'Level 3' within the CRITICAL CARE PERIOD.</p>
<b>ADULT CRITICAL CARE - DAILY CARE ACTIVITY CHARACTERISTICS</b>		
<b>Description</b>		
To carry the daily activity details of the first 9 Critical Care Periods for care provided using Adult Care facilities.		
<b>Group Status</b>		
Required		
<b>Additional Notes on Data Items</b>		
<b>Data Item Name</b>	<b>Relevant CDS Types</b>	<b>Additional Notes</b>
ACTIVITY DATE (CRITICAL CARE)	120, 130, 140, 180, 190, 200	<p>ACTIVITY DATE (CRITICAL CARE) is the date the PATIENT receives care which is a CRITICAL CARE ACTIVITY.</p> <p>ACTIVITY DATE (CRITICAL CARE) is the ACTIVITY DATE where the CARE ACTIVITY is during a CRITICAL CARE PERIOD.</p>
ORGAN SYSTEM SUPPORTED	120, 130, 140, 180, 190, 200	<p>The type of organ system supported within a CRITICAL CARE PERIOD.</p> <p>This includes the following options:</p> <p>01- <b>Basic Respiratory Support</b>. Indicated by one or more of the following:</p> <ul style="list-style-type: none"> <li>• More than 50% oxygen delivered by face mask. (Note: more than 50% has been chosen to identify the more seriously ill PATIENTS in a hospital). Short-term increases in the fraction of inspired oxygen (FiO2) to facilitate procedures such as transfers, or physiotherapy do not qualify.</li> <li>• Close observation due to the potential for acute deterioration to the point of needing advanced respiratory support. (e.g. severely compromised airway or deteriorating respiratory muscle function).</li> <li>• Physiotherapy or suction to clear secretions at least two hourly, whether via tracheostomy, minitracheostomy, or in the absence of an artificial airway.</li> </ul>

	<ul style="list-style-type: none"><li>• PATIENTS recently (within 24 hours) extubated after a period (greater than 24 hours) of mechanical ventilation via an endotracheal tube.</li><li>• Mask / hood continuous positive airway pressure (CPAP) or mask / hood Bi-level positive airway pressure ventilation (non-invasive ventilation).</li><li>• PATIENTS who are intubated to protect the airway but needing no ventilatory support.</li><li>• Continuous positive airway pressure (CPAP) via a tracheostomy. <b>Note:</b> The presence of a tracheostomy used for long term airway access only does not qualify for any respiratory support.</li></ul> <p><b>02 - Advanced Respiratory Support.</b> Indicated by:</p> <ul style="list-style-type: none"><li>• Invasive mechanical ventilatory support applied via a trans-laryngeal tracheal tube or applied via a tracheostomy.</li><li>• Bi-level positive airway pressure applied via a trans-laryngeal tracheal tube or applied via a tracheostomy.</li><li>• Continuous positive airway pressure via a trans-laryngeal tracheal tube.</li><li>• Extracorporeal respiratory support.</li></ul> <p><b>03 - Basic Cardiovascular Support.</b> Indicated by one or more of the following:</p> <ul style="list-style-type: none"><li>• Use of a central venous pressure (CVP) line for monitoring of central venous pressure and/or provision of central venous access to deliver titrated fluids to treat hypovolaemia.</li><li>• Use of an arterial line for monitoring of arterial pressure and/or sampling of arterial blood.</li><li>• Single intravenous vasoactive drug used to support or control arterial pressure, cardiac output or <b>organ</b> perfusion.</li><li>• Single intravenous rhythm controlling drug to support or control cardiac arrhythmias.</li></ul> <p><b>04 - Advanced Cardiovascular Support.</b> Indicated by one or more of the following:</p> <ul style="list-style-type: none"><li>• Multiple intravenous vasoactive and/or rhythm controlling drugs when used simultaneously to support or control arterial pressure, cardiac output or <b>organ</b> perfusion (e.g. inotropes, amiodarone, nitrates). To qualify for advanced support status, at least one drug needs to be vasoactive.</li><li>• Continuous observation of cardiac output and derived indices (e.g. pulmonary artery catheter, lithium dilution, pulse contour analyses, oesophageal doppler).</li><li>• Intra aortic balloon pumping and other assist devices.</li><li>• Insertion of a temporary cardiac pacemaker (criteria valid for each day of connection to a functioning external pacemaker unit).</li></ul> <p><b>05 - Renal Support.</b> In the context of critical illness, this is indicated by:</p> <ul style="list-style-type: none"><li>• Acute renal replacement therapy (e.g. haemodialysis, haemofiltration etc.) or the provision of renal replacement</li></ul>
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		<p>therapy to a chronic renal failure patient who is requiring other acute <b>organ</b> support in a critical care situation.</p> <p><b>06 - Neurological Support.</b> Indicated by one or more of the following:</p> <ul style="list-style-type: none"> <li>• Central nervous <b>system</b> depression sufficient to prejudice the airway and protective reflexes, excepting that caused by sedation prescribed to facilitate mechanical ventilation or poisoning (e.g. deliberate or accidental overdose, alcohol, drugs, etc.)</li> <li>• Invasive neurological monitoring e.g. intracranial pressure, jugular bulb sampling, external ventricular drain.</li> <li>• Continuous intravenous medication to control seizures and/or continuous cerebral monitoring.</li> <li>• Therapeutic hypothermia using cooling protocols or devices.</li> </ul> <p><b>07 - Gastrointestinal Support.</b> Indicated by:</p> <ul style="list-style-type: none"> <li>• Feeding with parenteral or enteral nutrition (implies methods of feeding other than normal oral intake).</li> </ul> <p><b>08 - Dermatological Support.</b> Indicated by one or more of the following:</p> <ul style="list-style-type: none"> <li>• PATIENTS with major skin rashes, exfoliation or burns (e.g. greater than 30% body surface area affected).</li> <li>• Use of complex dressings (e.g. large skin area greater than 30% body surface area, open abdomen, vacuum dressings or large trauma such as multiple limb or limb and head dressings).</li> </ul> <p><b>09 - Liver Support.</b> Indicated by:</p> <ul style="list-style-type: none"> <li>• Acute on chronic Hepatocellular failure requiring management of coagulopathy and/or portal hypertension (including liver purification and detoxification techniques), or</li> <li>• Primary Acute Hepatocellular failure PATIENTS who are being considered for transplantation and require management of coagulopathy and / or portal hypertension (including liver purification and detoxification techniques).</li> </ul>
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**CRITICAL CARE LEVEL**

120, 130, 140, 180, 190, 200

The level of critical care provided during a Hospital Provider spell.

## ADULT CRITICAL CARE - DISCHARGE CHARACTERISTICS

### Description

To carry the discharge details of the first 9 Critical Care Periods for care provided using Adult Care facilities.

### Group Status

Required

### Additional Notes on Data Items

Data Item Name	Relevant CDS Types	Additional Notes
CRITICAL CARE DISCHARGE DATE	120, 130, 140, 180, 190, 200	The end date of a CRITICAL CARE PERIOD. This may be the date the PATIENT is discharged from the critical care unit, the date the PATIENT died or the date of declaration of brainstem death. This is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TIME TYPE is National Code 11 'End Date' for the CRITICAL CARE PERIOD.
CRITICAL CARE DISCHARGE TIME	120, 130, 140, 180, 190, 200	CRITICAL CARE DISCHARGE TIME is CRITICAL CARE PERIOD end time.
CRITICAL CARE DISCHARGE READY DATE	120, 130, 140, 180, 190, 200	The date on which the PATIENT has been declared clinically ready for discharge or transfer from the CRITICAL CARE PERIOD and a formal request has been made to the Hospital Bed management system (or appropriate staff with authority to admit at the intended destination) and the date and time of this status is recorded as such in the clinical record. CRITICAL CARE DISCHARGE READY DATE should not be completed if it is deemed the PATIENT has been declared clinically ready for discharge or transfer from the CRITICAL CARE PERIOD prematurely.  CRITICAL CARE DISCHARGE READY DATE and CRITICAL CARE DISCHARGE READY TIME are recorded to identify and quantify significant problems in discharging PATIENTS from critical care units.
CRITICAL CARE DISCHARGE READY TIME	120, 130, 140, 180, 190, 200	The time at which the PATIENT has been declared clinically ready for discharge or transfer from the CRITICAL CARE PERIOD and a formal request has been made to the Hospital Bed management system (or appropriate staff with authority to admit at the intended destination) and the date and time of this status is recorded as such in the clinical record. CRITICAL CARE DISCHARGE READY DATE and CRITICAL CARE DISCHARGE READY TIME are recorded to identify and quantify significant problems in discharging PATIENTS from critical care units.
CRITICAL CARE DISCHARGE STATUS	120, 130, 140, 180, 190, 200	The discharge status of a PATIENT who is discharged from a Ward Stay where they were receiving care as part of a CRITICAL CARE PERIOD and the discharge ends the CRITICAL CARE PERIOD.
CRITICAL CARE DISCHARGE DESTINATION	120, 130, 140, 180, 190, 200	The primary Organisation type that the PATIENT has been discharged to at the end of the CRITICAL CARE PERIOD.
CRITICAL CARE DISCHARGE LOCATION	120, 130, 140, 180, 190, 200	The principal LOCATION that the PATIENT is discharged to at the end of the CRITICAL CARE PERIOD.

## 4.36 Data Group: GP Registration

GP REGISTRATION		
<b>Description</b>		
To carry the Patient's General Medical Practitioner and the General Practice details.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
020, 120, 180, 130, 140, 160, 150, 190, 200		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
GENERAL MEDICAL PRACTITIONER (SPECIFIED)	020, 120, 180, 130, 140, 160, 150, 190, 200	GENERAL MEDICAL PRACTITIONER (SPECIFIED) is the GENERAL MEDICAL PRACTITIONER PPD CODE of the GENERAL MEDICAL PRACTITIONER specified by the PATIENT.
GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION)	020, 120, 180, 130, 140, 160, 150, 190, 200	GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION) is the ORGANISATION CODE of the GP Practice that the PATIENT is registered with.

## 4.37 Data Group: Referrer

REFERRER		
<b>Description</b>		
To carry the details of the Referrer.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
020, 120, 180, 130, 140, 190, 200		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
REFERRER CODE	020, 120, 180, 130, 140, 190, 200	REFERRER CODE is the code of the PERSON making the REFERRAL REQUEST.

<b>ORGANISATION IDENTIFIER (REFERRING ORGANISATION)</b>	020, 120, 180, 130, 140, 190, 200	ORGANISATION IDENTIFIER (REFERRING) ORGANISATION is the ORGANISATION IDENTIFIER of the Organisation from which the referral is made, such as a GP Practice, NHS Trust or NHS Foundation Trust.
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## 4.38 Data Group: Pregnancy - Activity Characteristics

PREGNANCY - ACTIVITY CHARACTERISTICS		
<b>Description</b>		
To carry the details of the Pregnancy.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
120, 140, 150, 160, 180, 200		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
NUMBER OF BABIES INDICATION CODE	120, 140, 150, 160, 180, 200	The number of REGISTRABLE BIRTHS (live or still born at a particular delivery).

## 4.39 Data Group: Antenatal Care - Activity Characteristics

ANTENATAL CARE - ACTIVITY CHARACTERISTICS		
<b>Description</b>		
To carry the details of the Antenatal Care.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
120, 140, 150, 160, 180, 200		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes

FIRST ANTENATAL ASSESSMENT DATE	120, 140, 150, 160, 180, 200	A First Antenatal Assessment Date is the date on which the pregnant woman was assessed and arrangements made for Antenatal care as part of the Maternity Episode.
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## 4.40 Data Group: Antenatal Care - Person Group (Responsible Clinician)

ANTENATAL CARE - PERSON GROUP (RESPONSIBLE CLINICIAN)		
<b>Description</b>		
To carry the details of the General Medical Practitioner responsible for the Antenatal Care.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
120, 140, 150, 160, 180, 200		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE)	120, 140, 150, 160, 180, 200	GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE) is the GENERAL MEDICAL PRACTITIONER PPD CODE for the GENERAL MEDICAL PRACTITIONER responsible for the PATIENT's antenatal care.
GENERAL MEDICAL PRACTITIONER PRACTICE (PATIENT ANTENATAL CARE)	120, 140, 150, 160, 180, 200	GENERAL MEDICAL PRACTITIONER PRACTICE (PATIENT ANTENATAL CARE) is the ORGANISATION CODE for the General Medical Practitioner Practice responsible for the PATIENT's antenatal care.

## 4.41 Data Group: Antenatal Care - Location Group - Delivery Place Intended

ANTENATAL CARE - LOCATION GROUP - DELIVERY PLACE INTENDED
<b>Description</b>
To carry the details of the Intended Delivery Location.
<b>Group Status</b>

Required		
<b>CDS Types</b>		
120, 140, 150, 160, 180, 200		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
ACTIVITY LOCATION TYPE CODE	120, 140, 150, 160, 180, 200	The type of LOCATION for an ACTIVITY: - where PATIENTS are seen - where SERVICES are provided or - from which requests for SERVICES are sent
DELIVERY PLACE CHANGE REASON CODE	120, 140, 150, 160, 180, 200	This is to classify the reasons for change if the place of Delivery is different from the place originally intended, either in the type of place or geographically.
DELIVERY PLACE TYPE CODE (INTENDED)	120, 140, 150, 160, 180, 200	The Delivery place type where the pregnant woman plans to have her baby.

## 4.42 Data Group: Labour/Delivery - Activity Characteristics

LABOUR/DELIVERY - ACTIVITY CHARACTERISTICS		
<b>Description</b>		
To carry the details of the Labour/Delivery.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
120, 140, 180, 200		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY CODE	120, 140, 180, 200	ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY CODE is derived from attribute ANAESTHETIC OR ANALGESIC CATEGORY and PERIOD ADMINISTERED which records whether anaesthetic was given during Labour/Delivery, and the type used.

ANAESTHETIC GIVEN POST LABOUR OR DELIVERY CODE	120, 140, 180, 200	ANAESTHETIC GIVEN POST LABOUR OR DELIVERY CODE is derived from attribute ANAESTHETIC OR ANALGESIC CATEGORY and PERIOD ADMINISTERED which records whether anaesthetic was given after Delivery, and the type used.
GESTATION LENGTH (LABOUR ONSET)	120, 140, 180, 200	This is the number of weeks completed gestation, based upon an average 40 week gestation, which may be derived from: a) estimated date of delivery calculated by Ultrasound Scan measurements according to the trimester of the scan b) estimated date of delivery measured from the first day of last menstrual period (LMP) c) clinical assessment (in the absence of a or b) - antenatally for Maternity, postnatally for Neonatal.  GESTATION LENGTH (LABOUR ONSET) records a period of between 10 to 49 weeks in completed weeks at the onset of labour.
LABOUR OR DELIVERY ONSET METHOD CODE	120, 140, 180, 200	The method by which the process of Labour began, or Delivery by caesarean section occurred.
DELIVERY TIMESTAMP	120, 140, 180, 200	DELIVERY TIMESTAMP is the date, time and time zone of delivery for each REGISTRABLE BIRTH.

## 4.43 Data Group: Birth / Delivery Occurrence - Activity Characteristics

BIRTH OCCURRENCE - ACTIVITY CHARACTERISTICS		
DELIVERY OCCURRENCE - ACTIVITY CHARACTERISTICS		
<b>Description</b>		
To carry the details of the Birth or Delivery of the Baby.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
120, 140, 150, 160, 180, 200		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
BIRTH ORDER	120, 140, 150, 160, 180, 200	BIRTH ORDER records the sequence in which the baby was born, with 1 indicating the first or only birth in the sequence (i.e. singleton), 2 indicating the second birth in the sequence, 3 indicating the third, and so on.

<b>DELIVERY METHOD CODE</b>	120, 140, 150, 160, 180, 200	The method by which a baby is delivered, which is a REGISTRABLE BIRTH.
<b>GESTATION LENGTH (ASSESSMENT)</b>	120, 140, 150, 160, 180, 200	GESTATION LENGTH (ASSESSMENT) records a period of between 10 to 49 weeks in completed weeks that is a clinical assessment of GESTATION LENGTH IN WEEKS.
<b>RESUSCITATION METHOD CODE</b>	120, 140, 150, 160, 180, 200	RESUSCITATION METHOD CODE records the means by which regular respiration of the baby was attempted and is not recorded for stillbirths.
<b>STATUS OF PERSON CONDUCTING DELIVERY CODE</b>	120, 140, 150, 160, 180, 200	This is normally the status of the individual who delivers the baby.

#### 4.44 Data Group: Delivery Occurrence – Overseas Visitor Charging Category At CDS Activity Date

<b>DELIVERY OCCURRENCE - OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE</b>		
<b>Description</b>		
To carry the details of the Overseas Visitor Charging Category of the Mother.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
120, 180		
<b>Additional Notes on Data Items</b>		
<b>Data Item Name</b>	<b>Relevant CDS Types</b>	<b>Additional Notes</b>
OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE	120, 180	The charging category relating to an OVERSEAS VISITOR STATUS.

#### 4.45 Data Group: Location Group - Delivery Place Actual

<b>BIRTH OCCURRENCE - LOCATION GROUP - DELIVERY PLACE ACTUAL</b>
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DELIVERY OCCURRENCE - LOCATION GROUP - DELIVERY PLACE ACTUAL		
<b>Description</b>		
To carry the details of the Actual Delivery Location.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
120, 140, 180, 200		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
ACTIVITY LOCATION TYPE CODE	120, 140, 180, 200	The type of LOCATION for an ACTIVITY: - where PATIENTS are seen - where SERVICES are provided or - from which requests for SERVICES are sent
DELIVERY PLACE TYPE CODE (ACTUAL)	120, 140, 180, 200	The actual place type of Delivery.

## 4.46 Data Group: Care Episode - eMED3 Fit Note

CARE EPISODE - EMED3 FIT NOTE		
<b>Description</b>		
To carry the details of the eMED3 Fit Note issued.		
This group is designed to allow information about fit notes issued in secondary care to be submitted to CDS, in support of the forthcoming DAPB4011 eMED3 Fit Notes in Secondary Care information standard.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
020, 130, 190		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
EMED3 FIT NOTE ASSESSMENT DATE	020, 130, 190	An eMED3 Fit Note Assessment Date is the date on which a PATIENT was assessed as requiring an eMED3 Fit Note.

EMED3 FIT NOTE CONDITION (SNOMED CT EXPRESSION)	020, 130, 190	EMED3 FIT NOTE CONDITION (SNOMED CT EXPRESSION) is a structured combination of one or more SNOMED CT® concept identifiers which are used to describe the reason that a CARE PROFESSIONAL issued an eMED3 Fit Note for a PATIENT.
EMED3 FIT NOTE DIAGNOSIS (ICD)	020, 130, 190	EMED3 FIT NOTE DIAGNOSIS (ICD) is the International Classification of Diseases (ICD) code used to describe the reason that a CARE PROFESSIONAL issued an eMED3 Fit Note for a PATIENT.
EMED3 FIT NOTE START DATE	020, 130, 190	EMED3 FIT NOTE START DATE is the date that the eMED3 Fit Note Applicable Period commenced.
EMED3 FIT NOTE END DATE	020, 130, 190	EMED3 FIT NOTE END DATE is the date that the eMED3 Fit Note Applicable Period ended.
EMED3 FIT NOTE DURATION	020, 130, 190	EMED3 FIT NOTE DURATION is the number of days duration of an eMED3 Fit Note Applicable Period.
EMED3 FIT NOTE RECORDED DATE	020, 130, 190	An eMED3 Fit Note Recorded Date is the date on which a record of an eMED3 Fit Note issued to a PATIENT was recorded on the Health Care Provider's ELECTRONIC HEALTH RECORD.
EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR	020, 130, 190	An indication of whether a follow up CARE CONTACT is required at the end of the eMED3 Fit Note Applicable Period.

## 4.47 Data Group: Care Episode - Length Of Stay Adjustment

CARE EPISODE - LENGTH OF STAY ADJUSTMENT		
<b>Description</b>		
To carry details of length of stay adjustments to the Finished General Care Professional Admitted Care Episode.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
130, 190		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes

LENGTH OF STAY ADJUSTMENT (REHABILITATION)	130, 190	<p>The total number of days within a Consultant Episode (Hospital Provider) that a discrete period of Rehabilitation occurred, which requires an adjustment to the total length of stay for Payment by Results purposes.</p> <p>The LENGTH OF STAY ADJUSTMENT should be calculated using the Payment by Results rules (i.e. count of midnights). The LENGTH OF STAY ADJUSTMENT REASON should also be recorded.</p> <p>Where several discrete periods of applicable activity occur within one Consultant Episode (Hospital Provider), the number of days should be totalled and reported in a single LENGTH OF STAY ADJUSTMENT. Where several discrete periods of applicable activity for the same LENGTH OF STAY ADJUSTMENT REASON occur within one Consultant Episode (Hospital Provider), the number of days under the same LENGTH OF STAY ADJUSTMENT REASON should be totalled and reported in a single LENGTH OF STAY ADJUSTMENT.</p>
LENGTH OF STAY ADJUSTMENT (SPECIALIST PALLIATIVE CARE)	130, 190	<p>The total number of days within a Consultant Episode (Hospital Provider) that a discrete period of Specialist Palliative Care occurred, which requires an adjustment to the total length of stay for Payment by Results purposes.</p> <p>The LENGTH OF STAY ADJUSTMENT should be calculated using the Payment by Results rules (i.e. count of midnights). The LENGTH OF STAY ADJUSTMENT REASON should also be recorded.</p> <p>Where several discrete periods of applicable activity occur within one Consultant Episode (Hospital Provider), the number of days should be totalled and reported in a single LENGTH OF STAY ADJUSTMENT. Where several discrete periods of applicable activity for the same LENGTH OF STAY ADJUSTMENT REASON occur within one Consultant Episode (Hospital Provider), the number of days under the same LENGTH OF STAY ADJUSTMENT REASON should be totalled and reported in a single LENGTH OF STAY ADJUSTMENT.</p>

## 4.48 Data Group: Care Attendance - Activity Characteristics

CARE ATTENDANCE - ACTIVITY CHARACTERISTICS
<b>Description</b>
To carry the details of the Attendance or Missed/Cancelled Appointment.
<b>Group Status</b>
Mandatory
<b>CDS Types</b>
020

Additional Notes on Data Items		
Data Item Name	Relevant CDS Types	Additional Notes
OUTPATIENT ATTENDANCE IDENTIFIER	020	OUTPATIENT ATTENDANCE IDENTIFIER is a unique identifier for each Care Professional Out-Patient Attendance.
ADMINISTRATIVE CATEGORY CODE	020	This is recorded for PATIENT ACTIVITY. The PATIENT's ADMINISTRATIVE CATEGORY CODE may change during an episode or spell. For example, the PATIENT may opt to change from NHS to private health care.
ATTENDANCE STATUS	020	Indicates whether an APPOINTMENT for a CARE CONTACT took place and if the APPOINTMENT did not take place it whether advanced warning was given.
FIRST ATTENDANCE CODE	020	An indication of whether a PATIENT is making a first attendance or contact; or a follow-up attendance or contact and whether the CONSULTATION MECHANISM national code was 'Face to face' or 'Telephone' or 'Telemedicine'.
OUT-PATIENT ATTENDANCE OUTCOME	020	<p>This records the outcome of an Out-Patient Attendance.</p> <p><b>Additional guidance:</b></p> <p>Where a patient already subject to a Personalised Out-Patient Follow Up pathway attends a subsequent appointment and is expected to remain on a Personalised Out-Patient Follow Up pathway, value '4 - PATIENT moved to a Personalised Out-Patient Follow Up Pathway' should be recorded.</p> <p>The APPOINTMENT BOOKED REASON data item, as well as the PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR AT CDS ACTIVITY DATE and PATIENT SUBJECT TO REMOTE MONITORING INDICATOR AT CDS ACTIVITY DATE indicator items, will allow analysts to determine whether the patient was already on a personalised out-patient follow up pathway when the outpatient appointment took place, and differentiate patients being moved to personalised out-patient follow up pathways from those who remain on one.</p> <p>Where patient who was not a subject to an active Personalised Out-Patient Follow Up pathway prior to the appointment is discharged but remains on a personalised out-patient follow up pathway, value '5 - PATIENT discharged to a Personalised Out-Patient Follow Up Pathway' should be used.</p> <p>If the patient is discharged without planned follow-up, value '1 - PATIENT discharged from the care of the CARE PROFESSIONAL without Personalised Out-Patient Follow Up' should be recorded.</p> <p>More information about personalised follow up is available from <a href="#">the NHS England and NHS Improvement Outpatient Transformation Programme website</a>.</p>

APPOINTMENT BOOKED REASON	020	<p>The reason that an Out-Patient Appointment was booked.</p> <p>For the Commissioning Data Sets, APPOINTMENT BOOKED REASON refers to the reason that the APPOINTMENT record carried in the Commissioning Data Set message was booked, and not any subsequent APPOINTMENTS made as a result of that Care Professional Out-Patient Attendance.</p>
APPOINTMENT DATE	020	<p>The date of an APPOINTMENT.</p> <p>In the case of a PATIENT attending an Out-Patient Clinic without prior notice or APPOINTMENT, the PATIENT will be given an Out-Patient Appointment.</p>
APPOINTMENT TIME	020	<p>The time, recorded using the 24 hour clock, advised to a PATIENT for when they can expect to see a relevant CARE PROFESSIONAL at an Out-Patient Clinic.</p>
EXPECTED DURATION OF APPOINTMENT	020	<p>EXPECTED DURATION OF APPOINTMENT is the expected duration in minutes of an APPOINTMENT when booked, prior to the attendance of the PATIENT.</p>
AGE AT CDS ACTIVITY DATE	020	<p>AGE AT CDS ACTIVITY DATE is derived as the number of completed years between the PERSON BIRTH DATE of the PATIENT and the CDS ACTIVITY DATE.</p>
OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE	020	<p>The charging category relating to an OVERSEAS VISITOR STATUS.</p>

EARLIEST REASONABLE OFFER DATE	020	<p>It is the date of the earliest of the Reasonable Offers made to a PATIENT for an APPOINTMENT or Elective Admission. It should only be included on the Commissioning Data Sets where the PATIENT has declined at least two Reasonable Offers, and a Patient Pause is to be applied to the length of wait calculation performed by the Secondary Uses Service.</p> <p><b>Patient Cancellations</b></p> <p>Where, for any reason, a PATIENT cancels or does not attend an APPOINTMENT or an OFFER OF ADMISSION the EARLIEST REASONABLE OFFER DATE for the rearranged APPOINTMENT or OFFER OF ADMISSION will be the EARLIEST REASONABLE OFFER DATE of the cancelled APPOINTMENT or OFFER OF ADMISSION.</p> <p><b>Provider Cancellations</b></p> <p>Where, for any reason, any Health Care Provider cancels and re-arranges an APPOINTMENT or an OFFER OF ADMISSION, the EARLIEST REASONABLE OFFER DATE for the re-arranged APPOINTMENT or OFFER OF ADMISSION will be the date of the earliest Reasonable Offer made following the cancellation.</p> <p><b>Patients who are unavailable</b></p> <p>Where a PATIENT makes themselves unavailable for a longer period of time, for example a PATIENT who is a teacher who wishes to delay their admission until the summer holidays, making a Reasonable Offer may be inappropriate.</p> <p>In these circumstances, so long as the Health Care Provider could have made at least two Reasonable Offers, the EARLIEST REASONABLE OFFER DATE will be the date of the earliest Reasonable Offer that the provider could have offered the PATIENT. This must be communicated to the PATIENT.</p>
EARLIEST CLINICALLY APPROPRIATE DATE	020	The earliest DATE that it was clinically appropriate for an ACTIVITY to take place.
LATEST CLINICALLY APPROPRIATE DATE	020	For the Commissioning Data Sets, LATEST CLINICALLY APPROPRIATE DATE is the latest date by which the PATIENT should next be reviewed for the purposes of follow up consultation, Clinical Investigation or further management, in order to maintain a reasonable margin of clinical safety, as judged by the responsible CARE PROFESSIONAL.
CONSULTATION MECHANISM	020	The communication mechanism used to relay information between the CARE PROFESSIONAL and the PERSON who is the subject of the consultation, during a CARE CONTACT.

CONSULTATION TYPE	020	The type of consultation between the CARE PROFESSIONAL and the PATIENT.
MULTI-PROFESSIONAL OR MULTI-DISCIPLINARY INDICATION CODE (NATIONAL TARIFF PAYMENT SYSTEM)	020	An indication of whether a PATIENT was seen by a single or multiple CARE PROFESSIONALS during an Clinic Attendance Consultant or Clinic Attendance Non-Consultant, recorded for the purposes of the National Tariff Payment System.
REHABILITATION ASSESSMENT TEAM TYPE	020	An indication of whether the CARE PROFESSIONAL TEAM undertaking a Rehabilitation Assessment, is specialised or non-specialised.
PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR AT CDS ACTIVITY DATE	020	An indicator to identify whether the patient is on a patient initiated follow-up pathway at the CDS Activity Date.
PATIENT SUBJECT TO REMOTE MONITORING INDICATOR AT CDS ACTIVITY DATE	020	An indicator to identify whether the patient is subject to remote monitoring at the CDS Activity Date.
PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY REVIEW DATE	020	The review date of a Personalised Out-Patient Follow Up Pathway.  For the CDS V6-3 Type 020 - Outpatient Commissioning Data Set, where a Personalised Out-Patient Follow Up Pathway Review Date is submitted, this should be the next review date after the APPOINTMENT DATE carried in the CDS V6-3 Type 020 - Outpatient Commissioning Data Set record.
PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE	020	The expiry date of a Personalised Out-Patient Follow Up Pathway.

## 4.49 Data Group: Activity Characteristics - Referral

ACTIVITY CHARACTERISTICS - REFERRAL		
<b>Description</b>		
To carry the details of the Referral.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
020		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
PRIORITY TYPE CODE	020	The priority of a SERVICE REQUEST.
SERVICE TYPE REQUESTED CODE	020	The terms of reference for the REFERRAL REQUEST.
SOURCE OF REFERRAL FOR OUT-PATIENTS	020	The source of referral of each Consultant Out-Patient Episode.

REFERRAL REQUEST RECEIVED DATE	020	<p>This is the date the REFERRAL REQUEST was received by the Health Care Provider. The waiting time for a first Out-Patient Appointment should be calculated from the date when the REFERRAL REQUEST is received.</p> <p>For electronic REFERRAL REQUESTS the REFERRAL REQUEST RECEIVED DATE is the date the REFERRAL REQUEST is received electronically by the Health Care Provider. For Choose and Book, the referral is received when the PATIENT's Unique Booking Reference Number (UBRN) is used to book the first outpatient appointment slot (i.e. converted).</p> <p>Where an electronic REFERRAL REQUEST made through Choose and Book is rejected by the chosen provider, the ORIGINAL REFERRAL REQUEST RECEIVED DATE should be used when the PATIENT is subsequently re-referred to another service, so that patients are not unfairly disadvantaged when their waiting time calculations are made.</p> <p>In the circumstance that a PATIENT calls the national Choose and Book Appointments Line and an APPOINTMENT SLOT is not available with the chosen Health Care Provider, the national Choose and Book Appointments Line will electronically forward the REFERRAL REQUEST details to the chosen Health Care Provider so the Health Care Provider can liaise directly with the PATIENT to arrange their Out-Patient Appointment. The REFERRAL REQUEST RECEIVED DATE will be the date that the Health Care Provider receives electronic notification from the national Choose and Book Appointments Line that the PATIENT has experienced slot unavailability. (Note that this is NOT the date that the Health Care Provider opens or actions the electronic notification).</p> <p>For written REFERRAL REQUESTS letters must be opened and date stamped on the day of receipt. It is this date that must be entered on any PAS or similar system, not the date on which the information is fed into the system if this is later than the date of receipt.</p> <p>If the REFERRAL REQUEST takes the form of a phone call followed by a letter, record the date when the letter arrives. If there is no following letter, the date of the verbal request should be recorded.</p>
DIRECT ACCESS REFERRAL INDICATOR	020	<p>An indicator to identify that the patient has been referred into a Direct Access Service for a diagnostic test only and that Outpatient Appointment is not part of wider activity relating to the referral.</p>
REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR	020	<p>An indication of whether a PATIENT was referred by First Contact Practitioner.</p>

SERVICE REQUEST IDENTIFIER	020	<p>The unique identifier for a SERVICE REQUEST.</p> <p>SERVICE REQUEST IDENTIFIER is an existing NHS Data Dictionary data item that has been added to support potential linkage with other data sets and identify activity elsewhere – for example, community inpatient data relating to the same service request (the Service Request Identifier is also used in the Community Services Data Set, as well as the Mental Health Services Data Set).</p> <p>This is effectively the referral identifier used to register a referral on your system and link records that relate to a unique hospital stay. This may well currently be held in the background of your system, i.e. not visible to users. This also works similarly to the PREGNANCY IDENTIFIER used in the Maternity Services Data Set (MSDS) to tie together activity relating to a single pregnancy.</p>
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## 4.50 Data Group: Care Referral - Missed Appointment Occurrence

CARE REFERRAL - MISSED APPOINTMENT OCCURRENCE		
<b>Description</b>		
To carry the details of a Missed Appointment.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
020		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
LAST PATIENT DID NOT ATTEND DATE	020	For the CDS V6-3 Type 020 - Outpatient Commissioning Data Set, the LAST PATIENT DID NOT ATTEND DATE is the last APPOINTMENT which the PATIENT failed to attend without advance warning, on or prior to the APPOINTMENT DATE carried in that CDS V6-3 Type 020 - Outpatient Commissioning Data Set record.
LAST PATIENT CANCELLED DATE	020	For the CDS V6-3 Type 020 - Outpatient Commissioning Data Set, the LAST PATIENT CANCELLED DATE is the last APPOINTMENT which the PATIENT cancelled, on or prior to the APPOINTMENT DATE carried in that CDS V6-3 Type 020 - Outpatient Commissioning Data Set record.

## 4.51 Data Group: Data Group: Care Episode - Length Of Stay Adjustment

CARE EPISODE - LENGTH OF STAY ADJUSTMENT		
<b>Description</b>		
To carry details of length of stay adjustments to the Finished General Care Professional Admitted Care Episode.		
<b>Group Status</b>		
Required		
<b>CDS Types</b>		
130, 190		
<b>Additional Notes on Data Items</b>		
Data Item Name	Relevant CDS Types	Additional Notes
DURATION OF ELECTIVE WAIT	130, 190	DURATION OF ELECTIVE WAIT is a derived item that records the waiting time in days from the ORIGINAL DECIDED TO ADMIT DATE to the admission date at the provider where the treatment actually takes place, ranging from 0 to 8887 days.  A waiting time of 0 (zero) days is only to be entered after careful scrutiny.
INTENDED MANAGEMENT CODE	130, 190	This is the intended pattern of Hospital Bed use for a PATIENT, decided when the decision is made to admit. This only applies to PATIENTS on the ELECTIVE ADMISSION LIST.
DECIDED TO ADMIT DATE	130, 190	The date a DECISION TO ADMIT was made.

EARLIEST REASONABLE OFFER DATE	130, 190	<p>It is the date of the earliest of the Reasonable Offers made to a PATIENT for an APPOINTMENT or Elective Admission. It should only be included on the Commissioning Data Sets where the PATIENT has declined at least two Reasonable Offers, and a Patient Pause is to be applied to the length of wait calculation performed by the Secondary Uses Service.</p> <p>Patient Cancellations</p> <p>Where, for any reason, a PATIENT cancels or does not attend an APPOINTMENT or an OFFER OF ADMISSION the EARLIEST REASONABLE OFFER DATE for the rearranged APPOINTMENT or OFFER OF ADMISSION will be the EARLIEST REASONABLE OFFER DATE of the cancelled APPOINTMENT or OFFER OF ADMISSION.</p> <p>Provider Cancellations</p> <p>Where, for any reason, any Health Care Provider cancels and re-arranges an APPOINTMENT or an OFFER OF ADMISSION, the EARLIEST REASONABLE OFFER DATE for the re-arranged APPOINTMENT or OFFER OF ADMISSION will be the date of the earliest Reasonable Offer made following the cancellation.</p> <p>Patients who are unavailable</p> <p>Where a PATIENT makes themselves unavailable for a longer period of time, for example a PATIENT who is a teacher who wishes to delay their admission until the summer holidays, making a Reasonable Offer may be inappropriate.</p> <p>In these circumstances, so long as the Health Care Provider could have made at least two Reasonable Offers, the EARLIEST REASONABLE OFFER DATE will be the date of the earliest Reasonable Offer that the provider could have offered the PATIENT. This must be communicated to the PATIENT.</p>
EARLIEST CLINICALLY APPROPRIATE DATE	130, 190	The earliest DATE that it was clinically appropriate for an ACTIVITY to take place.
LATEST CLINICALLY APPROPRIATE DATE	130, 190	For the Commissioning Data Sets, LATEST CLINICALLY APPROPRIATE DATE is the latest date by which the PATIENT should next be reviewed for the purposes of follow up consultation, Clinical Investigation or further management, in order to maintain a reasonable margin of clinical safety, as judged by the responsible CARE PROFESSIONAL.