# NHS Data Model and Dictionary

NHS Digital

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| **Type:** | Change Request |
| **Reference:** | 1764 |
| **Version No:** | 1.0 |
| **Subject:** | Commissioning Data Sets Version 6-3 |
| **Effective Date:** | 1 April 2022 |
| **Reason for Change:** | New version of the Commissioning Data Sets |
| **Publication Date:** | 14 June 2021 |

**Background:**

A new version of the Commissioning Data Sets Information Standard DAPB0092, version 6-3, has been introduced. This version will be available alongside the existing Commissioning Data Set version 6-2 and does not immediately replace it.

The Commissioning Data Sets version 6-3 changes are designed to update the Commissioning Data Sets 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 Commissioning Data Sets version 6-2 was published in 2012.

Commissioning Data Sets version 6-3 introduces additional data items to allow submission of clinical terminology expressions and associated Timestamps (including Timezone Offset), or an optional reason for the absence of expected data where appropriate, for the following SNOMED CT areas:

- Social and Personal Circumstances
- Diagnoses
- Comorbidities
- Procedures
- Observations
- Findings
- Assessment Tools

The data structures allowing Read/CTV3 terms to be submitted have been removed, as these Terminologies have now been deprecated and replaced by SNOMED CT.

Also included are data items supporting new requirements from NHS England and NHS Improvement relating to the Out-Patient Transformation Programme:

- Personalised Out-Patient Follow Up Pathways
- Patient Initiated Out-Patient Follow Up Pathways
- Remote Monitoring Triggered Out-Patient Attendances
- First Contact Practitioner referrals
- Support for the recording of different Consultation Mechanisms
- Latest Clinically Appropriate Date (supporting attendances where patients must be seen within a certain time frame)

Additional data groups and items have also been introduced or updated to support the following:

- Recording of information relating to provision of eMED3 Fit Notes to the patient
- Updates to Organisation and Organisation Site Identifiers, including within the CDS Headers, to align with DCB0090: Health and Social Care Organisation Reference Data
- Extended format/length by replacement of some data items (eg replacement of Local Patient Identifier with Local Patient Identifier (Extended), replacement of Attendance Identifier with Outpatient Attendance Identifier)
- Replacement of Person Gender Code Current with Person Stated Gender Code
- Placeholder for the introduction of Ethnic Category 2021 when approved

- Submission of multiple Care Professionals involved in the care of the patient, including the ability to submit actual Nursing/Midwifery/Allied Health Professional registration codes, to replace the use of 'dummy' codes for Nurse, Midwife and Allied Health Professionals
- Removal of validation in the CDS-XML schema for fields which are likely to change outside of Commissioning Data Set releases (Care Professional Main Specialty Code, Activity Treatment Function Code, Mental Health Act Legal Status Classification Code, Critical Care Activity Code, Activity Location Type Code)
- Introduction of Overseas Visitor Charging Category data items to support DCB3017 Overseas Visitor Charging Category
- Update to Service Agreement group to allow submission of multiple associated Commissioners and Specialised Service Code
- Removal of some data items which are unused or are now better represented with other data items
- Separate Last Patient Did Not Attend and Last Patient Cancelled Date, with better definitional guidance
- Separate new data group for the recording of Home Leave, and associated changes to the Ward Stays data groups
- Cosmetic changes to the Unverified Identity Structure data group, to better reflect the requirements of the CDS-XML schema in the NHS Data Model and Dictionary data set view
- Additional data group within the Adult Critical Care structure, allowing submission of all details of organ systems supported and critical care levels for each day of critical care
- Changes to the Commissioning Data Set header types, to reflect current Secondary Uses Service processing of data recipients (replacing CDS Prime and Copy Recipient fields)
- Updates to enable better data linkage with the forthcoming Ambulance Data Set, including the addition of Care Contact Identifier (Ambulance Service)
- Updates to support the NHS @Home programme

Also note that the following CDS Types which are no longer required by NHS Digital or supported by the Secondary Uses Service, have been retired from Commissioning Data Sets version 6-3:

- Elective Admission List CDS types 030, 040, 050, 060, 070, 080, 090, 100, 110
- Future Out-Patients CDS type 021
- Psychiatric Census CDS Type 170

The Commissioning Data Set XML Schema version 6-3 (CDS-XML V6-3) will be made available on the Technology Reference Data Update Distribution (TRUD) system at a later date.

This Change Request adds the Commissioning Data Sets version 6-3 and supporting definitions to the NHS Data Model and Dictionary to support the Information Standard.

A short demonstration is available which describes "How to Read an NHS Data Model and Dictionary Change Request", in an easy to understand screen capture including a voice over and readable captions. This demonstration can be viewed at: https://datadictionary.nhs.uk/elearning/Change_Request/index.html.

Note: if the web page does not open, please copy the link and paste into the web browser. A guide to how to use the demonstration can be found at: Demonstrations.

**Summary of changes:**

| **Data Set** | |
|---|---|
| CDS V6-3 TYPE 001 - CDS INTERCHANGE HEADER | New Data Set |
| CDS V6-3 TYPE 002 - CDS INTERCHANGE TRAILER | New Data Set |
| CDS V6-3 TYPE 003 - CDS MESSAGE HEADER | New Data Set |
| CDS V6-3 TYPE 004 - CDS MESSAGE TRAILER | New Data Set |
| CDS V6-3 TYPE 005B - CDS TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL | New Data Set |
| CDS V6-3 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL | New Data Set |
| CDS V6-3 TYPE 020 - OUTPATIENT CDS | New Data Set |
| CDS V6-3 TYPE 120 - ADMITTED PATIENT CARE - FINISHED BIRTH EPISODE CDS | New Data Set |
| | New Data Set |

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|---|---|
| CDS V6-3 TYPE 130 - ADMITTED PATIENT CARE - FINISHED GENERAL EPISODE CDS | |
| CDS V6-3 TYPE 140 - ADMITTED PATIENT CARE - FINISHED DELIVERY EPISODE CDS | New Data Set |
| CDS V6-3 TYPE 150 - ADMITTED PATIENT CARE - OTHER BIRTH EVENT CDS | New Data Set |
| CDS V6-3 TYPE 160 - ADMITTED PATIENT CARE - OTHER DELIVERY EVENT CDS | New Data Set |
| CDS V6-3 TYPE 180 - ADMITTED PATIENT CARE - UNFINISHED BIRTH EPISODE CDS | New Data Set |
| CDS V6-3 TYPE 190 - ADMITTED PATIENT CARE - UNFINISHED GENERAL EPISODE CDS | New Data Set |
| CDS V6-3 TYPE 200 - ADMITTED PATIENT CARE - UNFINISHED DELIVERY EPISODE CDS | New Data Set |

**Supporting Information**

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|---|---|
| ALLIED HEALTH PROFESSIONAL REFERRAL TO TREATMENT MEASUREMENT | Changed Description |
| CARE PROFESSIONAL ADMITTED CARE EPISODE | Changed Description |
| CARE PROFESSIONAL OUT-PATIENT ATTENDANCE | New Supporting Information |
| CARE PROFESSIONAL OUT-PATIENT EPISODE | New Supporting Information |
| CDS TYPE | Changed Description |
| CDS V6-3 TYPE 001 - CDS INTERCHANGE HEADER OVERVIEW | New Supporting Information |
| CDS V6-3 TYPE 002 - CDS INTERCHANGE TRAILER OVERVIEW | New Supporting Information |
| CDS V6-3 TYPE 003 - CDS MESSAGE HEADER OVERVIEW | New Supporting Information |
| CDS V6-3 TYPE 004 - CDS MESSAGE TRAILER OVERVIEW | New Supporting Information |
| CDS V6-3 TYPE 005B - CDS TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL OVERVIEW | New Supporting Information |
| CDS V6-3 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL OVERVIEW | New Supporting Information |
| CDS V6-3 TYPE 020 - OUTPATIENT CDS OVERVIEW | New Supporting Information |
| CDS V6-3 TYPE 120 - ADMITTED PATIENT CARE - FINISHED BIRTH EPISODE CDS OVERVIEW | New Supporting Information |
| CDS V6-3 TYPE 130 - ADMITTED PATIENT CARE - FINISHED GENERAL EPISODE CDS OVERVIEW | New Supporting Information |
| CDS V6-3 TYPE 140 - ADMITTED PATIENT CARE - FINISHED DELIVERY EPISODE CDS OVERVIEW | New Supporting Information |
| CDS V6-3 TYPE 150 - ADMITTED PATIENT CARE - OTHER BIRTH EVENT CDS OVERVIEW | New Supporting Information |
| CDS V6-3 TYPE 160 - ADMITTED PATIENT CARE - OTHER DELIVERY EVENT CDS OVERVIEW | New Supporting Information |
| CDS V6-3 TYPE 180 - ADMITTED PATIENT CARE - UNFINISHED BIRTH EPISODE CDS OVERVIEW | New Supporting Information |
| CDS V6-3 TYPE 190 - ADMITTED PATIENT CARE - UNFINISHED GENERAL EPISODE CDS OVERVIEW | New Supporting Information |
| CDS V6-3 TYPE 200 - ADMITTED PATIENT CARE - UNFINISHED DELIVERY EPISODE CDS OVERVIEW | New Supporting Information |
| CDS VERSION 6-3 MENU | New Supporting Information |
| COMMISSIONING DATA SET ADDRESSING GRID | Changed Description |
| COMMISSIONING DATA SET BUSINESS RULES | Changed Dataset, Description |
| COMMISSIONING DATA SET MANDATED DATA FLOWS | Changed Description |
| COMMISSIONING DATA SET NOTATION | Changed Dataset, Description |
| COMMISSIONING DATA SETS INTRODUCTION | Changed Description |
| COMMISSIONING DATA SETS MENU | Changed Description |

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|---|---|
| COMMISSIONING DATA SETS OVERVIEW | Changed Description |
| COMMISSIONING DATA SET SUBMISSION PROTOCOL | Changed Description |
| COMMISSIONING DATA SET VERSION 6-3 TYPE LIST | New Supporting Information |
| COMMISSIONING DATA SET VERSIONS | Changed Description |
| COMMISSIONING DATA SET XML SCHEMA DESIGN | Changed Description |
| COMMISSIONING DATA SET XML SCHEMA DOCUMENTATION | Changed Description |
| COMMISSIONING DATA SET XML SCHEMA OVERVIEW | Changed Description |
| COMMISSIONING DATA SET XML SCHEMA VERSION NUMBERING | Changed Description |
| EMED3 FIT NOTE | New Supporting Information |
| EMED3 FIT NOTE APPLICABLE PERIOD | New Supporting Information |
| EMED3 FIT NOTE ASSESSMENT DATE | New Supporting Information |
| EMED3 FIT NOTE RECORDED DATE | New Supporting Information |
| FAST HEALTHCARE INTEROPERABILITY RESOURCES | New Supporting Information |
| FIRST CONTACT PRACTITIONER | New Supporting Information |
| LAST PATIENT CANCELLED DATE | New Supporting Information |
| LAST PATIENT DID NOT ATTEND DATE | New Supporting Information |
| MAIN SPECIALTY AND TREATMENT FUNCTION CODES TABLE | Changed Description |
| NHS ALLIED HEALTH PROFESSIONAL SERVICE (REFERRAL TO TREATMENT MEASUREMENT) | Changed Description |
| NHS AT HOME SERVICE | New Supporting Information |
| PATIENT INITIATED OUT-PATIENT FOLLOW UP APPOINTMENT | New Supporting Information |
| PATIENT INITIATED OUT-PATIENT FOLLOW-UP PATHWAY | New Supporting Information |
| PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY | New Supporting Information |
| PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE | New Supporting Information |
| PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY REVIEW DATE | New Supporting Information |
| REFERRAL TO TREATMENT CLOCK STOP ADMINISTRATIVE EVENT | Changed Description |
| REMOTE MONITORING | New Supporting Information |
| REMOTE MONITORING TRIGGERED OUT-PATIENT FOLLOW UP APPOINTMENT | New Supporting Information |
| SECURITY ISSUES AND PATIENT CONFIDENTIALITY | Changed Description |
| SUPPORTING DEFINITIONS MENU | Changed Description |
| TIMED OUT-PATIENT FOLLOW UP APPOINTMENT | New Supporting Information |

**Class Definitions**

| | |
|---|---|
| ACTIVITY GROUP | Changed Attributes |
| ALLIED HEALTH PROFESSIONAL | New Class |
| APPOINTMENT | Changed Attributes |
| CARE PROFESSIONAL TEAM | Changed Attributes |
| CLINICAL INTERVENTION | Changed Attributes |
| CODED CLINICAL ENTRY | Changed Relationships, Attributes, Description |
| NHS SERVICE AGREEMENT | Changed Attributes |
| NHS SERVICE AGREEMENT LINE | Changed Attributes |
| PATIENT PATHWAY | Changed Attributes |
| PERSON PROPERTY ASSIGNMENT PERIOD | Changed Attributes |
| SERVICE PROVIDED UNDER AGREEMENT | Changed Attributes |
| SERVICE REQUEST | Changed Attributes |
| WARD OPERATIONAL PLAN | Changed Attributes, Description |

**Attribute Definitions**

| | |
|---|---|
| ACTIVITY COUNT | Changed Dataset |
| ACTIVITY DATE | Changed Dataset |

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|---|---|
| ACTIVITY DATE TYPE | Changed Description |
| ACTIVITY DURATION | Changed Dataset |
| ACTIVITY GROUP TYPE | Changed Description |
| ACTIVITY IDENTIFIER | Changed Dataset |
| ACTIVITY LOCATION TYPE CODE | Changed Dataset, Description |
| ACTIVITY TIME | Changed Dataset |
| ACTUAL DELIVERY PLACE | Changed Dataset |
| ADDRESS | Changed Dataset |
| ADMINISTRATIVE CATEGORY CODE | Changed Dataset |
| ADMISSION SOURCE | Changed Dataset |
| AGE GROUP INTENDED | Changed Description |
| AMBULANCE CALL IDENTIFIER | Changed Dataset |
| ANAESTHETIC OR ANALGESIC CATEGORY | Changed Dataset |
| APPOINTMENT BOOKED REASON | New Attribute |
| APPOINTMENT DATE | Changed Dataset |
| APPOINTMENT DATE OFFERED | Changed Dataset |
| APPOINTMENT TIME | Changed Dataset |
| ATTENDED OR DID NOT ATTEND | Changed Dataset |
| BIRTH ORDER | Changed Dataset |
| CARE CONTACT TYPE | Changed Description |
| CARE PROFESSIONAL IDENTIFIER | Changed Dataset |
| CARE PROFESSIONAL TYPE | Changed Description |
| CARER SUPPORT INDICATOR | Changed Dataset |
| CDS BULK REPLACEMENT GROUP CODE | Changed Dataset, Description |
| CDS INTERCHANGE APPLICATION REFERENCE | Changed Dataset |
| CDS INTERCHANGE CONTROL COUNT | Changed Dataset |
| CDS INTERCHANGE CONTROL REFERENCE | Changed Dataset |
| CDS INTERCHANGE RECEIVER IDENTITY | Changed Dataset |
| CDS INTERCHANGE SENDER IDENTITY | Changed Dataset |
| CDS INTERCHANGE TEST INDICATOR | Changed Dataset |
| CDS MESSAGE REFERENCE | Changed Dataset |
| CDS MESSAGE TYPE | Changed Dataset |
| CDS MESSAGE VERSION NUMBER | Changed Dataset, Description |
| CDS PROTOCOL IDENTIFIER CODE | Changed Dataset |
| CDS TYPE CODE | Changed Dataset, Description |
| CDS UPDATE TYPE | Changed Dataset, Description |
| CLINICAL CARE INTENSITY | Changed Description |
| CLINICAL CLASSIFICATION CODE | Changed Dataset |
| CLINICAL INTERVENTION TYPE | Changed Description |
| CLINICAL INVESTIGATION RESULT VALUE | Changed Dataset |
| CLINICAL TERMINOLOGY CODE | Changed Dataset |
| CLINIC OR FACILITY CODE | Changed Dataset |
| CODED CLINICAL ENTRY SEQUENCE NUMBER | Changed Dataset |
| COMMISSIONER REFERENCE IDENTIFIER | New Attribute |
| COMMISSIONER REFERENCE NUMBER | Changed Description |
| CONSULTATION MECHANISM | Changed Dataset |
| CONSULTATION TYPE | Changed Dataset |
| CRITICAL CARE ACTIVITY CODE | |

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|---|---|
| | Changed Dataset, Description |
| CRITICAL CARE ADMISSION SOURCE | Changed Dataset |
| CRITICAL CARE ADMISSION TYPE | Changed Dataset |
| CRITICAL CARE DISCHARGE DESTINATION | Changed Dataset |
| CRITICAL CARE DISCHARGE LOCATION | Changed Dataset |
| CRITICAL CARE DISCHARGE READY DATE | Changed Dataset |
| CRITICAL CARE DISCHARGE READY TIME | Changed Dataset |
| CRITICAL CARE DISCHARGE STATUS | Changed Dataset |
| CRITICAL CARE LEVEL | Changed Dataset |
| CRITICAL CARE SOURCE LOCATION | Changed Dataset |
| CRITICAL CARE UNIT FUNCTION | Changed Dataset, Description |
| DATA ABSENT REASON | New Attribute |
| DECIDED TO ADMIT DATE | Changed Dataset |
| DELIVERY METHOD | Changed Dataset |
| DELIVERY PLACE CHANGE REASON | Changed Dataset |
| DESTINATION OF DISCHARGE | Changed Dataset |
| DIAGNOSIS SCHEME IN USE | Changed Dataset |
| DIRECT ACCESS REFERRAL INDICATOR | Changed Dataset |
| DISCHARGED TO NHS AT HOME SERVICE INDICATOR | New Attribute |
| EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR | New Attribute |
| ETHNIC CATEGORY 2021 | Changed Dataset |
| ETHNIC CATEGORY CODE 2001 | Changed Dataset |
| EVENT DATE | Changed Dataset |
| EVENT TIME | Changed Dataset |
| FIRST ATTENDANCE | Changed Dataset |
| FIRST REGULAR DAY OR NIGHT ADMISSION | Changed Dataset |
| GENERAL MEDICAL PRACTITIONER PPD CODE | Changed Dataset |
| GESTATION LENGTH IN WEEKS | Changed Dataset |
| INTENDED DELIVERY PLACE | Changed Dataset |
| INTENDED MANAGEMENT | Changed Dataset |
| LABOUR OR DELIVERY ONSET METHOD | Changed Dataset |
| LAST EPISODE IN SPELL INDICATOR CODE | Changed Dataset |
| LENGTH OF STAY ADJUSTMENT | Changed Dataset |
| LIVE OR STILL BIRTH | Changed Dataset |
| LOCAL PATIENT IDENTIFIER | Changed Dataset |
| LOCAL SUB-SPECIALTY CODE | Changed Dataset |
| MAIN SPECIALTY CODE | Changed Dataset |
| MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE | Changed Dataset |
| METHOD OF ADMISSION | Changed Dataset |
| METHOD OF DISCHARGE | Changed Dataset |
| MULTI-PROFESSIONAL OR MULTI-DISCIPLINARY INDICATION CODE | Changed Dataset |
| NEONATAL LEVEL OF CARE | Changed Dataset |
| NHS NUMBER | Changed Dataset |
| NHS NUMBER STATUS INDICATOR CODE | Changed Dataset |
| NHS SERVICE AGREEMENT IDENTIFIER | New Attribute |
| NHS SERVICE AGREEMENT LINE IDENTIFIER | New Attribute |
| NHS SERVICE AGREEMENT LINE NUMBER | Changed Description |
| NHS SERVICE AGREEMENT NUMBER | Changed Description |
| NUMBER OF BABIES INDICATION CODE | Changed Dataset |
| OBSERVATION VALUE | Changed Dataset |

| | |
|---|---|
| OFFERED FOR ADMISSION DATE | Changed Dataset |
| ORGANISATION CODE | Changed Dataset |
| ORGANISATION IDENTIFIER | Changed Dataset |
| ORGANISATION SITE IDENTIFIER | Changed Dataset |
| ORGAN SUPPORT MAXIMUM | Changed Dataset |
| ORGAN SYSTEM SUPPORTED | Changed Dataset |
| OUT-PATIENT ATTENDANCE OUTCOME | New Attribute |
| OVERSEAS VISITOR CHARGING CATEGORY | Changed Dataset |
| PATIENT CLASSIFICATION | Changed Dataset |
| PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR | New Attribute |
| PATIENT PATHWAY IDENTIFIER | Changed Dataset |
| PATIENT SUBJECT TO REMOTE MONITORING INDICATOR | New Attribute |
| PERSON AGE | Changed Dataset |
| PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE | New Attribute |
| PERSON BIRTH DATE | Changed Dataset |
| PERSON BIRTH TIME | Changed Dataset |
| PERSON MARITAL STATUS | Changed Dataset |
| PERSON NAME WORD TEXT | Changed Dataset |
| PERSON PHENOTYPIC SEX CLASSIFICATION | Changed Dataset |
| PERSON PROPERTY ASSIGNMENT PERIOD DURATION | New Attribute |
| PERSON PROPERTY ASSIGNMENT PERIOD TYPE | Changed Description |
| PERSON PROPERTY EFFECTIVE END DATE | Changed Dataset |
| PERSON PROPERTY EFFECTIVE START DATE | Changed Dataset |
| PERSON PROPERTY OBSERVED DATE | Changed Dataset |
| PERSON PROPERTY OBSERVED TIME | Changed Dataset |
| PERSON PROPERTY RECORDED DATE | Changed Dataset |
| PERSON PROPERTY RECORDED TIME | Changed Dataset |
| PERSON SCORE | Changed Dataset |
| PERSON STATED GENDER CODE | Changed Dataset |
| PLANNED ACTIVITY DATE | Changed Dataset |
| PLANNED ACTIVITY DATE TYPE | Changed Description |
| POSTCODE | Changed Dataset |
| PRESENT ON ADMISSION INDICATOR | Changed Dataset, Description |
| PRIORITY TYPE | Changed Dataset |
| PROCEDURE SCHEME IN USE | Changed Dataset |
| PROFESSIONAL REGISTRATION BODY CODE | Changed Dataset |
| PROFESSIONAL REGISTRATION ENTRY IDENTIFIER | Changed Dataset |
| PROVIDER REFERENCE IDENTIFIER | New Attribute |
| PROVIDER REFERENCE NUMBER | Changed Description |
| PSYCHIATRIC PATIENT STATUS | Changed Dataset |
| RECORD IDENTIFIER | Changed Dataset |
| REFERRAL REQUEST RECEIVED DATE | Changed Dataset |
| REFERRAL TO TREATMENT PERIOD END DATE | Changed Dataset |
| REFERRAL TO TREATMENT PERIOD START DATE | Changed Dataset |
| REFERRAL TO TREATMENT PERIOD STATUS | Changed Dataset |
| REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR | New Attribute |
| REHABILITATION ASSESSMENT TEAM TYPE | Changed Dataset |
| RESPONSIBLE CARE PROFESSIONAL INDICATOR | New Attribute |
| RESUSCITATION METHOD CODE | Changed Dataset |
| SERVICE REQUEST IDENTIFIER | Changed Dataset |

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|---|---|
| SERVICE TYPE REQUESTED | Changed Dataset |
| SEX OF PATIENTS | Changed Description |
| SOURCE OF REFERRAL FOR OUT-PATIENTS | Changed Dataset |
| SPECIALISED SERVICE CODE | Changed Dataset |
| STATUS OF PERSON CONDUCTING DELIVERY | Changed Dataset |
| TREATMENT FUNCTION CODE | Changed Dataset |
| UCUM UNIT OF MEASUREMENT | Changed Dataset |
| UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) | Changed Dataset |
| UNIT BED CONFIGURATION | Changed Dataset |
| WAITING TIME MEASUREMENT TYPE | Changed Dataset |
| WARD CODE | Changed Dataset |
| WARD DAY PERIOD AVAILABILITY | Changed Description |
| WARD INTENDED AGE GROUP | New Attribute |
| WARD INTENDED CLINICAL CARE INTENSITY | New Attribute |
| WARD INTENDED DAY PERIOD AVAILABILITY | New Attribute |
| WARD INTENDED NIGHT PERIOD AVAILABILITY | New Attribute |
| WARD INTENDED SEX OF PATIENTS | New Attribute |
| WARD NIGHT PERIOD AVAILABILITY | Changed Description |
| WARD SECURITY LEVEL | Changed Dataset |
| WITHHELD IDENTITY REASON | Changed Dataset |

**Data Elements**

| | |
|---|---|
| ACTIVITY DATE (CRITICAL CARE) | Changed Dataset |
| ACTIVITY LOCATION TYPE CODE | Changed Dataset |
| ACTIVITY TREATMENT FUNCTION CODE | Changed Dataset |
| ADMINISTRATIVE CATEGORY CODE | Changed Dataset |
| ADMINISTRATIVE CATEGORY CODE (ON ADMISSION) | Changed Dataset |
| ADMISSION SOURCE (HOSPITAL PROVIDER SPELL) | Changed Dataset |
| ADVANCED CARDIOVASCULAR SUPPORT DAYS | Changed Dataset |
| ADVANCED RESPIRATORY SUPPORT DAYS | Changed Dataset |
| AGE AT CDS ACTIVITY DATE | Changed Dataset |
| AGE ON ADMISSION | Changed Dataset |
| AMBULANCE CALL IDENTIFIER | Changed Dataset |
| ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY CODE | Changed Dataset, Description |
| ANAESTHETIC GIVEN POST LABOUR OR DELIVERY CODE | Changed Dataset, Description |
| APPOINTMENT BOOKED REASON | New Data Element |
| APPOINTMENT DATE | Changed Dataset, Description |
| APPOINTMENT TIME | Changed Dataset |
| ASSESSMENT TOOL (SNOMED CT EXPRESSION) | Changed Dataset |
| ASSESSMENT TOOL COMPLETION TIMESTAMP | Changed Dataset |
| ATTENDANCE STATUS | Changed Dataset, Description |
| BASIC CARDIOVASCULAR SUPPORT DAYS | Changed Dataset |
| BASIC RESPIRATORY SUPPORT DAYS | Changed Dataset |
| BIRTH ORDER | Changed Dataset |
| BIRTH WEIGHT | Changed Dataset |
| CARE CONTACT IDENTIFIER (AMBULANCE SERVICE) | Changed Dataset |
| CARE PROFESSIONAL MAIN SPECIALTY CODE | Changed Dataset |
| CARER SUPPORT INDICATOR | Changed Dataset |
| CDS ACTIVITY DATE | |

| | Changed Dataset, Description |
|---|---|
| CDS APPLICABLE DATE | Changed Dataset |
| CDS APPLICABLE TIME | Changed Dataset |
| CDS BULK REPLACEMENT GROUP CODE | Changed Dataset, Description |
| CDS EXTRACT DATE | Changed Dataset |
| CDS EXTRACT TIME | Changed Dataset |
| CDS INTERCHANGE APPLICATION REFERENCE | Changed Dataset |
| CDS INTERCHANGE CONTROL COUNT | Changed Dataset |
| CDS INTERCHANGE CONTROL REFERENCE | Changed Dataset, Description |
| CDS INTERCHANGE DATE OF PREPARATION | Changed Dataset |
| CDS INTERCHANGE RECEIVER IDENTITY | Changed Dataset |
| CDS INTERCHANGE SENDER IDENTITY | Changed Dataset |
| CDS INTERCHANGE TEST INDICATOR | Changed Dataset |
| CDS INTERCHANGE TIME OF PREPARATION | Changed Dataset |
| CDS MESSAGE REFERENCE | Changed Dataset, Description |
| CDS MESSAGE TYPE | Changed Dataset |
| CDS MESSAGE VERSION NUMBER | Changed Dataset |
| CDS PRIME RECIPIENT IDENTITY | Changed Description |
| CDS PROTOCOL IDENTIFIER CODE | Changed Dataset |
| CDS RECORD IDENTIFIER | Changed Dataset, Description |
| CDS REPORT PERIOD END DATE | Changed Dataset |
| CDS REPORT PERIOD START DATE | Changed Dataset |
| CDS TYPE CODE | Changed Dataset |
| CDS UNIQUE IDENTIFIER | Changed Dataset, Description |
| CDS UPDATE TYPE | Changed Dataset |
| CLINIC CODE | Changed Dataset |
| CODED CLINICAL ENTRY SEQUENCE NUMBER | Changed Dataset |
| CODED DIAGNOSIS TIMESTAMP | Changed Dataset |
| CODED FINDING TIMESTAMP | Changed Dataset |
| CODED OBSERVATION TIMESTAMP | Changed Dataset |
| CODED PROCEDURE TIMESTAMP | Changed Dataset |
| COMMISSIONER REFERENCE IDENTIFIER | New Data Element |
| COMMISSIONER REFERENCE NUMBER | Changed Description, linked Attribute |
| COMMISSIONING SERIAL NUMBER | Changed Description |
| COMORBIDITY (SNOMED CT EXPRESSION) | Changed Dataset |
| CONSULTATION MECHANISM | New Data Element |
| CONSULTATION MEDIUM USED | Changed Description |
| CONSULTATION TYPE | Changed Dataset |
| CRITICAL CARE ACTIVITY CODE | Changed Dataset |
| CRITICAL CARE ADMISSION SOURCE | Changed Dataset |
| CRITICAL CARE ADMISSION TYPE | Changed Dataset |
| CRITICAL CARE DISCHARGE DATE | Changed Dataset |
| CRITICAL CARE DISCHARGE DESTINATION | Changed Dataset |
| CRITICAL CARE DISCHARGE LOCATION | Changed Dataset |
| CRITICAL CARE DISCHARGE READY DATE | Changed Dataset |
| CRITICAL CARE DISCHARGE READY TIME | Changed Dataset |

| | |
|---|---|
| CRITICAL CARE DISCHARGE STATUS | Changed Dataset |
| CRITICAL CARE DISCHARGE TIME | Changed Dataset |
| CRITICAL CARE LEVEL | New Data Element |
| CRITICAL CARE LEVEL 2 DAYS | Changed Dataset |
| CRITICAL CARE LEVEL 3 DAYS | Changed Dataset |
| CRITICAL CARE LOCAL IDENTIFIER | Changed Dataset |
| CRITICAL CARE SOURCE LOCATION | Changed Dataset |
| CRITICAL CARE START DATE | Changed Dataset |
| CRITICAL CARE START TIME | Changed Dataset |
| CRITICAL CARE UNIT BED CONFIGURATION | Changed Dataset |
| CRITICAL CARE UNIT FUNCTION | Changed Dataset |
| DATA ABSENT REASON (FHIR R4) | New Data Element |
| DECIDED TO ADMIT DATE | Changed Dataset |
| DELIVERY METHOD CODE | Changed Dataset |
| DELIVERY PLACE CHANGE REASON CODE | Changed Dataset |
| DELIVERY PLACE TYPE CODE (ACTUAL) | Changed Dataset |
| DELIVERY PLACE TYPE CODE (INTENDED) | Changed Dataset |
| DELIVERY TIMESTAMP | Changed Dataset |
| DERMATOLOGICAL SUPPORT DAYS | Changed Dataset |
| DESTINATION OF DISCHARGE (HOSPITAL PROVIDER SPELL) | Changed Dataset |
| DIAGNOSIS (SNOMED CT EXPRESSION) | Changed Dataset |
| DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET) | New Data Element |
| DIRECT ACCESS REFERRAL INDICATOR | Changed Dataset |
| DISCHARGE DATE (HOSPITAL PROVIDER SPELL) | Changed Dataset |
| DISCHARGED TO NHS AT HOME SERVICE INDICATOR | New Data Element |
| DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL) | Changed Dataset |
| DISCHARGE TIME (HOSPITAL PROVIDER SPELL) | Changed Dataset |
| DURATION OF ELECTIVE WAIT | Changed Dataset |
| EARLIEST CLINICALLY APPROPRIATE DATE | Changed Dataset |
| EARLIEST REASONABLE OFFER DATE | Changed Dataset |
| EMED3 FIT NOTE ASSESSMENT DATE | New Data Element |
| EMED3 FIT NOTE CONDITION (SNOMED CT EXPRESSION) | New Data Element |
| EMED3 FIT NOTE DIAGNOSIS (ICD) | New Data Element |
| EMED3 FIT NOTE DURATION | New Data Element |
| EMED3 FIT NOTE END DATE | New Data Element |
| EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR | New Data Element |
| EMED3 FIT NOTE RECORDED DATE | New Data Element |
| EMED3 FIT NOTE START DATE | New Data Element |
| END DATE (COMMISSIONER ASSIGNMENT PERIOD) | Changed Dataset |
| END DATE (EPISODE) | Changed Dataset |
| END DATE (HOME LEAVE) | Changed Dataset |
| END DATE (WARD STAY) | Changed Dataset |
| END TIME (EPISODE) | Changed Dataset |
| END TIME (HOME LEAVE) | Changed Dataset |
| END TIME (WARD STAY) | Changed Dataset |
| EPISODE NUMBER | Changed Dataset |
| ETHNIC CATEGORY | Changed Dataset |
| ETHNIC CATEGORY 2021 | Changed Dataset |
| EXPECTED DURATION OF APPOINTMENT | Changed Dataset |
| FINDING (SNOMED CT EXPRESSION) | Changed Dataset |
| FIRST ANTENATAL ASSESSMENT DATE | Changed Dataset |
| FIRST ATTENDANCE CODE | Changed Dataset |

| | |
|---|---|
| FIRST REGULAR DAY OR NIGHT ADMISSION CODE | Changed Dataset |
| GASTRO-INTESTINAL SUPPORT DAYS | Changed Dataset |
| GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION) | Changed Dataset |
| GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE) | Changed Dataset |
| GENERAL MEDICAL PRACTITIONER (SPECIFIED) | Changed Dataset |
| GENERAL MEDICAL PRACTITIONER PRACTICE (PATIENT ANTENATAL CARE) | Changed Dataset |
| GESTATION LENGTH (ASSESSMENT) | Changed Dataset |
| GESTATION LENGTH (AT DELIVERY) | Changed Dataset |
| GESTATION LENGTH (LABOUR ONSET) | Changed Dataset |
| HIGH COST DRUGS (OPCS) | Changed Dataset |
| HOSPITAL PROVIDER SPELL IDENTIFIER | Changed Dataset |
| INTENDED MANAGEMENT CODE | Changed Dataset |
| LABOUR OR DELIVERY ONSET METHOD CODE | Changed Dataset |
| LAST EPISODE IN SPELL INDICATOR CODE | Changed Dataset |
| LAST PATIENT CANCELLED DATE | New Data Element |
| LAST PATIENT DID NOT ATTEND DATE | New Data Element |
| LATEST CLINICALLY APPROPRIATE DATE | New Data Element |
| LENGTH OF STAY ADJUSTMENT (REHABILITATION) | Changed Dataset |
| LENGTH OF STAY ADJUSTMENT (SPECIALIST PALLIATIVE CARE) | Changed Dataset |
| LIVE OR STILL BIRTH CODE | Changed Dataset |
| LIVER SUPPORT DAYS | Changed Dataset |
| LOCAL PATIENT IDENTIFIER (EXTENDED (BABY)) | Changed Dataset |
| LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER)) | Changed Dataset |
| LOCAL PATIENT IDENTIFIER (EXTENDED) | Changed Dataset |
| LOCAL SUB-SPECIALTY CODE | Changed Dataset |
| MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION) | Changed Dataset |
| METHOD OF ADMISSION (HOSPITAL PROVIDER SPELL) | Changed Dataset |
| METHOD OF DISCHARGE (HOSPITAL PROVIDER SPELL) | Changed Dataset |
| MULTI-PROFESSIONAL OR MULTI-DISCIPLINARY INDICATION CODE (NATIONAL TARIFF PAYMENT SYSTEM) | New Data Element |
| NEONATAL LEVEL OF CARE CODE | Changed Dataset |
| NEUROLOGICAL SUPPORT DAYS | Changed Dataset |
| NHS NUMBER | Changed Dataset |
| NHS NUMBER (BABY) | Changed Dataset |
| NHS NUMBER (MOTHER) | Changed Dataset |
| NHS NUMBER STATUS INDICATOR CODE | Changed Dataset |
| NHS NUMBER STATUS INDICATOR CODE (BABY) | Changed Dataset |
| NHS NUMBER STATUS INDICATOR CODE (MOTHER) | Changed Dataset |
| NHS SERVICE AGREEMENT IDENTIFIER | New Data Element |
| NHS SERVICE AGREEMENT LINE IDENTIFIER | New Data Element |
| NHS SERVICE AGREEMENT LINE NUMBER | Changed Description |
| NUMBER OF BABIES INDICATION CODE | Changed Dataset |
| NUMBER OF PREVIOUS PREGNANCIES RESULTING IN REGISTRABLE BIRTH | Changed Dataset |
| OBSERVATION (SNOMED CT EXPRESSION) | Changed Dataset |
| OBSERVATION VALUE | Changed Dataset |
| ORGANISATION IDENTIFIER (CDS RECIPIENT) | Changed Dataset |
| ORGANISATION IDENTIFIER (CDS SENDER) | Changed Dataset |
| ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) | Changed Dataset |
| ORGANISATION IDENTIFIER (CODE OF PROVIDER) | Changed Dataset |
| ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST) | Changed Dataset |
| ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (BABY)) | Changed Dataset |

| | |
|---|---|
| ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER)) | Changed Dataset |
| ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) | Changed Dataset |
| ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER) | Changed Dataset, Description |
| ORGANISATION IDENTIFIER (REFERRING ORGANISATION) | Changed Dataset |
| ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | Changed Dataset |
| ORGANISATION SITE IDENTIFIER (OF TREATMENT) | Changed Dataset |
| ORGAN SUPPORT MAXIMUM | Changed Dataset |
| ORGAN SYSTEM SUPPORTED | New Data Element |
| OUTPATIENT ATTENDANCE IDENTIFIER | Changed Dataset, Description |
| OUT-PATIENT ATTENDANCE OUTCOME | New Data Element |
| OVERSEAS VISITOR CHARGING CATEGORY | Changed Dataset |
| OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE END DATE | Changed Dataset |
| OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE FROM DATE | Changed Dataset |
| OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE | Changed Dataset |
| PATIENT CLASSIFICATION CODE | Changed Dataset |
| PATIENT FAMILY NAME | New Data Element |
| PATIENT FULL NAME | New Data Element |
| PATIENT GIVEN NAME | New Data Element |
| PATIENT INITIALS | New Data Element |
| PATIENT NAME SUFFIX | New Data Element |
| PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR AT CDS ACTIVITY DATE | New Data Element |
| PATIENT PATHWAY IDENTIFIER | Changed Dataset, Description |
| PATIENT SUBJECT TO REMOTE MONITORING INDICATOR AT CDS ACTIVITY DATE | New Data Element |
| PATIENT TITLE | New Data Element |
| PATIENT USUAL ADDRESS (STRUCTURED (BABY)) | New Data Element |
| PATIENT USUAL ADDRESS (STRUCTURED (MOTHER)) | New Data Element |
| PATIENT USUAL ADDRESS (STRUCTURED) | New Data Element |
| PATIENT USUAL ADDRESS (UNSTRUCTURED (BABY)) | New Data Element |
| PATIENT USUAL ADDRESS (UNSTRUCTURED (MOTHER)) | New Data Element |
| PATIENT USUAL ADDRESS (UNSTRUCTURED) | New Data Element |
| PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE | New Data Element |
| PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY REVIEW DATE | New Data Element |
| PERSON BIRTH DATE | Changed Dataset |
| PERSON BIRTH DATE (BABY) | Changed Dataset |
| PERSON BIRTH DATE (MOTHER) | Changed Dataset |
| PERSON MARITAL STATUS | Changed Dataset |
| PERSON PHENOTYPIC SEX | Changed Dataset |
| PERSON SCORE | Changed Dataset |
| PERSON STATED GENDER CODE | Changed Dataset |
| PERSON WEIGHT | Changed Dataset |
| POSTCODE OF USUAL ADDRESS | Changed Dataset |
| POSTCODE OF USUAL ADDRESS (MOTHER) | Changed Dataset |
| PRESENT ON ADMISSION INDICATOR | Changed Dataset, Description |
| PRIMARY DIAGNOSIS (ICD) | Changed Dataset |
| PRIMARY PROCEDURE (OPCS) | Changed Dataset |
| PRIORITY TYPE CODE | Changed Dataset |
| PROCEDURE (OPCS) | Changed Dataset |

| | |
|---|---|
| PROCEDURE (SNOMED CT EXPRESSION) | Changed Dataset |
| PROCEDURE DATE | Changed Dataset |
| PROCEDURE SCHEME IN USE (COMMISSIONING DATA SET) | New Data Element |
| PROFESSIONAL REGISTRATION ENTRY IDENTIFIER | Changed Dataset |
| PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | Changed Dataset, Description |
| PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | Changed Dataset, Description |
| PROFESSIONAL REGISTRATION ISSUER CODE | Changed Dataset, Description |
| PROVIDER REFERENCE IDENTIFIER | New Data Element |
| PROVIDER REFERENCE NUMBER | Changed Description |
| PSYCHIATRIC PATIENT STATUS CODE | Changed Dataset |
| REFERRAL REQUEST RECEIVED DATE | Changed Dataset |
| REFERRAL TO TREATMENT PERIOD END DATE | Changed Dataset, Description |
| REFERRAL TO TREATMENT PERIOD START DATE | Changed Dataset, Description |
| REFERRAL TO TREATMENT PERIOD STATUS | Changed Dataset, Description |
| REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR | New Data Element |
| REFERRER CODE | Changed Dataset |
| REHABILITATION ASSESSMENT TEAM TYPE | Changed Dataset |
| RENAL SUPPORT DAYS | Changed Dataset |
| RESPONSIBLE CARE PROFESSIONAL INDICATOR | New Data Element |
| RESUSCITATION METHOD CODE | Changed Dataset |
| SECONDARY DIAGNOSIS (ICD) | Changed Dataset |
| SERVICE REQUEST IDENTIFIER | Changed Dataset |
| SERVICE TYPE REQUESTED CODE | Changed Dataset |
| SEX OF PATIENTS CODE | Changed Description |
| SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION) | Changed Dataset |
| SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP | Changed Dataset |
| SOURCE OF REFERRAL FOR OUT-PATIENTS | Changed Dataset |
| SPECIALISED SERVICE CODE | Changed Dataset |
| START DATE (COMMISSIONER ASSIGNMENT PERIOD) | Changed Dataset |
| START DATE (EPISODE) | Changed Dataset |
| START DATE (HOME LEAVE) | Changed Dataset |
| START DATE (HOSPITAL PROVIDER SPELL) | Changed Dataset |
| START DATE (WARD STAY) | Changed Dataset |
| START TIME (EPISODE) | Changed Dataset |
| START TIME (HOME LEAVE) | Changed Dataset |
| START TIME (HOSPITAL PROVIDER SPELL) | Changed Dataset |
| START TIME (WARD STAY) | Changed Dataset |
| STATUS OF PERSON CONDUCTING DELIVERY CODE | Changed Dataset |
| UCUM UNIT OF MEASUREMENT | Changed Dataset |
| UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) | Changed Dataset, Description |
| WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET) | New Data Element |
| WARD CODE | Changed Dataset |
| WARD INTENDED AGE GROUP | New Data Element |
| WARD INTENDED CLINICAL CARE INTENSITY | New Data Element |
| WARD INTENDED DAY PERIOD AVAILABILITY | New Data Element |
| WARD INTENDED NIGHT PERIOD AVAILABILITY | New Data Element |

| | |
|---|---|
| WARD INTENDED SEX OF PATIENTS | New Data Element |
| WARD SECURITY LEVEL | Changed Dataset |
| WITHHELD IDENTITY REASON | Changed Dataset |

**XML Schema Constraint**

| | |
|---|---|
| COMMISSIONING DATA SET VERSION 6-3 XML SCHEMA CONSTRAINTS | New XML Schema Constraint |

**Date:** 14 June 2021

**Sponsor:** Ming Tang, National Director for Data and Analytics, NHS England and NHS Improvement

**Note:** New text is shown with a blue background. Deleted text is crossed out. Retired text is shown in grey. Within the Diagrams deleted classes and relationships are red, changed items are blue and new items are green.

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#### CDS V6-3 TYPE 001 - CDS INTERCHANGE HEADER

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Change to Data Set: New Data Set

| Notation | | DATA GROUP: CDS V6-3 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER |
|---|---|---|
| Group Status<br>M | Group Repeats<br>1..1 | FUNCTION:<br>To carry the details of the mandatory identity and addressing information for the Commissioning Data Set submission.<br>One per Interchange submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| | | | | | |
|---|---|---|---|---|---|
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | CDS INTERCHANGE SENDER IDENTITY | F<br>S8 |
| | | M | 1..1 | CDS INTERCHANGE RECEIVER IDENTITY | F<br>S8 |
| | | M | 1..1 | CDS INTERCHANGE CONTROL REFERENCE | F<br>S8 |
| | | M | 1..1 | CDS INTERCHANGE DATE OF PREPARATION | F<br>S8<br>S13 |
| | | M | 1..1 | CDS INTERCHANGE TIME OF PREPARATION | F<br>S8<br>S14 |
| | | M | 1..1 | CDS INTERCHANGE APPLICATION REFERENCE | F<br>S8 |
| | | O | 0..1 | CDS INTERCHANGE TEST INDICATOR | F |

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#### CDS V6-3 TYPE 002 - CDS INTERCHANGE TRAILER

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Change to Data Set: New Data Set

| Notation | | DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER |
|---|---|---|
| Group Status<br>M | Group Repeats<br>1..1 | FUNCTION:<br>To carry the details of the mandatory identity and addressing information for the Commissioning Data Set submission.<br>One per Interchange submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | CDS INTERCHANGE CONTROL REFERENCE | F<br>S8 |
| | | M | 1..1 | CDS INTERCHANGE CONTROL COUNT | F<br>S8 |
| | | O | 0..1 | CDS INTERCHANGE SENDER IDENTITY | F |
| | | O | 0..1 | CDS INTERCHANGE RECEIVER IDENTITY | F |

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**CDS V6-3 TYPE 003 - CDS MESSAGE HEADER**

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Change to Data Set: New Data Set

| Notation | | DATA GROUP: CDS V6-3 TYPE 003 - COMMISSIONING DATA SET MESSAGE HEADER |
|---|---|---|
| Group Status<br>M | Group Repeats<br>1..1 | FUNCTION:<br>To carry the details of the mandatory identity controls for each Commissioning Data Set Message.<br>One per Commissioning Data Set Message submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | CDS MESSAGE TYPE | V |
| | | M | 1..1 | CDS MESSAGE VERSION NUMBER | F |
| | | M | 1..1 | CDS MESSAGE REFERENCE | F |
| | | O | 0..1 | CDS RECORD IDENTIFIER | F |

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**CDS V6-3 TYPE 004 - CDS MESSAGE TRAILER**

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Change to Data Set: New Data Set

| Notation | | DATA GROUP: CDS V6-3 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER |
|---|---|---|
| Group Status<br>M | Group Repeats<br>1..1 | FUNCTION:<br>To carry the details of the mandatory identity controls for each Commissioning Data Set Message.<br>One per Commissioning Data Set Message submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | CDS MESSAGE REFERENCE | F |

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**CDS V6-3 TYPE 005B - CDS TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL**

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Change to Data Set: New Data Set

| Notation | | DATA GROUP: CDS V6-3 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL |
|---|---|---|
| Group Status<br>M | Group Repeats<br>1..1 | FUNCTION:<br>To carry the details of the mandatory Commissioning Data Set Submission Protocol controls for when using the Bulk Update mechanism.<br>One per Commissioning Data Set Message submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | CDS TYPE CODE | V |
| | | M | 1..1 | CDS PROTOCOL IDENTIFIER CODE | V |
| | | O | 0..1 | CDS UNIQUE IDENTIFIER | F<br>S9 |
| | | M | 1..1 | CDS BULK REPLACEMENT GROUP CODE | V |
| | | M | 1..1 | CDS EXTRACT DATE | F<br>S13 |
| | | M | 1..1 | CDS EXTRACT TIME | F<br>S14 |
| | | M | 1..1 | CDS REPORT PERIOD START DATE | F<br>S6<br>S13 |
| | | M | 1..1 | CDS REPORT PERIOD END DATE | F<br>S6<br>S13 |
| | | M | 1..1 | CDS ACTIVITY DATE | F<br>S6<br>S13 |
| | | M | 1..1 | ORGANISATION IDENTIFIER (CDS SENDER) | F<br>S5 |
| | | O | 0..7 | ORGANISATION IDENTIFIER (CDS RECIPIENT) | F<br>S5 |

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**CDS V6-3 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL**

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Change to Data Set: New Data Set

| Notation | | DATA GROUP: CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL |
|---|---|---|
| Group Status<br>M | Group Repeats<br>1..1 | FUNCTION:<br>To carry the details of the mandatory Commissioning Data Set Submission Protocol controls for when using the Net Change mechanism.<br>One per Commissioning Data Set Message submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | CDS TYPE CODE | V |
| | | M | 1..1 | CDS PROTOCOL IDENTIFIER CODE | V |
| | | M | 1..1 | CDS UNIQUE IDENTIFIER | F<br>S9 |
| | | M | 1..1 | CDS UPDATE TYPE | V |
| | | M | 1..1 | CDS APPLICABLE DATE | F<br>S8<br>S13 |
| | | M | 1..1 | CDS APPLICABLE TIME | F<br>S8<br>S14 |
| | | M | 1..1 | CDS ACTIVITY DATE | F<br>S6<br>S13 |
| | | M | 1..1 | ORGANISATION IDENTIFIER (CDS SENDER) | F<br>S5 |
| | | O | 0..7 | ORGANISATION IDENTIFIER (CDS RECIPIENT) | |

| | | | | | F<br>S5 |
|---|---|---|---|---|---|

## CDS V6-3 TYPE 020 - OUTPATIENT CDS

Change to Data Set: New Data Set

| CDS V6-3 TYPE 020 - OUTPATIENT COMMISSIONING DATA SET |
|---|
| FUNCTION: To support the details of an Care Professional Outpatient Attendance. |

| Notation | | DATA GROUP: CDS V6-3 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 001 - Commissioning Data Set Interchange Header<br>One per Interchange submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| Notation | | DATA GROUP: CDS V6-3 TYPE 003 - COMMISSIONING DATA SET MESSAGE HEADER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 003 - Commissioning Data Set Message Header<br>One per Commissioning Data Set Message submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

**ONE OF THE FOLLOWING TWO OPTIONS MUST BE USED:**

| Notation | | DATA GROUP: CDS V6-3 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of the Bulk Replacement Update Mechanism of the Commissioning Data Set Submission Protocol. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol<br>One per Commissioning Data Set record submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

**OR**

| Notation | | DATA GROUP: CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of one of the Net Change Update Mechanism of the Commissioning Data Set Submission Protocol. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol<br>One per Commissioning Data Set record submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| Notation | | DATA GROUP: PATIENT PATHWAY |
|---|---|---|
| | | |

| Group Status | Group Repeats | FUNCTION: |
| --- | --- | --- |
| R | 0..1 | 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. |

| | | | | |
| --- | --- | --- | --- | --- |
| **M** | **1..1** | **DATA GROUP: PATIENT PATHWAY IDENTITY** | | **Rules** |
| | **M**<br>*Or*<br>**M** | **1..1**<br><br>**1..1** | UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)<br>*Or*<br>PATIENT PATHWAY IDENTIFIER | F<br><br>F<br>I2 |
| | **M** | **1..1** | ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER) | F<br>I2 |
| **M** | **1..1** | **DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS** | | **Rules** |
| | **M** | **1..1** | REFERRAL TO TREATMENT PERIOD STATUS | V |
| | **M** | **1..1** | WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET) | V |
| | O | 0..1 | REFERRAL TO TREATMENT PERIOD START DATE | F<br>S13 |
| | O | 0..1 | REFERRAL TO TREATMENT PERIOD END DATE | F<br>S13 |

| Notation | DATA GROUP: PATIENT IDENTITY |
| --- | --- |

| Group Status | Group Repeats | FUNCTION: |
| --- | --- | --- |
| M | 1..1 | To carry the Identity of the Patient. See Note: S3 in Commissioning Data Set Business Rules. |

**One of the following DATA GROUPS must be used:**

| | | | | | |
| --- | --- | --- | --- | --- | --- |
| **1..1** | **DATA GROUP: WITHHELD IDENTITY STRUCTURE**<br>**Must be used where the Commissioning Data Set record has been anonymised** | | | | |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | **M** | **1..1** | NHS NUMBER STATUS INDICATOR CODE | V |
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | WITHHELD IDENTITY REASON | V |

**OR**

| | | | | | |
| --- | --- | --- | --- | --- | --- |
| **1..1** | **DATA GROUP: VERIFIED IDENTITY STRUCTURE**<br>**Must be used where the NHS NUMBER STATUS INDICATOR CODE National Code = 01 (Number present and verified)** | | | | |
| R | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | **Rules** |
| | | **M** | **1..1** | LOCAL PATIENT IDENTIFIER (EXTENDED) | F<br>S3 |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) | F |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | **M** | **1..1** | NHS NUMBER | F<br>S3 |
| | | **M** | **1..1** | NHS NUMBER STATUS INDICATOR CODE | V |
| | | **M** | **1..1** | POSTCODE OF USUAL ADDRESS | F<br>S3 |
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | PERSON BIRTH DATE | F<br>S3<br>S12 |

**OR**

| | | | | | |
| --- | --- | --- | --- | --- | --- |
| **1..1** | **DATA GROUP: UNVERIFIED IDENTITY STRUCTURE**<br>**Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE NOT included in the above** | | | | |
| R | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | **Rules** |

| | | M | 1..1 | LOCAL PATIENT IDENTIFIER (EXTENDED) | F<br>S3 |
|---|---|---|---|---|---|
| | | M | 1..1 | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) | F |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | NHS NUMBER | F<br>S3 |
| | | M | 1..1 | NHS NUMBER STATUS INDICATOR CODE | V |
| R | 0..1 | Data Element Components | | | **Rules** |
| | | **M**<br>**OR**<br>O<br>and<br>**M**<br>**and**<br>**M**<br>and<br>O<br>and<br>O | **1..1**<br>**OR**<br>0..1<br>and<br>**1..1**<br>**and**<br>**1..1**<br>and<br>0..1<br>and<br>0..1 | PATIENT FULL NAME<br>**OR**<br>PATIENT TITLE<br>and<br>PATIENT GIVEN NAME<br>**and**<br>PATIENT FAMILY NAME<br>and<br>PATIENT NAME SUFFIX<br>and<br>PATIENT INITIALS | F<br>S3<br>I4 |
| R | 0..1 | Data Element Components | | | **Rules** |
| | | **M**<br>**OR**<br>**M** | **1..1**<br>**OR**<br>**2..5** | PATIENT USUAL ADDRESS (UNSTRUCTURED)<br>**OR**<br>PATIENT USUAL ADDRESS (STRUCTURED) | F<br>S3<br>I5 |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | POSTCODE OF USUAL ADDRESS | F<br>S3 |
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | PERSON BIRTH DATE | F<br>S3<br>S12 |

| **Notation** | | **DATA GROUP: PATIENT CHARACTERISTICS** |
|---|---|---|
| **Group Status**<br>**R** | **Group Repeats**<br>**0..1** | **FUNCTION:**<br>**To carry the characteristics of the Patient.** |

| **M** | **1..1** | **Data Element Components** | | | **Rules** |
|---|---|---|---|---|---|
| | | R | 0..1 | PERSON STATED GENDER CODE | V<br>H4 |
| | | O | 0..1 | CARER SUPPORT INDICATOR | V |
| | | R | 0..1 | ETHNIC CATEGORY | V |
| | | X | 0..1 | ETHNIC CATEGORY 2021 | N2 |

| **Notation** | | **DATA GROUP: PATIENT CHARACTERISTICS - SOCIAL AND PERSONAL CIRCUMSTANCES (SNOMED CT)** |
|---|---|---|
| **Group Status**<br>**R** | **Group Repeats**<br>**0..*** | **FUNCTION:**<br>**To carry the details of the SNOMED CT coded Social and Personal Circumstances for the Patient.** |

**One of the following DATA GROUPS may be used:**

| **M** | **1..1** | **DATA GROUP: SNOMED CT SOCIAL AND PERSONAL CIRCUMSTANCES** | | | **Rules** |
|---|---|---|---|---|---|
| | | **M** | **1..1** | SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION) | F |
| | | **M** | **1..1** | SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | **Rules** |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: CARE EPISODE - PERSON GROUP (CARE PROFESSIONAL) | | | |
|---|---|---|---|---|---|
| Group Status<br>R | Group Repeats<br>0..* | FUNCTION:<br>To carry the details of the Care Professionals active during the Care Attendance. | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER | F |
| | | M | 1..1 | CARE PROFESSIONAL MAIN SPECIALTY CODE | F<br>H4 |
| | | M | 1..1 | ACTIVITY TREATMENT FUNCTION CODE | F<br>H4 |
| | | O | 0..1 | LOCAL SUB-SPECIALTY CODE | F |
| | | M | 1..1 | RESPONSIBLE CARE PROFESSIONAL INDICATOR | V |

| Notation | | DATA GROUP: CARE EPISODE - CLINICAL DIAGNOSIS GROUP (ICD) | | | |
|---|---|---|---|---|---|
| Group Status<br>O | Group Repeats<br>0..1 | FUNCTION:<br>To carry the details of the ICD coded Clinical Diagnoses for the Patient. | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET) | V |
| M | 1..1 | DATA GROUP: PRIMARY DIAGNOSIS | | | Rules |
| | | M | 1..1 | PRIMARY DIAGNOSIS (ICD) | F |
| O | 0..* | DATA GROUP: SECONDARY DIAGNOSES | | | Rules |
| | | M | 1..1 | SECONDARY DIAGNOSIS (ICD) | F |

| Notation | | DATA GROUP: CARE EPISODE - CLINICAL DIAGNOSIS GROUP (SNOMED CT) |
|---|---|---|
| Group Status<br>R | Group Repeats<br>0..* | FUNCTION:<br>To carry the details of the SNOMED CT coded Clinical Diagnoses for the Patient. |

**One of the following DATA GROUPS may be used:**

| M | 1..1 | DATA GROUP: SNOMED CT DIAGNOSIS | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | DIAGNOSIS (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | CODED CLINICAL ENTRY SEQUENCE NUMBER | F |
| | | M | 1..1 | CODED DIAGNOSIS TIMESTAMP | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: CARE EPISODE - COMORBIDITY (SNOMED CT) |
|---|---|---|
| Group Status<br>R | Group Repeats<br>0..* | FUNCTION:<br>To carry the details of the SNOMED CT coded Comorbidities for the Patient. |

**One of the following DATA GROUPS may be used:**

| M | 1..1 | DATA GROUP: SNOMED CT COMORBIDITY | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | COMORBIDITY (SNOMED CT EXPRESSION) | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: CARE EPISODE - EMED3 FIT NOTE |
|---|---|---|
| | | |

| Group Status | Group Repeats | FUNCTION: |
|---|---|---|
| R | 0..1 | To carry the details of EMED3 Fit Note issued. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | EMED3 FIT NOTE ASSESSMENT DATE | F<br>S13 |
| | | R | 0..1 | EMED3 FIT NOTE CONDITION (SNOMED CT EXPRESSION) | F |
| | | R | 0..1 | EMED3 FIT NOTE DIAGNOSIS (ICD) | F |
| | | R | 0..1 | EMED3 FIT NOTE START DATE | F<br>S13 |
| | | R | 0..1 | EMED3 FIT NOTE END DATE | F<br>S13 |
| | | R | 0..1 | EMED3 FIT NOTE DURATION | F |
| | | R | 0..1 | EMED3 FIT NOTE RECORDED DATE | F<br>S13 |
| | | R | 0..1 | EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR | V |

| Notation | DATA GROUP: CARE ATTENDANCE - ACTIVITY CHARACTERISTICS | |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| M | 1..1 | To carry the details of the Attendance or Missed/Cancelled Appointment. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | **M** | **1..1** | OUTPATIENT ATTENDANCE IDENTIFIER | F |
| | | R | 0..1 | ADMINISTRATIVE CATEGORY CODE | V |
| | | R | 0..1 | ATTENDANCE STATUS | V |
| | | R | 0..1 | FIRST ATTENDANCE CODE | V<br>H4 |
| | | R | 0..1 | OUT-PATIENT ATTENDANCE OUTCOME | V |
| | | R | 0..1 | APPOINTMENT BOOKED REASON | V |
| | | **M** | **1..1** | APPOINTMENT DATE | F<br>S1<br>S13 |
| | | O | 0..1 | APPOINTMENT TIME | F<br>S14 |
| | | O | 0..1 | EXPECTED DURATION OF APPOINTMENT | F |
| | | **M** | **1..1** | AGE AT CDS ACTIVITY DATE | F<br>H4<br>S8 |
| | | R | 0..1 | OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE | V |
| | | R | 0..1 | EARLIEST REASONABLE OFFER DATE | F<br>S13 |
| | | R | 0..1 | EARLIEST CLINICALLY APPROPRIATE DATE | F<br>S13 |
| | | R | 0..1 | LATEST CLINICALLY APPROPRIATE DATE | F<br>S13 |
| | | R | 0..1 | CONSULTATION MECHANISM | V |
| | | R | 0..1 | CONSULTATION TYPE | V |
| | | O | 0..1 | MULTI-PROFESSIONAL OR MULTI-DISCIPLINARY INDICATION CODE (NATIONAL TARIFF PAYMENT SYSTEM) | V |
| | | O | 0..1 | REHABILITATION ASSESSMENT TEAM TYPE | V<br>N3 |
| | | R | 0..1 | PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR AT CDS ACTIVITY DATE | V |

| | | R | 0..1 | PATIENT SUBJECT TO REMOTE MONITORING INDICATOR AT CDS ACTIVITY DATE | V |
|---|---|---|---|---|---|
| | | R | 0..1 | PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY REVIEW DATE | F S13 |
| | | R | 0..1 | PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE | F S13 |

| Notation | | DATA GROUP: CARE ATTENDANCE - SERVICE AGREEMENT DETAILS | | | |
|---|---|---|---|---|---|
| Group Status M | Group Repeats 1..1 | FUNCTION: To carry the details of the Provider, Commissioners and Service Agreements. | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | ORGANISATION IDENTIFIER (CODE OF PROVIDER) | F |
| M | 1..* | DATA GROUP: COMMISSIONERS | | | Rules |
| | | M | 1..1 | ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) | F |
| | | R | 0..1 | START DATE (COMMISSIONER ASSIGNMENT PERIOD) | F S13 |
| | | R | 0..1 | END DATE (COMMISSIONER ASSIGNMENT PERIOD) | F S13 |
| | | R | 0..1 | NHS SERVICE AGREEMENT IDENTIFIER | F |
| | | O | 0..1 | NHS SERVICE AGREEMENT LINE IDENTIFIER | F |
| | | O | 0..1 | PROVIDER REFERENCE IDENTIFIER | F |
| | | R | 0..1 | COMMISSIONER REFERENCE IDENTIFIER | F |
| | | R | 0..1 | SPECIALISED SERVICE CODE | F |

| Notation | | DATA GROUP: CARE ATTENDANCE - PROCEDURE GROUP (OPCS) | | | |
|---|---|---|---|---|---|
| Group Status O | Group Repeats 0..1 | FUNCTION: To carry the details of the OPCS coded Procedures for the Patient. | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | PROCEDURE SCHEME IN USE (COMMISSIONING DATA SET) | V |
| M | 1..1 | DATA GROUP: PRIMARY PROCEDURE | | | Rules |
| | | M | 1..1 | PRIMARY PROCEDURE (OPCS) | F H4 |
| | | R | 0..1 | PROCEDURE DATE | F S13 |
| O | 0..1 | DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | F |
| O | 0..1 | DATA GROUP: RESPONSIBLE ANAESTHETIST | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | F |
| R | 0..* | DATA GROUP: SECONDARY PROCEDURES | | | Rules |
| | | M | 1..1 | PROCEDURE (OPCS) | F H4 |
| | | R | 0..1 | PROCEDURE DATE | F S13 |
| O | 0..1 | DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | | F |

| | | | | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | |
|---|---|---|---|---|---|
| O | 0..1 | DATA GROUP: RESPONSIBLE ANAESTHETIST | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | F |

| Notation | | DATA GROUP: CARE ATTENDANCE - PROCEDURE GROUP (SNOMED CT) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To carry the details of the SNOMED CT coded Procedures for the Patient. |
| R | 0..* | |

One of the following DATA GROUPS may be used:

| M | 1..1 | DATA GROUP: SNOMED CT PROCEDURE | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | PROCEDURE (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | CODED CLINICAL ENTRY SEQUENCE NUMBER | F |
| | | M | 1..1 | CODED PROCEDURE TIMESTAMP | F |
| O | 0..1 | DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | F |
| O | 0..1 | DATA GROUP: RESPONSIBLE ANAESTHETIST | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | F |

OR

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: CARE ATTENDANCE - OBSERVATION GROUP (SNOMED CT) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To carry the details of the SNOMED CT coded Clinical Observations for the Patient. |
| R | 0..* | |

One of the following DATA GROUPS may be used:

| M | 1..1 | DATA GROUP: SNOMED CT OBSERVATION | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | OBSERVATION (SNOMED CT EXPRESSION) | F |
| | | R | 0..1 | OBSERVATION VALUE | F |
| | | R | 0..1 | UCUM UNIT OF MEASUREMENT | F |
| | | M | 1..1 | CODED OBSERVATION TIMESTAMP | F |

OR

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: CARE ATTENDANCE - FINDING GROUP (SNOMED CT) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To carry the details of the SNOMED CT coded Clinical Findings for the Patient. |
| R | 0..* | |

One of the following DATA GROUPS may be used:

| M | 1..1 | DATA GROUP: SNOMED CT FINDING | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | FINDING (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | CODED FINDING TIMESTAMP | F |

OR

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|

| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |
|---|---|---|---|---|---|

| Notation | DATA GROUP: CARE ATTENDANCE - ASSESSMENT TOOL GROUP (SNOMED CT) |
|---|---|
| Group Status R / Group Repeats 0..* | FUNCTION: To carry the details of the SNOMED CT coded Assessment Tools for the Patient. |

One of the following DATA GROUPS may be used:

| M | 1..1 | DATA GROUP: SNOMED CT ASSESSMENT TOOL | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | ASSESSMENT TOOL (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | PERSON SCORE | F |
| | | M | 1..1 | ASSESSMENT TOOL COMPLETION TIMESTAMP | F |

OR

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: LOCATION GROUP - ATTENDANCE |
|---|---|
| Group Status R / Group Repeats 0..1 | FUNCTION: To carry the details of the Location and Site Code Of Treatment. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | ORGANISATION SITE IDENTIFIER (OF TREATMENT) | F |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | O | 0..1 | CLINIC CODE | F |

| Notation | DATA GROUP: GP REGISTRATION |
|---|---|
| Group Status R / Group Repeats 0..1 | FUNCTION: To carry the Patient's General Medical Practitioner and the General Practice details. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | GENERAL MEDICAL PRACTITIONER (SPECIFIED) | F |
| | | R | 0..1 | GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION) | F |

| Notation | DATA GROUP: ACTIVITY CHARACTERISTICS - REFERRAL |
|---|---|
| Group Status R / Group Repeats 0..1 | FUNCTION: To carry the details of the Referral. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | PRIORITY TYPE CODE | V |
| | | R | 0..1 | SERVICE TYPE REQUESTED CODE | V |
| | | R | 0..1 | SOURCE OF REFERRAL FOR OUT-PATIENTS | V |
| | | R | 0..1 | REFERRAL REQUEST RECEIVED DATE | F S13 |
| | | O | 0..1 | DIRECT ACCESS REFERRAL INDICATOR | V |
| | | O | 0..1 | REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR | V |
| | | R | 0..1 | SERVICE REQUEST IDENTIFIER | F |

| Notation | DATA GROUP: REFERRER |
|---|---|
| Group Status R / Group Repeats 0..1 | FUNCTION: To carry the details of the Referrer. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | REFERRER CODE | F |

| | | R | 0..1 | ORGANISATION IDENTIFIER (REFERRING ORGANISATION) | F |
|---|---|---|---|---|---|

| Notation | | DATA GROUP: CARE REFERRAL - MISSED APPOINTMENT OCCURRENCE | | | |
|---|---|---|---|---|---|
| Group Status<br>R | Group Repeats<br>0..1 | FUNCTION:<br>To carry the details of a Missed Appointment. | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | LAST PATIENT DID NOT ATTEND DATE | F<br>S13 |
| | | R | 0..1 | LAST PATIENT CANCELLED DATE | F<br>S13 |

| Notation | | DATA GROUP: CDS V6-3 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 004 - Commissioning Data Set Message Trailer<br>One per Commissioning Data Set Message submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |
| Notation | | DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER |
| Group Status | Group Repeats | FUNCTION:<br>To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer<br>One per Interchange submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

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**CDS V6-3 TYPE 120 - ADMITTED PATIENT CARE - FINISHED BIRTH EPISODE CDS**

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Change to Data Set: New Data Set

| CDS TYPE V6-3 120 - FINISHED BIRTH EPISODE COMMISSIONING DATA SET |
|---|
| FUNCTION: To support the details of a Finished Care Professional Admitted Care Birth Episode. |

| Notation | | DATA GROUP: CDS V6-3 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 001 - Commissioning Data Set Interchange Header<br>One per Interchange submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| Notation | | DATA GROUP: CDS V6-3 TYPE 003 - COMMISSIONING DATA SET MESSAGE HEADER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 003 - Commissioning Data Set Message Header<br>One per Commissioning Data Set Message submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

**ONE OF THE FOLLOWING TWO OPTIONS MUST BE USED:**

| Notation | | DATA GROUP: CDS V6-3 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of the Bulk Replacement Update Mechanism of the Commissioning Data Set Submission Protocol. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol<br>One per Commissioning Data Set record submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

**OR**

| Notation | | DATA GROUP: CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of one of the Net Change Update Mechanism of the Commissioning Data Set Submission Protocol. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol<br>One per Commissioning Data Set record submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| Notation | | | | DATA GROUP: PATIENT PATHWAY | |
|---|---|---|---|---|---|
| Group Status<br>O | Group Repeats<br>0..1 | | | FUNCTION: To carry the details of the Patient Pathway. | |
| M | 1..1 | | | DATA GROUP: PATIENT PATHWAY IDENTITY | Rules |
| | | M<br>*Or*<br>M | 1..1<br><br>1..1 | UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)<br>*Or*<br>PATIENT PATHWAY IDENTIFIER | F<br><br>F<br>I2 |
| | | M | 1..1 | ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER) | F<br>I2 |
| M | 1..1 | | | DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS | Rules |
| | | M | 1..1 | REFERRAL TO TREATMENT PERIOD STATUS | V |
| | | M | 1..1 | WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET) | V |
| | | O | 0..1 | REFERRAL TO TREATMENT PERIOD START DATE | F<br>S13 |
| | | O | 0..1 | REFERRAL TO TREATMENT PERIOD END DATE | F<br>S13 |

| Notation | | DATA GROUP: PATIENT IDENTITY (BABY) |
|---|---|---|
| Group Status<br>M | Group Repeats<br>1..1 | FUNCTION: To carry the Identity of the Patient (the Baby).<br>See Note: S3 in Commissioning Data Set Business Rules. |

**One of the following DATA GROUPS must be used:**

| 1..1 | | | | DATA GROUP: WITHHELD IDENTITY STRUCTURE<br>Must be used where the Commissioning Data Set record has been anonymised | |
|---|---|---|---|---|---|
| M | 1..1 | | | Data Element Components | Rules |
| | | M | 1..1 | NHS NUMBER STATUS INDICATOR CODE | V |
| | | R | 0..1 | PERSON BIRTH DATE | |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | F<br>S3<br>S12 |
| | | R | 0..1 | WITHHELD IDENTITY REASON | V |

**OR**

| | | | | | |
|---|---|---|---|---|---|
| 1..1 | **DATA GROUP: VERIFIED IDENTITY STRUCTURE**<br>**Must be used where the NHS NUMBER STATUS INDICATOR CODE National Code = 01 (Number present and verified)** | | | | |
| R | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | **Rules** |
| | | **M** | **1..1** | LOCAL PATIENT IDENTIFIER (EXTENDED) | F<br>S3 |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) | F |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | **M** | **1..1** | NHS NUMBER | F<br>S3 |
| | | **M** | **1..1** | NHS NUMBER STATUS INDICATOR CODE | V |
| | | R | 0..1 | PERSON BIRTH DATE | F<br>S3<br>S12 |

**OR**

| | | | | | |
|---|---|---|---|---|---|
| 1..1 | **DATA GROUP: UNVERIFIED IDENTITY STRUCTURE**<br>**Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE NOT included in the above** | | | | |
| R | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | **Rules** |
| | | **M** | **1..1** | LOCAL PATIENT IDENTIFIER (EXTENDED) | F<br>S3 |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) | F |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | NHS NUMBER | F<br>S3 |
| | | **M** | **1..1** | NHS NUMBER STATUS INDICATOR CODE | V |
| R | 0..1 | Data Element Components | | | **Rules** |
| | | **M**<br>**OR**<br>O<br>and<br>**M**<br>**and**<br>**M**<br>and<br>O<br>and<br>O | **1..1**<br>**OR**<br>0..1<br>and<br>**1..1**<br>**and**<br>**1..1**<br>and<br>0..1<br>and<br>0..1 | PATIENT FULL NAME<br>**OR**<br>PATIENT TITLE<br>and<br>PATIENT GIVEN NAME<br>**and**<br>PATIENT FAMILY NAME<br>and<br>PATIENT NAME SUFFIX<br>and<br>PATIENT INITIALS | F<br>S3<br>I4 |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | PERSON BIRTH DATE | F<br>S3<br>S12 |

| **Notation** | | **DATA GROUP: PATIENT CHARACTERISTICS** |
|---|---|---|
| **Group Status**<br>**R** | **Group Repeats**<br>**0..1** | **FUNCTION:**<br>**To carry the characteristics of the Patient (the Baby).** |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | PERSON PHENOTYPIC SEX | V<br>H4 |

| | | | | | |
|---|---|---|---|---|---|
| | | R | 0..1 | ETHNIC CATEGORY | V |
| | | X | 0..1 | ETHNIC CATEGORY 2021 | N2 |
| | | R | 0..1 | LIVE OR STILL BIRTH CODE | V |
| | | R | 0..1 | BIRTH WEIGHT | F |

| Notation | | DATA GROUP: PATIENT CHARACTERISTICS - SOCIAL AND PERSONAL CIRCUMSTANCES (SNOMED CT) |
|---|---|---|
| Group Status R | Group Repeats 0..* | FUNCTION: To carry the details of the SNOMED CT coded Social and Personal Circumstances for the Patient (the Baby). |

One of the following DATA GROUPS may be used:

| M | 1..1 | DATA GROUP: SNOMED CT SOCIAL AND PERSONAL CIRCUMSTANCES | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP | F |

OR

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: HOSPITAL PROVIDER SPELL - ADMISSION CHARACTERISTICS |
|---|---|---|
| Group Status M | Group Repeats 1..1 | FUNCTION: To carry the admission details of the Hospital Provider Spell containing the Finished Birth Care Professional Admitted Care Episode. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | HOSPITAL PROVIDER SPELL IDENTIFIER | F H4 |
| | | R | 0..1 | ADMINISTRATIVE CATEGORY CODE (ON ADMISSION) | V |
| | | R | 0..1 | PATIENT CLASSIFICATION CODE | V H4 |
| | | R | 0..1 | METHOD OF ADMISSION (HOSPITAL PROVIDER SPELL) | V H4 |
| | | R | 0..1 | ADMISSION SOURCE (HOSPITAL PROVIDER SPELL) | V H4 |
| | | M | 1..1 | START DATE (HOSPITAL PROVIDER SPELL) | F H4 S13 |
| | | O | 0..1 | START TIME (HOSPITAL PROVIDER SPELL) | F S14 |
| | | M | 1..1 | AGE ON ADMISSION | F H4 |

| Notation | | DATA GROUP: HOSPITAL PROVIDER SPELL - DISCHARGE CHARACTERISTICS |
|---|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the discharge details of the Hospital Provider Spell containing the Finished Birth Care Professional Admitted Care Episode. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | DESTINATION OF DISCHARGE (HOSPITAL PROVIDER SPELL) | V H4 |
| | | R | 0..1 | METHOD OF DISCHARGE (HOSPITAL PROVIDER SPELL) | V H4 |
| | | R | 0..1 | DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL) | F S13 |
| | | R | 0..1 | DISCHARGE DATE (HOSPITAL PROVIDER SPELL) | F S13 |

| | | | | | |
|---|---|---|---|---|---|
| | | O | 0..1 | DISCHARGE TIME (HOSPITAL PROVIDER SPELL) | F<br>S14 |
| | | R | 0..1 | DISCHARGED TO NHS AT HOME SERVICE INDICATOR | V |

| Notation | | DATA GROUP: BIRTH EPISODE - ACTIVITY CHARACTERISTICS | | | |
|---|---|---|---|---|---|
| Group Status<br>**M** | Group Repeats<br>**1..1** | **FUNCTION:**<br>To carry the details of the Finished Birth Care Professional Admitted Care Episode. | | | |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | EPISODE NUMBER | F<br>H4 |
| | | R | 0..1 | LAST EPISODE IN SPELL INDICATOR CODE | V |
| | | R | 0..1 | NEONATAL LEVEL OF CARE CODE | V<br>H4 |
| | | **M** | **1..1** | START DATE (EPISODE) | F<br>H4<br>S13 |
| | | O | 0..1 | START TIME (EPISODE) | F<br>S14 |
| | | **M** | **1..1** | END DATE (EPISODE) | F<br>H4<br>S1<br>S13 |
| | | O | 0..1 | END TIME (EPISODE) | F<br>S14 |
| | | **M** | **1..1** | AGE AT CDS ACTIVITY DATE | F<br>H4 |

| Notation | | DATA GROUP: BIRTH EPISODE- OVERSEAS VISITOR CHARGING CATEGORY | | | |
|---|---|---|---|---|---|
| Group Status<br>**R** | Group Repeats<br>**0..5** | **FUNCTION:**<br>To carry the details of the Overseas Visitor Charging Categories of the Patient (the Baby) during the Finished Birth Care Professional Admitted Care Episode. | | | |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | **M** | **1..1** | OVERSEAS VISITOR CHARGING CATEGORY | V |
| | | **M** | **1..1** | OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE FROM DATE | F<br>S13 |
| | | R | 0..1 | OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE END DATE | F<br>S13 |

| Notation | | DATA GROUP: BIRTH EPISODE - SERVICE AGREEMENT DETAILS | | | |
|---|---|---|---|---|---|
| Group Status<br>**M** | Group Repeats<br>**1..1** | **FUNCTION:**<br>To carry the details of the Provider, Commissioners and Service Agreements. | | | |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (CODE OF PROVIDER) | F |
| **M** | **1..*** | **DATA GROUP: COMMISSIONERS** | | | **Rules** |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) | F |
| | | R | 0..1 | START DATE (COMMISSIONER ASSIGNMENT PERIOD) | F<br>S13 |
| | | R | 0..1 | END DATE (COMMISSIONER ASSIGNMENT PERIOD) | F<br>S13 |
| | | R | 0..1 | NHS SERVICE AGREEMENT IDENTIFIER | F |
| | | O | 0..1 | NHS SERVICE AGREEMENT LINE IDENTIFIER | F |

| | | O | 0..1 | PROVIDER REFERENCE IDENTIFIER | F |
|---|---|---|---|---|---|
| | | R | 0..1 | COMMISSIONER REFERENCE IDENTIFIER | F |
| | | R | 0..1 | SPECIALISED SERVICE CODE | F |

| Notation | | DATA GROUP: CARE EPISODE - PERSON GROUP (CARE PROFESSIONAL) |
|---|---|---|
| Group Status R | Group Repeats 0..* | FUNCTION: To carry the details of the Care Professionals active during the Finished Birth Care Professional Admitted Care Episode. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER | F |
| | | M | 1..1 | CARE PROFESSIONAL MAIN SPECIALTY CODE | F H4 |
| | | M | 1..1 | ACTIVITY TREATMENT FUNCTION CODE | F H4 |
| | | O | 0..1 | LOCAL SUB-SPECIALTY CODE | F |
| | | M | 1..1 | RESPONSIBLE CARE PROFESSIONAL INDICATOR | V |

| Notation | | DATA GROUP: BIRTH EPISODE - CLINICAL DIAGNOSIS GROUP (ICD) |
|---|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the ICD coded Clinical Diagnoses for the Patient (the Baby). |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET) | V |
| M | 1..1 | DATA GROUP: PRIMARY DIAGNOSIS | | | Rules |
| | | M | 1..1 | PRIMARY DIAGNOSIS (ICD) | F H4 |
| R | 0..* | DATA GROUP: SECONDARY DIAGNOSES | | | Rules |
| | | M | 1..1 | SECONDARY DIAGNOSIS (ICD) | F H4 |

| Notation | | DATA GROUP: BIRTH EPISODE - CLINICAL DIAGNOSIS GROUP (SNOMED CT) |
|---|---|---|
| Group Status R | Group Repeats 0..* | FUNCTION: To carry the details of the SNOMED CT coded Clinical Diagnoses for the Patient (the Baby). |

**One of the following DATA GROUPS may be used:**

| M | 1..1 | DATA GROUP: SNOMED CT DIAGNOSIS | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | DIAGNOSIS (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | CODED CLINICAL ENTRY SEQUENCE NUMBER | F |
| | | M | 1..1 | CODED DIAGNOSIS TIMESTAMP | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: BIRTH EPISODE - COMORBIDITY (SNOMED CT) |
|---|---|---|
| Group Status R | Group Repeats 0..* | FUNCTION: To carry the details of the SNOMED CT coded Comorbidities for the Patient (the Baby). |

**One of the following DATA GROUPS may be used:**

| M | 1..1 | DATA GROUP: SNOMED CT COMORBIDITY | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | COMORBIDITY (SNOMED CT EXPRESSION) | F |

**OR**

| | | | | | |
|---|---|---|---|---|---|
| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: BIRTH EPISODE - PROCEDURE GROUP (OPCS) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To carry the details of the OPCS coded Procedures for the Patient (the Baby). |
| R | 0..1 | |

| | | | | | |
|---|---|---|---|---|---|
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | PROCEDURE SCHEME IN USE (COMMISSIONING DATA SET) | V |
| M | 1..1 | DATA GROUP: PRIMARY PROCEDURE | | | Rules |
| | | M | 1..1 | PRIMARY PROCEDURE (OPCS) | F |
| | | R | 0..1 | PROCEDURE DATE | F S13 |
| O | 0..1 | DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | F |
| O | 0..1 | DATA GROUP: RESPONSIBLE ANAESTHETIST | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | F |
| R | 0..* | DATA GROUP: SECONDARY PROCEDURES | | | Rules |
| | | M | 1..1 | PROCEDURE (OPCS) | F |
| | | R | 0..1 | PROCEDURE DATE | F S13 |
| O | 0..1 | DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | F |
| O | 0..1 | DATA GROUP: RESPONSIBLE ANAESTHETIST | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | F |

| Notation | | DATA GROUP: BIRTH EPISODE - PROCEDURE GROUP (SNOMED CT) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To carry the details of the SNOMED CT coded Procedures for the Patient (the Baby). |
| R | 0..* | |

**One of the following DATA GROUPS may be used:**

| | | | | | |
|---|---|---|---|---|---|
| M | 1..1 | DATA GROUP: SNOMED CT PROCEDURE | | | Rules |
| | | M | 1..1 | PROCEDURE (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | CODED CLINICAL ENTRY SEQUENCE NUMBER | F |
| | | M | 1..1 | CODED PROCEDURE TIMESTAMP | F |
| O | 0..1 | DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | F |
| O | 0..1 | DATA GROUP: RESPONSIBLE ANAESTHETIST | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: BIRTH EPISODE - OBSERVATION GROUP (SNOMED CT) |
|---|---|
| Group Status R / Group Repeats 0..* | FUNCTION: To carry the details of the SNOMED CT coded Clinical Observations for the Patient (the baby). |

One of the following DATA GROUPS may be used:

| M | 1..1 | DATA GROUP: SNOMED CT OBSERVATION | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | OBSERVATION (SNOMED CT EXPRESSION) | F |
| | | R | 0..1 | OBSERVATION VALUE | F |
| | | R | 0..1 | UCUM UNIT OF MEASUREMENT | F |
| | | M | 1..1 | CODED OBSERVATION TIMESTAMP | F |

OR

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: BIRTH EPISODE - FINDING GROUP (SNOMED CT) |
|---|---|
| Group Status R / Group Repeats 0..* | FUNCTION: To carry the details of the SNOMED CT coded Clinical Findings for the Patient (the Baby). |

One of the following DATA GROUPS may be used:

| M | 1..1 | DATA GROUP: SNOMED CT FINDING | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | FINDING (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | CODED FINDING TIMESTAMP | F |

OR

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: BIRTH EPISODE - ASSESSMENT TOOL GROUP (SNOMED CT) |
|---|---|
| Group Status R / Group Repeats 0..* | FUNCTION: To carry the details of the SNOMED CT coded Assessment Tools for the Patient (the Baby). |

One of the following DATA GROUPS may be used:

| M | 1..1 | DATA GROUP: SNOMED CT ASSESSMENT TOOL | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | ASSESSMENT TOOL (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | PERSON SCORE | F |
| | | M | 1..1 | ASSESSMENT TOOL COMPLETION TIMESTAMP | F |

OR

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: LOCATION GROUP (AT START OF BIRTH EPISODE) |
|---|---|
| Group Status R / Group Repeats 0..1 | FUNCTION: To carry the details of the Location at the Start of the Finished Birth Care Professional Admitted Care Episode. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | ORGANISATION SITE IDENTIFIER (OF TREATMENT) | F |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | O | 0..1 | WARD INTENDED CLINICAL CARE INTENSITY | V |
| | | O | 0..1 | WARD INTENDED AGE GROUP | V |
| | | O | 0..1 | WARD INTENDED SEX OF PATIENTS | V |

| | | | | | |
|---|---|---|---|---|---|
| | | O | 0..1 | WARD INTENDED DAY PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD INTENDED NIGHT PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD SECURITY LEVEL | V |
| | | O | 0..1 | WARD CODE | F |

| Notation | | DATA GROUP: LOCATION GROUP (AT WARD STAY) | | | |
|---|---|---|---|---|---|
| Group Status R | Group Repeats 0..97 | FUNCTION: To carry the details of one or more Ward Stays during the Finished Birth Care Professional Admitted Care Episode. | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | ORGANISATION SITE IDENTIFIER (OF TREATMENT) | F |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | O | 0..1 | WARD INTENDED CLINICAL CARE INTENSITY | V |
| | | O | 0..1 | WARD INTENDED AGE GROUP | V |
| | | O | 0..1 | WARD INTENDED SEX OF PATIENTS | V |
| | | O | 0..1 | WARD INTENDED DAY PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD INTENDED NIGHT PERIOD AVAILABILITY | V |
| | | O | 0..1 | START DATE (WARD STAY) | F S13 |
| | | O | 0..1 | START TIME (WARD STAY) | F S14 |
| | | O | 0..1 | END DATE (WARD STAY) | F S13 |
| | | O | 0..1 | END TIME (WARD STAY) | F S14 |
| | | O | 0..1 | WARD SECURITY LEVEL | V |
| | | O | 0..1 | WARD CODE | F |

| Notation | | DATA GROUP: LOCATION GROUP (AT END OF BIRTH EPISODE) | | | |
|---|---|---|---|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the Location at the End of the Finished Birth Care Professional Admitted Care Episode. | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | ORGANISATION SITE IDENTIFIER (OF TREATMENT) | F |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | O | 0..1 | WARD INTENDED CLINICAL CARE INTENSITY | V |
| | | O | 0..1 | WARD INTENDED AGE GROUP | V |
| | | O | 0..1 | WARD INTENDED SEX OF PATIENTS | V |
| | | O | 0..1 | WARD INTENDED DAY PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD INTENDED NIGHT PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD SECURITY LEVEL | V |
| | | O | 0..1 | WARD CODE | F |

| Notation | | DATA GROUP: LOCATION GROUP - HOME LEAVE | | | |
|---|---|---|---|---|---|
| Group Status R | Group Repeats 0..* | FUNCTION: To carry the details of each separate period of Home Leave within the Finished Birth Care Professional Admitted Care Episode. | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | START DATE (HOME LEAVE) | F S13 |
| | | R | 0..1 | START TIME (HOME LEAVE) | F S14 |

| | | Status | Repeats | Data Element | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | END DATE (HOME LEAVE) | F S13 |
| | | R | 0..1 | END TIME (HOME LEAVE) | F S14 |

| Notation | | DATA GROUP: BIRTH EPISODE - NEONATAL CRITICAL CARE PERIOD | | | |
|---|---|---|---|---|---|
| Group Status R | Group Repeats 0..9 | **FUNCTION: See CRITICAL CARE PERIOD** To carry the details of the first 9 Critical Care Periods for care provided using Neonatal Care facilities. | | | |
| **M** | **1..1** | **DATA GROUP: NEONATAL CARE - ADMISSION CHARACTERISTICS** | | | **Rules** |
| | | **M** | **1..1** | CRITICAL CARE LOCAL IDENTIFIER | F |
| | | **M** | **1..1** | CRITICAL CARE START DATE | F H4 S13 |
| | | **M** | **1..1** | CRITICAL CARE START TIME | F S14 |
| | | **M** | **1..1** | CRITICAL CARE UNIT FUNCTION | V H4 |
| | | **M** | **1..1** | GESTATION LENGTH (AT DELIVERY) | V |
| **M** | **1..999** | **DATA GROUP: NEONATAL DAILY CARE - ACTIVITY CHARACTERISTICS** | | | **Rules** |
| | | **M** | **1..1** | ACTIVITY DATE (CRITICAL CARE) | F S13 |
| | | R | 0..1 | PERSON WEIGHT | F |
| | | **M** | **1..20** | CRITICAL CARE ACTIVITY CODE | F N4 |
| | | R | 0..20 | HIGH COST DRUGS (OPCS) | F N4 |
| R | 0..1 | DATA GROUP: NEONATAL CARE - DISCHARGE CHARACTERISTICS | | | **Rules** |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE DATE | F H4 S13 |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE TIME | F S14 |

| Notation | | DATA GROUP: BIRTH EPISODE - PAEDIATRIC CRITICAL CARE PERIOD | | | |
|---|---|---|---|---|---|
| Group Status R | Group Repeats 0..9 | **FUNCTION: See CRITICAL CARE PERIOD** To carry the details of the first 9 Critical Care Periods for care provided using Paediatric Care facilities. | | | |
| **M** | **1..1** | **DATA GROUP: PAEDIATRIC CRITICAL CARE - ADMISSION CHARACTERISTICS** | | | **Rules** |
| | | **M** | **1..1** | CRITICAL CARE LOCAL IDENTIFIER | F |
| | | **M** | **1..1** | CRITICAL CARE START DATE | F H4 S13 |
| | | **M** | **1..1** | CRITICAL CARE START TIME | F S14 |
| | | **M** | **1..1** | CRITICAL CARE UNIT FUNCTION | V H4 |
| **M** | **1..999** | **DATA GROUP: PAEDIATRIC DAILY CARE - ACTIVITY CHARACTERISTICS** | | | **Rules** |
| | | **M** | **1..1** | ACTIVITY DATE (CRITICAL CARE) | F S13 |
| | | **M** | **1..20** | CRITICAL CARE ACTIVITY CODE | F N4 |
| | | R | 0..20 | HIGH COST DRUGS (OPCS) | |

| | | | | | F<br>N4 |
|---|---|---|---|---|---|
| R | 0..1 | DATA GROUP: PAEDIATRIC CRITICAL CARE - DISCHARGE CHARACTERISTICS | | | Rules |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE DATE | F<br>H4<br>S13 |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE TIME | F<br>S14 |

| Notation | **DATA GROUP: BIRTH EPISODE - ADULT CRITICAL CARE PERIOD** |
|---|---|
| Group Status **R** / Group Repeats **0..9** | **FUNCTION: See CRITICAL CARE PERIOD**<br>**To carry the details of the first 9 Critical Care Periods for care provided using Adult Care facilities.** |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **DATA GROUP: ADULT CRITICAL CARE - ADMISSION CHARACTERISTICS** | | | **Rules** |
| | | **M** | **1..1** | CRITICAL CARE LOCAL IDENTIFIER | F |
| | | **M** | **1..1** | CRITICAL CARE START DATE | F<br>H4<br>S13 |
| | | O | 0..1 | CRITICAL CARE START TIME | F<br>S14 |
| | | **M** | **1..1** | CRITICAL CARE UNIT FUNCTION | V<br>H4 |
| | | O | 0..1 | CRITICAL CARE UNIT BED CONFIGURATION | V |
| | | O | 0..1 | CRITICAL CARE ADMISSION SOURCE | V |
| | | O | 0..1 | CRITICAL CARE SOURCE LOCATION | V |
| | | O | 0..1 | CRITICAL CARE ADMISSION TYPE | V |
| **M** | **1..1** | **DATA GROUP: ADULT CRITICAL CARE - ACTIVITY CHARACTERISTICS** | | | **Rules** |
| | | R | 0..1 | ADVANCED RESPIRATORY SUPPORT DAYS | F<br>H4 |
| | | R | 0..1 | BASIC RESPIRATORY SUPPORT DAYS | F<br>H4 |
| | | R | 0..1 | ADVANCED CARDIOVASCULAR SUPPORT DAYS | F<br>H4 |
| | | R | 0..1 | BASIC CARDIOVASCULAR SUPPORT DAYS | F<br>H4 |
| | | R | 0..1 | RENAL SUPPORT DAYS | F<br>H4 |
| | | R | 0..1 | NEUROLOGICAL SUPPORT DAYS | F<br>H4 |
| | | O | 0..1 | GASTRO-INTESTINAL SUPPORT DAYS | F |
| | | R | 0..1 | DERMATOLOGICAL SUPPORT DAYS | F<br>H4 |
| | | R | 0..1 | LIVER SUPPORT DAYS | F<br>H4 |
| | | O | 0..1 | ORGAN SUPPORT MAXIMUM | V |
| | | R | 0..1 | CRITICAL CARE LEVEL 2 DAYS | F<br>H4 |
| | | R | 0..1 | CRITICAL CARE LEVEL 3 DAYS | F<br>H4 |
| R | 0..* | DATA GROUP: ADULT CRITICAL CARE - DAILY CARE ACTIVITY CHARACTERISTICS | | | **Rules** |
| | | **M** | **1..1** | ACTIVITY DATE (CRITICAL CARE) | F<br>S13 |
| | | **M** | **1..9** | ORGAN SYSTEM SUPPORTED | V |

| | | M | 1..1 | CRITICAL CARE LEVEL | V |
|---|---|---|---|---|---|
| R | 0..1 | DATA GROUP: ADULT CRITICAL CARE - DISCHARGE CHARACTERISTICS | | | Rules |
| | | M | 1..1 | CRITICAL CARE DISCHARGE DATE | F<br>H4<br>S13 |
| | | M | 1..1 | CRITICAL CARE DISCHARGE TIME | F<br>S14 |
| | | O | 0..1 | CRITICAL CARE DISCHARGE READY DATE | F<br>S13 |
| | | O | 0..1 | CRITICAL CARE DISCHARGE READY TIME | F<br>S14 |
| | | O | 0..1 | CRITICAL CARE DISCHARGE STATUS | V |
| | | O | 0..1 | CRITICAL CARE DISCHARGE DESTINATION | V |
| | | O | 0..1 | CRITICAL CARE DISCHARGE LOCATION | V |

| Notation | | DATA GROUP: GP REGISTRATION | | | |
|---|---|---|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To carry the Patient's General Medical Practitioner and the General Practice details. | | | |
| R | 0..1 | | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | O | 0..1 | GENERAL MEDICAL PRACTITIONER (SPECIFIED) | F |
| | | R | 0..1 | GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION) | F |

| Notation | | DATA GROUP: REFERRER | | | |
|---|---|---|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To carry the details of the Referrer. | | | |
| R | 0..1 | | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | REFERRER CODE | F |
| | | R | 0..1 | ORGANISATION IDENTIFIER (REFERRING ORGANISATION) | F |

| Notation | | DATA GROUP: PREGNANCY - ACTIVITY CHARACTERISTICS | | | |
|---|---|---|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To carry the details of the Pregnancy. | | | |
| R | 0..1 | | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | NUMBER OF BABIES INDICATION CODE | V |

| Notation | | DATA GROUP: ANTENATAL CARE - ACTIVITY CHARACTERISTICS | | | |
|---|---|---|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To carry the details of the Antenatal Care. | | | |
| R | 0..1 | | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | FIRST ANTENATAL ASSESSMENT DATE | F<br>S13 |

| Notation | | DATA GROUP: ANTENATAL CARE - PERSON GROUP (RESPONSIBLE CLINICIAN) | | | |
|---|---|---|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To carry the details of the General Medical Practitioner responsible for the Antenatal Care. | | | |
| R | 0..1 | | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE) | F |

| | | O | 0..1 | GENERAL MEDICAL PRACTITIONER PRACTICE (PATIENT ANTENATAL CARE) | F |
|---|---|---|---|---|---|

| Notation | | DATA GROUP: ANTENATAL CARE - LOCATION GROUP - DELIVERY PLACE INTENDED | | | |
|---|---|---|---|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the Intended Delivery Location. | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | V |
| | | R | 0..1 | DELIVERY PLACE CHANGE REASON CODE | V |
| | | R | 0..1 | DELIVERY PLACE TYPE CODE (INTENDED) | V |

| Notation | | DATA GROUP: LABOUR/DELIVERY - ACTIVITY CHARACTERISTICS | | | |
|---|---|---|---|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the Labour/Delivery. | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY CODE | V |
| | | R | 0..1 | ANAESTHETIC GIVEN POST LABOUR OR DELIVERY CODE | V |
| | | O | 0..1 | GESTATION LENGTH (LABOUR ONSET) | F |
| | | R | 0..1 | LABOUR OR DELIVERY ONSET METHOD CODE | V |
| | | R | 0..1 | DELIVERY TIMESTAMP | F |

| Notation | | DATA GROUP: DELIVERY OCCURRENCE - ACTIVITY CHARACTERISTICS | | | |
|---|---|---|---|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the Delivery of the Baby. | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | BIRTH ORDER | F |
| | | R | 0..1 | DELIVERY METHOD CODE | V |
| | | R | 0..1 | GESTATION LENGTH (ASSESSMENT) | F |
| | | R | 0..1 | RESUSCITATION METHOD CODE | V |
| | | R | 0..1 | STATUS OF PERSON CONDUCTING DELIVERY CODE | V |

| Notation | | DATA GROUP: PERSON IDENTITY (MOTHER) |
|---|---|---|
| Group Status M | Group Repeats 1..1 | FUNCTION: To carry the Identity details of the Baby's mother. See Note: S3 in Commissioning Data Set Business Rules. |

**One of the following DATA GROUPS must be used:**

| 1..1 | DATA GROUP: WITHHELD IDENTITY STRUCTURE<br>Must be used where the Commissioning Data Set record has been anonymised | | | | |
|---|---|---|---|---|---|
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | NHS NUMBER STATUS INDICATOR CODE (MOTHER) | V |
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | WITHHELD IDENTITY REASON | V |

**OR**

| 1..1 | DATA GROUP: VERIFIED IDENTITY STRUCTURE<br>Must be used where the NHS NUMBER STATUS INDICATOR CODE (MOTHER) National Code = 01 (Number present and verified) | | | | |
|---|---|---|---|---|---|
| O | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | Rules |
| | | M | 1..1 | LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER)) | F<br>S3 |
| | | M | 1..1 | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER)) | F |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | NHS NUMBER (MOTHER) | F S3 |
| | | M | 1..1 | NHS NUMBER STATUS INDICATOR CODE (MOTHER) | V |
| | | M | 1..1 | POSTCODE OF USUAL ADDRESS (MOTHER) | F S3 |
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | PERSON BIRTH DATE (MOTHER) | F S3 S12 |

**OR**

| 1..1 | **DATA GROUP: UNVERIFIED IDENTITY STRUCTURE**<br>**Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE (MOTHER) NOT included in the above** | | | | |
|---|---|---|---|---|---|
| O | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | Rules |
| | | M | 1..1 | LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER)) | F S3 |
| | | M | 1..1 | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER)) | F |
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | NHS NUMBER (MOTHER) | F S3 |
| | | M | 1..1 | NHS NUMBER STATUS INDICATOR CODE (MOTHER) | V |
| O | 0..1 | Data Element Components | | | Rules |
| | | M<br>OR<br>M | 1..1<br>OR<br>2..5 | PATIENT USUAL ADDRESS (UNSTRUCTURED (MOTHER))<br>OR<br>PATIENT USUAL ADDRESS (STRUCTURED (MOTHER)) | F S3 I5 |
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | POSTCODE OF USUAL ADDRESS (MOTHER) | F S3 |
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | PERSON BIRTH DATE (MOTHER) | F S3 S12 |

| Notation | | **DATA GROUP: DELIVERY OCCURRENCE - OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE** |
|---|---|---|
| Group Status | Group Repeats | **FUNCTION:**<br>**To carry the details of the Overseas Visitor Charging Category of the Mother.** |
| R | 0..1 | |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE | V |

| Notation | | **DATA GROUP: DELIVERY OCCURRENCE - LOCATION GROUP - DELIVERY PLACE ACTUAL** |
|---|---|---|
| Group Status | Group Repeats | **FUNCTION:**<br>**To carry the details of the Actual Delivery Location.** |
| R | 0..1 | |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | R | 0..1 | DELIVERY PLACE TYPE CODE (ACTUAL) | V |

| Notation | | **DATA GROUP: CDS V6-3 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER** |
|---|---|---|
| Group Status | Group Repeats | **FUNCTION:**<br>**To define the mandatory identity and addressing information for a Commissioning Data Set submission.** |

| M | 1..* | DATA GROUP: CDS V6-3 Type 004 - Commissioning Data Set Message Trailer<br>One per Commissioning Data Set Message submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |
|---|---|---|

| Notation | | DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer<br>One per Interchange submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

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**CDS V6-3 TYPE 130 - ADMITTED PATIENT CARE - FINISHED GENERAL EPISODE CDS**

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Change to Data Set: New Data Set

| CDS V6-3 TYPE 130 - FINISHED GENERAL EPISODE COMMISSIONING DATA SET |
|---|
| FUNCTION: To support the details of a Finished Care Professional Admitted Care General Episode. |

| Notation | | DATA GROUP: CDS V6-3 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 001 - Commissioning Data Set Interchange Header<br>One per Interchange submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| Notation | | DATA GROUP: CDS V6-3 TYPE 003 - COMMISSIONING DATA SET MESSAGE HEADER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..* | DATA GROUP: CDS V6-3 Type 003 - Commissioning Data Set Message Header<br>One per Commissioning Data Set Message submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

**ONE OF THE FOLLOWING TWO OPTIONS MUST BE USED:**

| Notation | | DATA GROUP: CDS V6-3 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of the Bulk Replacement Update Mechanism of the Commissioning Data Set Submission Protocol. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol<br>One per Commissioning Data Set record submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

**OR**

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

| Group Status | Group Repeats | FUNCTION: To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of one of the Net Change Update Mechanism of the Commissioning Data Set Submission Protocol. |
| --- | --- | --- |
| M | 1..1 | **DATA GROUP: CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol**<br>One per Commissioning Data Set record submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| Notation | | DATA GROUP: PATIENT PATHWAY | | | |
| --- | --- | --- | --- | --- | --- |
| Group Status<br>R | Group Repeats<br>0..1 | **FUNCTION:**<br>**To carry the details of the Patient Pathway.**<br>**This Group must be present if the record relates to a Referral To Treatment Period Included In 18 Weeks Target.** | | | |
| M | 1..1 | **DATA GROUP: PATIENT PATHWAY IDENTITY** | | | **Rules** |
| | **M**<br>*Or*<br>**M** | **1..1**<br><br>**1..1** | UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)<br>*Or*<br>PATIENT PATHWAY IDENTIFIER | | F<br><br>F<br>I2 |
| | **M** | **1..1** | ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER) | | F<br>I2 |
| M | 1..1 | **DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS** | | | **Rules** |
| | **M** | **1..1** | REFERRAL TO TREATMENT PERIOD STATUS | | V |
| | **M** | **1..1** | WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET) | | V |
| | O | 0..1 | REFERRAL TO TREATMENT PERIOD START DATE | | F<br>S13 |
| | O | 0..1 | REFERRAL TO TREATMENT PERIOD END DATE | | F<br>S13 |

| Notation | | DATA GROUP: PATIENT IDENTITY |
| --- | --- | --- |
| Group Status<br>M | Group Repeats<br>1..1 | **FUNCTION:**<br>**To carry the Identity of the Patient.**<br>**See Note: S3 in Commissioning Data Set Business Rules.** |

**One of the following DATA GROUPS must be used:**

| 1..1 | **DATA GROUP: WITHHELD IDENTITY STRUCTURE**<br>**Must be used where the Commissioning Data Set record has been anonymised** | | | | |
| --- | --- | --- | --- | --- | --- |
| M | 1..1 | **Data Element Components** | | | **Rules** |
| | | **M** | **1..1** | NHS NUMBER STATUS INDICATOR CODE | V |
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | WITHHELD IDENTITY REASON | V |

**OR**

| 1..1 | **DATA GROUP: VERIFIED IDENTITY STRUCTURE**<br>**Must be used where the NHS NUMBER STATUS INDICATOR CODE National Code = 01 (Number present and verified)** | | | | |
| --- | --- | --- | --- | --- | --- |
| R | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | **Rules** |
| | | **M** | **1..1** | LOCAL PATIENT IDENTIFIER (EXTENDED) | F<br>S3 |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) | F |
| M | 1..1 | **Data Element Components** | | | **Rules** |
| | | **M** | **1..1** | NHS NUMBER | F<br>S3 |
| | | **M** | **1..1** | NHS NUMBER STATUS INDICATOR CODE | V |
| | | **M** | **1..1** | POSTCODE OF USUAL ADDRESS | |

| | | | | | F<br>S3 |
|---|---|---|---|---|---|
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | PERSON BIRTH DATE | F<br>S3<br>S12 |

**OR**

| **1..1** | **DATA GROUP: UNVERIFIED IDENTITY STRUCTURE**<br>**Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE NOT included in the above** | | | | |
|---|---|---|---|---|---|
| R | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | **Rules** |
| | | **M** | **1..1** | LOCAL PATIENT IDENTIFIER (EXTENDED) | F<br>S3 |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) | F |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | NHS NUMBER | F<br>S3 |
| | | **M** | **1..1** | NHS NUMBER STATUS INDICATOR CODE | V |
| R | 0..1 | Data Element Components | | | **Rules** |
| | | **M**<br>**OR**<br>O<br>and<br>**M**<br>**and**<br>**M**<br>and<br>O<br>and<br>O | **1..1**<br>**OR**<br>0..1<br>and<br>**1..1**<br>**and**<br>**1..1**<br>and<br>0..1<br>and<br>0..1 | PATIENT FULL NAME<br>**OR**<br>PATIENT TITLE<br>and<br>PATIENT GIVEN NAME<br>**and**<br>PATIENT FAMILY NAME<br>and<br>PATIENT NAME SUFFIX<br>and<br>PATIENT INITIALS | F<br>S3<br>I4 |
| R | 0..1 | Data Element Components | | | **Rules** |
| | | **M**<br>**OR**<br>**M** | **1..1**<br>**OR**<br>**2..5** | PATIENT USUAL ADDRESS (UNSTRUCTURED)<br>**OR**<br>PATIENT USUAL ADDRESS (STRUCTURED) | F<br>S3<br>I5 |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | POSTCODE OF USUAL ADDRESS | F<br>S3 |
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | PERSON BIRTH DATE | F<br>S3<br>S12 |

| **Notation** | | **DATA GROUP: PATIENT CHARACTERISTICS** |
|---|---|---|
| **Group Status**<br>**R** | **Group Repeats**<br>**0..1** | **FUNCTION:**<br>**To carry the characteristics of the Patient.** |

| **M** | **1..1** | **Data Element Components** | | | **Rules** |
|---|---|---|---|---|---|
| | | R | 0..1 | PERSON STATED GENDER CODE | V<br>H4 |
| | | O | 0..1 | CARER SUPPORT INDICATOR | V |
| | | R | 0..1 | ETHNIC CATEGORY | V |
| | | X | 0..1 | ETHNIC CATEGORY 2021 | N2 |
| | | R | 0..1 | PERSON MARITAL STATUS | V<br>N1 |
| | | R | 0..1 | | |

| | | | | MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION) | F N1 |
|---|---|---|---|---|---|

| Notation | DATA GROUP: PATIENT CHARACTERISTICS - SOCIAL AND PERSONAL CIRCUMSTANCES (SNOMED CT) |
|---|---|
| Group Status R / Group Repeats 0..* | FUNCTION: To carry the details of the SNOMED CT coded Social and Personal Circumstances for the Patient. |

One of the following DATA GROUPS may be used:

| M | 1..1 | DATA GROUP: SNOMED CT SOCIAL AND PERSONAL CIRCUMSTANCES | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP | F |

OR

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: HOSPITAL PROVIDER SPELL - ADMISSION CHARACTERISTICS |
|---|---|
| Group Status M / Group Repeats 1..1 | FUNCTION: To carry the admission details of the Hospital Provider Spell containing the Finished General Care Professional Admitted Care Episode. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | HOSPITAL PROVIDER SPELL IDENTIFIER | F H4 |
| | | R | 0..1 | ADMINISTRATIVE CATEGORY CODE (ON ADMISSION) | V |
| | | R | 0..1 | PATIENT CLASSIFICATION CODE | V H4 |
| | | R | 0..1 | METHOD OF ADMISSION (HOSPITAL PROVIDER SPELL) | V H4 |
| | | R | 0..1 | ADMISSION SOURCE (HOSPITAL PROVIDER SPELL) | V H4 |
| | | M | 1..1 | START DATE (HOSPITAL PROVIDER SPELL) | F H4 S13 |
| | | O | 0..1 | START TIME (HOSPITAL PROVIDER SPELL) | F S14 |
| | | M | 1..1 | AGE ON ADMISSION | F H4 |
| | | R | 0..1 | AMBULANCE CALL IDENTIFIER | F |
| | | R | 0..1 | ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST) | F |
| | | R | 0..1 | CARE CONTACT IDENTIFIER (AMBULANCE SERVICE) | F |

| Notation | DATA GROUP: HOSPITAL PROVIDER SPELL - DISCHARGE CHARACTERISTICS |
|---|---|
| Group Status R / Group Repeats 0..1 | FUNCTION: To carry the discharge details of the Hospital Provider Spell containing the Finished General Care Professional Admitted Care Episode. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | DESTINATION OF DISCHARGE (HOSPITAL PROVIDER SPELL) | V H4 |
| | | R | 0..1 | METHOD OF DISCHARGE (HOSPITAL PROVIDER SPELL) | V H4 |
| | | R | 0..1 | DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL) | F S13 |
| | | R | 0..1 | DISCHARGE DATE (HOSPITAL PROVIDER SPELL) | F S13 |

| | | | | | |
|---|---|---|---|---|---|
| | | O | 0..1 | DISCHARGE TIME (HOSPITAL PROVIDER SPELL) | F S14 |
| | | R | 0..1 | DISCHARGED TO NHS AT HOME SERVICE INDICATOR | V |

| Notation | | DATA GROUP: CARE EPISODE - ACTIVITY CHARACTERISTICS | | | |
|---|---|---|---|---|---|
| Group Status **M** | Group Repeats **1..1** | FUNCTION: To carry the details of the Patient's Finished General Care Professional Admitted Care Episode. | | | |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | EPISODE NUMBER | F H4 |
| | | R | 0..1 | LAST EPISODE IN SPELL INDICATOR CODE | V |
| | | R | 0..1 | NEONATAL LEVEL OF CARE CODE | V H4 |
| | | O | 0..1 | FIRST REGULAR DAY OR NIGHT ADMISSION CODE | V |
| | | R | 0..1 | PSYCHIATRIC PATIENT STATUS CODE | V |
| | | **M** | **1..1** | START DATE (EPISODE) | F S13 |
| | | O | 0..1 | START TIME (EPISODE) | F S14 |
| | | **M** | **1..1** | END DATE (EPISODE) | F H4 S1 S13 |
| | | O | 0..1 | END TIME (EPISODE) | F S14 |
| | | **M** | **1..1** | AGE AT CDS ACTIVITY DATE | F H4 S8 |
| | | O | 0..1 | REHABILITATION ASSESSMENT TEAM TYPE | V N3 |

| Notation | | DATA GROUP: CARE EPISODE - LENGTH OF STAY ADJUSTMENT | | | |
|---|---|---|---|---|---|
| Group Status **R** | Group Repeats **0..1** | FUNCTION: To carry details of length of stay adjustments to the Finished General Care Professional Admitted Care Episode . | | | |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | LENGTH OF STAY ADJUSTMENT (REHABILITATION) | F H4 |
| | | R | 0..1 | LENGTH OF STAY ADJUSTMENT (SPECIALIST PALLIATIVE CARE) | F H4 |

| Notation | | DATA GROUP: CARE EPISODE- OVERSEAS VISITOR CHARGING CATEGORY | | | |
|---|---|---|---|---|---|
| Group Status **R** | Group Repeats **0..5** | FUNCTION: To carry the details of the Overseas Visitor Charging Categories of the Patient during the Finished General Care Professional Admitted Care Episode. | | | |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | **M** | **1..1** | OVERSEAS VISITOR CHARGING CATEGORY | V |
| | | **M** | **1..1** | OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE FROM DATE | F S13 |
| | | R | 0..1 | OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE END DATE | F S13 |

| Notation | DATA GROUP: CARE EPISODE - SERVICE AGREEMENT DETAILS |
|---|---|

| Group Status | Group Repeats | FUNCTION: | |
|---|---|---|---|
| M | 1..1 | To carry the details of the Provider, Commissioners and Service Agreements. | |

| | | | | | |
|---|---|---|---|---|---|
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | ORGANISATION IDENTIFIER (CODE OF PROVIDER) | F |
| M | 1..* | DATA GROUP: COMMISSIONERS | | | Rules |
| | | M | 1..1 | ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) | F |
| | | R | 0..1 | START DATE (COMMISSIONER ASSIGNMENT PERIOD) | F<br>S13 |
| | | R | 0..1 | END DATE (COMMISSIONER ASSIGNMENT PERIOD) | F<br>S13 |
| | | R | 0..1 | NHS SERVICE AGREEMENT IDENTIFIER | F |
| | | O | 0..1 | NHS SERVICE AGREEMENT LINE IDENTIFIER | F |
| | | O | 0..1 | PROVIDER REFERENCE IDENTIFIER | F |
| | | R | 0..1 | COMMISSIONER REFERENCE IDENTIFIER | F |
| | | R | 0..1 | SPECIALISED SERVICE CODE | F |

| Notation | | DATA GROUP: CARE EPISODE - PERSON GROUP (CARE PROFESSIONAL) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| R | 0..* | To carry the details of the Care Professionals active during the Finished General Care Professional Admitted Care Episode. |

| | | | | | |
|---|---|---|---|---|---|
| M | 1..1 | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER | F |
| | | M | 1..1 | CARE PROFESSIONAL MAIN SPECIALTY CODE | F<br>H4 |
| | | M | 1..1 | ACTIVITY TREATMENT FUNCTION CODE | F<br>H4 |
| | | O | 0..1 | LOCAL SUB-SPECIALTY CODE | F |
| | | M | 1..1 | RESPONSIBLE CARE PROFESSIONAL INDICATOR | V |

| Notation | | DATA GROUP: CARE EPISODE - CLINICAL DIAGNOSIS GROUP (ICD) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| R | 0..1 | To carry the details of the ICD coded Clinical Diagnoses for the Patient. |

| | | | | | |
|---|---|---|---|---|---|
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET) | V |
| M | 1..1 | DATA GROUP: PRIMARY DIAGNOSIS | | | Rules |
| | | M | 1..1 | PRIMARY DIAGNOSIS (ICD) | F<br>H4 |
| | | O | 0..1 | PRESENT ON ADMISSION INDICATOR | V |
| R | 0..* | DATA GROUP: SECONDARY DIAGNOSES | | | Rules |
| | | M | 1..1 | SECONDARY DIAGNOSIS (ICD) | F<br>H4 |
| | | O | 0..1 | PRESENT ON ADMISSION INDICATOR | V |

| Notation | | DATA GROUP: CARE EPISODE - CLINICAL DIAGNOSIS GROUP (SNOMED CT) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| R | 0..* | To carry the details of the SNOMED CT coded Clinical Diagnoses for the Patient. |

One of the following DATA GROUPS may be used:

| | | | | | |
|---|---|---|---|---|---|
| M | 1..1 | DATA GROUP: SNOMED CT DIAGNOSIS | | | Rules |
| | | M | 1..1 | DIAGNOSIS (SNOMED CT EXPRESSION) | F |

| | | M | 1..1 | CODED CLINICAL ENTRY SEQUENCE NUMBER | F |
|---|---|---|---|---|---|
| | | M | 1..1 | CODED DIAGNOSIS TIMESTAMP | F |

OR

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: CARE EPISODE - COMORBIDITY (SNOMED CT) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To carry the details of the SNOMED CT coded Comorbidities for the Patient. |
| R | 0..* | |

One of the following DATA GROUPS may be used:

| M | 1..1 | DATA GROUP: SNOMED CT COMORBIDITY | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | COMORBIDITY (SNOMED CT EXPRESSION) | F |

OR

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: CARE EPISODE - EMED3 FIT NOTE |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To carry the details of the EMED3 Fit Note issued. |
| R | 0..1 | |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | EMED3 FIT NOTE ASSESSMENT DATE | F S13 |
| | | R | 0..1 | EMED3 FIT NOTE CONDITION (SNOMED CT EXPRESSION) | F |
| | | R | 0..1 | EMED3 FIT NOTE DIAGNOSIS (ICD) | F |
| | | R | 0..1 | EMED3 FIT NOTE START DATE | F S13 |
| | | R | 0..1 | EMED3 FIT NOTE END DATE | F S13 |
| | | R | 0..1 | EMED3 FIT NOTE DURATION | F |
| | | R | 0..1 | EMED3 FIT NOTE RECORDED DATE | F S13 |
| | | R | 0..1 | EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR | V |

| Notation | | DATA GROUP: CARE EPISODE - PROCEDURE GROUP (OPCS) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To carry the details of the OPCS coded Procedures for the Patient. |
| R | 0..1 | |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | PROCEDURE SCHEME IN USE (COMMISSIONING DATA SET) | V |
| M | 1..1 | DATA GROUP: PRIMARY PROCEDURE | | | Rules |
| | | M | 1..1 | PRIMARY PROCEDURE (OPCS) | F |
| | | R | 0..1 | PROCEDURE DATE | F S13 |
| O | 0..1 | DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | F |
| O | 0..1 | DATA GROUP: RESPONSIBLE ANAESTHETIST | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | | F |

| | | | | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | |
|---|---|---|---|---|---|
| R | 0..* | DATA GROUP: SECONDARY PROCEDURES | | | Rules |
| | | **M** | **1..1** | PROCEDURE (OPCS) | F |
| | | R | 0..1 | PROCEDURE DATE | F<br>S13 |
| O | 0..1 | DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL | | | Rules |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | F |
| O | 0..1 | DATA GROUP: RESPONSIBLE ANAESTHETIST | | | Rules |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | F |

| Notation | | **DATA GROUP: CARE EPISODE - PROCEDURE GROUP (SNOMED CT)** |
|---|---|---|
| **Group Status** | **Group Repeats** | **FUNCTION:**<br>**To carry the details of the SNOMED CT coded Procedures for the Patient.** |
| **R** | **0..*** | |

**One of the following DATA GROUPS may be used:**

| **M** | **1..1** | **DATA GROUP: SNOMED CT PROCEDURE** | | | Rules |
|---|---|---|---|---|---|
| | | **M** | **1..1** | PROCEDURE (SNOMED CT EXPRESSION) | F |
| | | **M** | **1..1** | CODED CLINICAL ENTRY SEQUENCE NUMBER | F |
| | | **M** | **1..1** | CODED PROCEDURE TIMESTAMP | F |
| O | 0..1 | DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL | | | Rules |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | F |
| O | 0..1 | DATA GROUP: RESPONSIBLE ANAESTHETIST | | | Rules |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | **DATA GROUP: CARE EPISODE - OBSERVATION GROUP (SNOMED CT)** |
|---|---|---|
| **Group Status** | **Group Repeats** | **FUNCTION:**<br>**To carry the details of the SNOMED CT coded Clinical Observations for the Patient.** |
| **R** | **0..*** | |

**One of the following DATA GROUPS may be used:**

| **M** | **1..1** | **DATA GROUP: SNOMED CT OBSERVATION** | | | Rules |
|---|---|---|---|---|---|
| | | **M** | **1..1** | OBSERVATION (SNOMED CT EXPRESSION) | F |
| | | R | 0..1 | OBSERVATION VALUE | F |
| | | R | 0..1 | UCUM UNIT OF MEASUREMENT | F |
| | | **M** | **1..1** | CODED OBSERVATION TIMESTAMP | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | **DATA GROUP: CARE EPISODE - FINDING GROUP (SNOMED CT)** |
|---|---|---|
| | | |

| Group Status | Group Repeats | FUNCTION: |
|---|---|---|
| R | 0..* | To carry the details of the SNOMED CT coded Clinical Findings for the Patient. |

**One of the following DATA GROUPS may be used:**

| M | 0..1 | **DATA GROUP: SNOMED CT FINDING** | | | Rules |
|---|---|---|---|---|---|
| | | **M** | **1..1** | FINDING (SNOMED CT EXPRESSION) | F |
| | | **M** | **1..1** | CODED FINDING TIMESTAMP | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: CARE EPISODE - ASSESSMENT TOOL GROUP (SNOMED CT) |
|---|---|

| Group Status | Group Repeats | FUNCTION: |
|---|---|---|
| R | 0..* | To carry the details of the SNOMED CT coded Assessment Tools for the Patient. |

**One of the following DATA GROUPS may be used:**

| M | 1..1 | **DATA GROUP: SNOMED CT ASSESSMENT TOOL** | | | Rules |
|---|---|---|---|---|---|
| | | **M** | **1..1** | ASSESSMENT TOOL (SNOMED CT EXPRESSION) | F |
| | | **M** | **1..1** | PERSON SCORE | F |
| | | **M** | **1..1** | ASSESSMENT TOOL COMPLETION TIMESTAMP | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: LOCATION GROUP (AT START OF CARE EPISODE) |
|---|---|

| Group Status | Group Repeats | FUNCTION: |
|---|---|---|
| R | 0..1 | To carry the details of the Location at the Start of the Finished General Care Professional Admitted Care Episode. |

| M | 1..1 | **Data Element Components** | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | ORGANISATION SITE IDENTIFIER (OF TREATMENT) | F |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | O | 0..1 | WARD INTENDED CLINICAL CARE INTENSITY | V |
| | | O | 0..1 | WARD INTENDED AGE GROUP | V |
| | | O | 0..1 | WARD INTENDED SEX OF PATIENTS | V |
| | | O | 0..1 | WARD INTENDED DAY PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD INTENDED NIGHT PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD SECURITY LEVEL | V |
| | | O | 0..1 | WARD CODE | F |

| Notation | DATA GROUP: LOCATION GROUP (AT WARD STAY) |
|---|---|

| Group Status | Group Repeats | FUNCTION: |
|---|---|---|
| R | 0..97 | To carry the details of one or more Ward Stays during the Finished General Care Professional Admitted Care Episode. |

| M | 1..1 | **Data Element Components** | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | ORGANISATION SITE IDENTIFIER (OF TREATMENT) | F |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | O | 0..1 | WARD INTENDED CLINICAL CARE INTENSITY | V |
| | | O | 0..1 | WARD INTENDED AGE GROUP | V |
| | | O | 0..1 | WARD INTENDED SEX OF PATIENTS | V |
| | | O | 0..1 | WARD INTENDED DAY PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD INTENDED NIGHT PERIOD AVAILABILITY | V |

| | | | | | |
|---|---|---|---|---|---|
| | | O | 0..1 | START DATE (WARD STAY) | F S13 |
| | | O | 0..1 | START TIME (WARD STAY) | F S14 |
| | | O | 0..1 | END DATE (WARD STAY) | F S13 |
| | | O | 0..1 | END TIME (WARD STAY) | F S14 |
| | | O | 0..1 | WARD SECURITY LEVEL | V |
| | | O | 0..1 | WARD CODE | F |

| Notation | | DATA GROUP: LOCATION GROUP (AT END OF CARE EPISODE) | | | |
|---|---|---|---|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the Location at the End of the Finished General Care Professional Admitted Care Episode. | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | ORGANISATION SITE IDENTIFIER (OF TREATMENT) | F |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | O | 0..1 | WARD INTENDED CLINICAL CARE INTENSITY | V |
| | | O | 0..1 | WARD INTENDED AGE GROUP | V |
| | | O | 0..1 | WARD INTENDED SEX OF PATIENTS | V |
| | | O | 0..1 | WARD INTENDED DAY PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD INTENDED NIGHT PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD SECURITY LEVEL | V |
| | | O | 0..1 | WARD CODE | F |

| Notation | | DATA GROUP: LOCATION GROUP - HOME LEAVE | | | |
|---|---|---|---|---|---|
| Group Status R | Group Repeats 0..* | FUNCTION: To carry the details of each separate period of Home Leave within the Finished General Care Professional Admitted Care Episode. | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | **M** | **1..1** | START DATE (HOME LEAVE) | F S13 |
| | | R | 0..1 | START TIME (HOME LEAVE) | F S14 |
| | | R | 0..1 | END DATE (HOME LEAVE) | F S13 |
| | | R | 0..1 | END TIME (HOME LEAVE) | F S14 |

| Notation | | DATA GROUP: CARE EPISODE - NEONATAL CRITICAL CARE PERIOD | | | |
|---|---|---|---|---|---|
| Group Status R | Group Repeats 0..9 | FUNCTION: See CRITICAL CARE PERIOD To carry the details of the first 9 Critical Care Periods for care provided using Neonatal Care facilities. | | | |
| M | 1..1 | DATA GROUP: NEONATAL CARE - ADMISSION CHARACTERISTICS | | | Rules |
| | | **M** | **1..1** | CRITICAL CARE LOCAL IDENTIFIER | F |
| | | **M** | **1..1** | CRITICAL CARE START DATE | F H4 S13 |
| | | **M** | **1..1** | CRITICAL CARE START TIME | F S14 |
| | | **M** | **1..1** | CRITICAL CARE UNIT FUNCTION | V H4 |

| | | M | 1..1 | GESTATION LENGTH (AT DELIVERY) | V |
|---|---|---|---|---|---|
| **M** | **1..999** | **DATA GROUP: NEONATAL DAILY CARE - ACTIVITY CHARACTERISTICS** | | | **Rules** |
| | | **M** | **1..1** | ACTIVITY DATE (CRITICAL CARE) | F S13 |
| | | R | 0..1 | PERSON WEIGHT | F |
| | | **M** | **1..20** | CRITICAL CARE ACTIVITY CODE | F N4 |
| | | R | 0..20 | HIGH COST DRUGS (OPCS) | F N4 |
| R | 0..1 | DATA GROUP: NEONATAL CARE - DISCHARGE CHARACTERISTICS | | | **Rules** |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE DATE | F H4 S13 |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE TIME | F S14 |

| Notation | | **DATA GROUP: CARE EPISODE - PAEDIATRIC CRITICAL CARE PERIOD** |
|---|---|---|
| **Group Status R** | **Group Repeats 0..9** | **FUNCTION: See CRITICAL CARE PERIOD**<br>**To carry the details of the first 9 Critical Care Periods for care provided using Paediatric Care facilities.** |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **DATA GROUP: PAEDIATRIC CRITICAL CARE - ADMISSION CHARACTERISTICS** | | | **Rules** |
| | | **M** | **1..1** | CRITICAL CARE LOCAL IDENTIFIER | F |
| | | **M** | **1..1** | CRITICAL CARE START DATE | F H4 S13 |
| | | **M** | **1..1** | CRITICAL CARE START TIME | F S14 |
| | | **M** | **1..1** | CRITICAL CARE UNIT FUNCTION | V H4 |
| **M** | **1..999** | **DATA GROUP: PAEDIATRIC DAILY CARE - ACTIVITY CHARACTERISTICS** | | | **Rules** |
| | | **M** | **1..1** | ACTIVITY DATE (CRITICAL CARE) | F S13 |
| | | **M** | **1..20** | CRITICAL CARE ACTIVITY CODE | F N4 |
| | | R | 0..20 | HIGH COST DRUGS (OPCS) | F N4 |
| R | 0..1 | DATA GROUP: PAEDIATRIC CRITICAL CARE - DISCHARGE CHARACTERISTICS | | | **Rules** |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE DATE | F H4 S13 |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE TIME | F S14 |

| Notation | | **DATA GROUP: CARE EPISODE - ADULT CRITICAL CARE PERIOD** |
|---|---|---|
| **Group Status R** | **Group Repeats 0..9** | **FUNCTION: See CRITICAL CARE PERIOD**<br>**To carry the details of the first 9 Critical Care Periods for care provided using Adult Care facilities.** |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **DATA GROUP: ADULT CRITICAL CARE - ADMISSION CHARACTERISTICS** | | | **Rules** |
| | | **M** | **1..1** | CRITICAL CARE LOCAL IDENTIFIER | F |
| | | **M** | **1..1** | CRITICAL CARE START DATE | F H4 S13 |
| | | O | 0..1 | CRITICAL CARE START TIME | |

| | | | | | Rules |
|---|---|---|---|---|---|
| | | | | | F S14 |
| | | M | 1..1 | CRITICAL CARE UNIT FUNCTION | V H4 |
| | | O | 0..1 | CRITICAL CARE UNIT BED CONFIGURATION | V |
| | | O | 0..1 | CRITICAL CARE ADMISSION SOURCE | V |
| | | O | 0..1 | CRITICAL CARE SOURCE LOCATION | V |
| | | O | 0..1 | CRITICAL CARE ADMISSION TYPE | V |
| **M** | **1..1** | **DATA GROUP: ADULT CRITICAL CARE - ACTIVITY CHARACTERISTICS** | | | **Rules** |
| | | R | 0..1 | ADVANCED RESPIRATORY SUPPORT DAYS | F H4 |
| | | R | 0..1 | BASIC RESPIRATORY SUPPORT DAYS | F H4 |
| | | R | 0..1 | ADVANCED CARDIOVASCULAR SUPPORT DAYS | F H4 |
| | | R | 0..1 | BASIC CARDIOVASCULAR SUPPORT DAYS | F H4 |
| | | R | 0..1 | RENAL SUPPORT DAYS | F H4 |
| | | R | 0..1 | NEUROLOGICAL SUPPORT DAYS | F H4 |
| | | O | 0..1 | GASTRO-INTESTINAL SUPPORT DAYS | F |
| | | R | 0..1 | DERMATOLOGICAL SUPPORT DAYS | F H4 |
| | | R | 0..1 | LIVER SUPPORT DAYS | F H4 |
| | | O | 0..1 | ORGAN SUPPORT MAXIMUM | V |
| | | R | 0..1 | CRITICAL CARE LEVEL 2 DAYS | F H4 |
| | | R | 0..1 | CRITICAL CARE LEVEL 3 DAYS | F H4 |
| R | 0..* | DATA GROUP: ADULT CRITICAL CARE - DAILY CARE ACTIVITY CHARACTERISTICS | | | **Rules** |
| | | **M** | **1..1** | ACTIVITY DATE (CRITICAL CARE) | F S13 |
| | | **M** | **1..9** | ORGAN SYSTEM SUPPORTED | V |
| | | **M** | **1..1** | CRITICAL CARE LEVEL | V |
| R | 0..1 | DATA GROUP: ADULT CRITICAL CARE - DISCHARGE CHARACTERISTICS | | | **Rules** |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE DATE | F H4 S13 |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE TIME | F S14 |
| | | O | 0..1 | CRITICAL CARE DISCHARGE READY DATE | F S13 |
| | | O | 0..1 | CRITICAL CARE DISCHARGE READY TIME | F S14 |
| | | O | 0..1 | CRITICAL CARE DISCHARGE STATUS | V |
| | | O | 0..1 | CRITICAL CARE DISCHARGE DESTINATION | V |
| | | O | 0..1 | CRITICAL CARE DISCHARGE LOCATION | V |

| **Notation** | | **DATA GROUP: GP REGISTRATION** |
|---|---|---|
| | | **FUNCTION:**<br>**To carry the Patient's General Medical Practitioner and the General Practice details.** |

| Group Status | Group Repeats | |
|---|---|---|
| R | 0..1 | |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | GENERAL MEDICAL PRACTITIONER (SPECIFIED) | F |
| | | R | 0..1 | GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION) | F |

| Notation | DATA GROUP: REFERRER |
|---|---|
| Group Status / Group Repeats | FUNCTION: |
| R / 0..1 | To carry the details of the Referrer. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | REFERRER CODE | F |
| | | R | 0..1 | ORGANISATION IDENTIFIER (REFERRING ORGANISATION) | F |

| Notation | DATA GROUP: REFERRAL |
|---|---|
| Group Status / Group Repeats | FUNCTION: |
| O / 0..1 | To carry the details of the Referral. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DIRECT ACCESS REFERRAL INDICATOR | V |

| Notation | DATA GROUP: ELECTIVE ADMISSION LIST ENTRY |
|---|---|
| Group Status / Group Repeats | FUNCTION: |
| R / 0..1 | To carry the details of the Elective Admission List Entry. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | DURATION OF ELECTIVE WAIT | F |
| | | R | 0..1 | INTENDED MANAGEMENT CODE | V |
| | | R | 0..1 | DECIDED TO ADMIT DATE | F S13 |
| | | R | 0..1 | EARLIEST REASONABLE OFFER DATE | F S13 |
| | | R | 0..1 | EARLIEST CLINICALLY APPROPRIATE DATE | F S13 |
| | | R | 0..1 | LATEST CLINICALLY APPROPRIATE DATE | F S13 |

| Notation | DATA GROUP: CDS V6-3 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER |
|---|---|
| Group Status / Group Repeats | FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission. |

| M | 1..* | DATA GROUP: CDS V6-3 Type 004 - Commissioning Data Set Message Trailer<br>One per Commissioning Data Set Message submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |
|---|---|---|

| Notation | DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER |
|---|---|
| Group Status / Group Repeats | FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission. |

| M | 1..1 | DATA GROUP: CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer<br>One per Interchange submitted to the Secondary Uses Service. |
|---|---|---|

| | | Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |
|---|---|---|

**CDS V6-3 TYPE 140 - ADMITTED PATIENT CARE - FINISHED DELIVERY EPISODE CDS**

Change to Data Set: New Data Set

| **CDS V6-3 TYPE 140 - FINISHED DELIVERY EPISODE COMMISSIONING DATA SET** |
|---|
| **FUNCTION: To support the details of a Finished Care Professional Admitted Care Delivery Episode.** |

| Notation | | DATA GROUP: CDS V6-3 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 001 - Commissioning Data Set Interchange Header<br>One per Interchange submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| Notation | | DATA GROUP: CDS V6-3 TYPE 003 - COMMISSIONING DATA SET MESSAGE HEADER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..* | DATA GROUP: CDS V6-3 Type 003 - Commissioning Data Set Message Header<br>One per Commissioning Data Set Message submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

**ONE OF THE FOLLOWING TWO OPTIONS MUST BE USED:**

| Notation | | DATA GROUP: CDS V6-3 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of the Bulk Replacement Update Mechanism of the Commissioning Data Set Submission Protocol. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol<br>One per Commissioning Data Set record submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

**OR**

| Notation | | DATA GROUP: CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of one of the Net Change Update Mechanism of the Commissioning Data Set Submission Protocol. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol<br>One per Commissioning Data Set record submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| Notation | | DATA GROUP: PATIENT PATHWAY |
|---|---|---|
| | | |

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

| | | | | |
| --- | --- | --- | --- | --- |
| **M** | **1..1** | **DATA GROUP: PATIENT PATHWAY IDENTITY** | | **Rules** |
| | **M** | **1..1** | UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) | F |
| | *Or* | | *Or* | |
| | **M** | **1..1** | PATIENT PATHWAY IDENTIFIER | F |
| | **M** | **1..1** | ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER) | F<br>I2 |
| **M** | **1..1** | **DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS** | | **Rules** |
| | **M** | **1..1** | REFERRAL TO TREATMENT PERIOD STATUS | V |
| | **M** | **1..1** | WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET) | V |
| | O | 0..1 | REFERRAL TO TREATMENT PERIOD START DATE | F<br>S13 |
| | O | 0..1 | REFERRAL TO TREATMENT PERIOD END DATE | F<br>S13 |

| Notation | | DATA GROUP: PATIENT IDENTITY (MOTHER) |
| --- | --- | --- |
| **Group Status** | **Group Repeats** | **FUNCTION:** |
| **M** | **1..1** | **To carry the Identity of the Patient (the Mother).<br>See Note: S3 in Commissioning Data Set Business Rules.** |

**One of the following DATA GROUPS must be used:**

| | | | | | |
| --- | --- | --- | --- | --- | --- |
| **1..1** | **DATA GROUP: WITHHELD IDENTITY STRUCTURE**<br>**Must be used where the Commissioning Data Set record has been anonymised** | | | | |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | **M** | **1..1** | NHS NUMBER STATUS INDICATOR CODE | V |
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | WITHHELD IDENTITY REASON | V |

**OR**

| | | | | | |
| --- | --- | --- | --- | --- | --- |
| **1..1** | **DATA GROUP: VERIFIED IDENTITY STRUCTURE**<br>**Must be used where the NHS NUMBER STATUS INDICATOR CODE National Code = 01 (Number present and verified)** | | | | |
| R | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | **Rules** |
| | | **M** | **1..1** | LOCAL PATIENT IDENTIFIER (EXTENDED) | F<br>S3 |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) | F |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | **M** | **1..1** | NHS NUMBER | F<br>S3 |
| | | **M** | **1..1** | NHS NUMBER STATUS INDICATOR CODE | V |
| | | **M** | **1..1** | POSTCODE OF USUAL ADDRESS | F<br>S3 |
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | PERSON BIRTH DATE | F<br>S3<br>S12 |

**OR**

| | | | | | |
| --- | --- | --- | --- | --- | --- |
| **1..1** | **DATA GROUP: UNVERIFIED IDENTITY STRUCTURE**<br>**Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE NOT included in the above** | | | | |
| R | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | **Rules** |
| | | **M** | **1..1** | LOCAL PATIENT IDENTIFIER (EXTENDED) | F<br>S3 |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) | F |

| M | 1..1 | **Data Element Components** | | | **Rules** |
|---|---|---|---|---|---|
| | | R | 0..1 | NHS NUMBER | F S3 |
| | | **M** | **1..1** | NHS NUMBER STATUS INDICATOR CODE | V |
| R | 0..1 | Data Element Components | | | **Rules** |
| | | **M**<br>**OR**<br>O<br>and<br>**M**<br>**and**<br>**M**<br>and<br>O<br>and<br>O | **1..1**<br>**OR**<br>0..1<br>and<br>**1..1**<br>**and**<br>**1..1**<br>and<br>0..1<br>and<br>0..1 | PATIENT FULL NAME<br>**OR**<br>PATIENT TITLE<br>and<br>PATIENT GIVEN NAME<br>**and**<br>PATIENT FAMILY NAME<br>and<br>PATIENT NAME SUFFIX<br>and<br>PATIENT INITIALS | F S3 I4 |
| R | 0..1 | Data Element Components | | | **Rules** |
| | | **M**<br>**OR**<br>**M** | **1..1**<br>**OR**<br>**2..5** | PATIENT USUAL ADDRESS (UNSTRUCTURED)<br>**OR**<br>PATIENT USUAL ADDRESS (STRUCTURED) | F S3 I5 |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | POSTCODE OF USUAL ADDRESS | F S3 |
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | PERSON BIRTH DATE | F S3 S12 |

| **Notation** | | **DATA GROUP: PATIENT CHARACTERISTICS** |
|---|---|---|
| **Group Status** | **Group Repeats** | **FUNCTION:** To carry the characteristics of the Patient (the Mother). |
| **R** | **0..1** | |

| **M** | **1..1** | **Data Element Components** | | | **Rules** |
|---|---|---|---|---|---|
| | | R | 0..1 | PERSON STATED GENDER CODE | V H4 |
| | | O | 0..1 | CARER SUPPORT INDICATOR | V |
| | | R | 0..1 | ETHNIC CATEGORY | V |
| | | X | 0..1 | ETHNIC CATEGORY 2021 | N2 |
| | | R | 0..1 | PERSON MARITAL STATUS | V |
| | | R | 0..1 | MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION) | F |

| **Notation** | | **DATA GROUP: DELIVERY CHARACTERISTICS** |
|---|---|---|
| **Group Status** | **Group Repeats** | **FUNCTION:** To carry the delivery characteristics of the Patient (the Mother). |
| **R** | **0..1** | |

| **M** | **1..1** | **Data Element Components** | | | **Rules** |
|---|---|---|---|---|---|
| | | R | 0..1 | NUMBER OF PREVIOUS PREGNANCIES RESULTING IN REGISTRABLE BIRTH | V |

| **Notation** | | **DATA GROUP: PATIENT CHARACTERISTICS - SOCIAL AND PERSONAL CIRCUMSTANCES (SNOMED CT)** |
|---|---|---|
| **Group Status** | **Group Repeats** | **FUNCTION:** To carry the Social and Personal Circumstances for the Patient (the Mother). |
| **R** | **0..*** | |

**One of the following DATA GROUPS may be used:**

| | | | | | Rules |
|---|---|---|---|---|---|
| **M** | **1..1** | **DATA GROUP: SNOMED CT SOCIAL AND PERSONAL CIRCUMSTANCES** | | | **Rules** |
| | | **M** | **1..1** | SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION) | F |
| | | **M** | **1..1** | SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP | F |

**OR**

| | | | | | |
|---|---|---|---|---|---|
| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | **Rules** |
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: HOSPITAL PROVIDER SPELL - ADMISSION CHARACTERISTICS |
|---|---|---|
| Group Status | Group Repeats | **FUNCTION:** |
| **M** | **1..1** | **To carry the admission details of the Hospital Provider Spell containing the Finished Delivery Care Professional Admitted Care Episode.** |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | HOSPITAL PROVIDER SPELL IDENTIFIER | F<br>H4 |
| | | R | 0..1 | ADMINISTRATIVE CATEGORY CODE (ON ADMISSION) | V |
| | | R | 0..1 | PATIENT CLASSIFICATION CODE | V<br>H4 |
| | | R | 0..1 | METHOD OF ADMISSION (HOSPITAL PROVIDER SPELL) | V<br>H4 |
| | | R | 0..1 | ADMISSION SOURCE (HOSPITAL PROVIDER SPELL) | V<br>H4 |
| | | **M** | **1..1** | START DATE (HOSPITAL PROVIDER SPELL) | F<br>H4<br>S13 |
| | | O | 0..1 | START TIME (HOSPITAL PROVIDER SPELL) | F<br>S14 |
| | | **M** | **1..1** | AGE ON ADMISSION | F<br>H4 |
| | | R | 0..1 | AMBULANCE CALL IDENTIFIER | F |
| | | R | 0..1 | ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST) | F |
| | | R | 0..1 | CARE CONTACT IDENTIFIER (AMBULANCE SERVICE) | F |

| Notation | | DATA GROUP: HOSPITAL PROVIDER SPELL - DISCHARGE CHARACTERISTICS |
|---|---|---|
| Group Status | Group Repeats | **FUNCTION:** |
| **R** | **0..1** | **To carry the discharge details of the Hospital Provider Spell containing the Finished Delivery Care Professional Admitted Care Episode.** |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | DESTINATION OF DISCHARGE (HOSPITAL PROVIDER SPELL) | V<br>H4 |
| | | R | 0..1 | METHOD OF DISCHARGE (HOSPITAL PROVIDER SPELL) | V<br>H4 |
| | | R | 0..1 | DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL) | F<br>S13 |
| | | R | 0..1 | DISCHARGE DATE (HOSPITAL PROVIDER SPELL) | F<br>S13 |
| | | O | 0..1 | DISCHARGE TIME (HOSPITAL PROVIDER SPELL) | F<br>S14 |
| | | R | 0..1 | DISCHARGED TO NHS AT HOME SERVICE INDICATOR | V |

| Notation | | DATA GROUP: DELIVERY EPISODE - ACTIVITY CHARACTERISTICS |
|---|---|---|
| Group Status | Group Repeats | **FUNCTION:** |
| **M** | **1..1** | **To carry the details of the Finished Delivery Care Professional Admitted Care Episode.** |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | EPISODE NUMBER | F<br>H4 |
| | | R | 0..1 | LAST EPISODE IN SPELL INDICATOR CODE | V |
| | | R | 0..1 | PSYCHIATRIC PATIENT STATUS CODE | V |
| | | **M** | **1..1** | START DATE (EPISODE) | F<br>H4<br>S13 |
| | | O | 0..1 | START TIME (EPISODE) | F<br>S14 |
| | | **M** | **1..1** | END DATE (EPISODE) | F<br>H4<br>S1<br>S13 |
| | | O | 0..1 | END TIME (EPISODE) | F<br>S14 |
| | | **M** | **1..1** | AGE AT CDS ACTIVITY DATE | F<br>H4 |
| | | O | 0..1 | REHABILITATION ASSESSMENT TEAM TYPE | V<br>N3 |

| Notation | | DATA GROUP: DELIVERY EPISODE- OVERSEAS VISITOR CHARGING CATEGORY |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| R | 0..5 | To carry the details of the Overseas Visitor Charging Categories of the Patient (the Mother) during the Finished Delivery Care Professional Admitted Care Episode. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | **M** | **1..1** | OVERSEAS VISITOR CHARGING CATEGORY | V |
| | | **M** | **1..1** | OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE FROM DATE | F<br>S13 |
| | | R | 0..1 | OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE END DATE | F<br>S13 |

| Notation | | DATA GROUP: DELIVERY EPISODE - SERVICE AGREEMENT DETAILS |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| M | 1..1 | To carry the details of the Provider, Commissioners and Service Agreements. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (CODE OF PROVIDER) | F |
| **M** | **1..*** | **DATA GROUP: COMMISSIONERS** | | | **Rules** |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) | F |
| | | R | 0..1 | START DATE (COMMISSIONER ASSIGNMENT PERIOD) | F<br>S13 |
| | | R | 0..1 | END DATE (COMMISSIONER ASSIGNMENT PERIOD) | F<br>S13 |
| | | R | 0..1 | NHS SERVICE AGREEMENT IDENTIFIER | F |
| | | O | 0..1 | NHS SERVICE AGREEMENT LINE IDENTIFIER | F |
| | | O | 0..1 | PROVIDER REFERENCE IDENTIFIER | F |
| | | R | 0..1 | COMMISSIONER REFERENCE IDENTIFIER | F |
| | | R | 0..1 | SPECIALISED SERVICE CODE | F |

| Notation | | DATA GROUP: CARE EPISODE - PERSON GROUP (CARE PROFESSIONAL) |
|---|---|---|
| | | |

| Group Status | Group Repeats | FUNCTION: |
| --- | --- | --- |
| R | 0..* | To carry the details of the Care Professionals active during the Finished Delivery Care Professional Admitted Care Episode. |

| | | | | | |
| --- | --- | --- | --- | --- | --- |
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER | F |
| | | M | 1..1 | CARE PROFESSIONAL MAIN SPECIALTY CODE | F H4 |
| | | M | 1..1 | ACTIVITY TREATMENT FUNCTION CODE | F H4 |
| | | O | 0..1 | LOCAL SUB-SPECIALTY CODE | F |
| | | M | 1..1 | RESPONSIBLE CARE PROFESSIONAL INDICATOR | V |

| Notation | | DATA GROUP: DELIVERY EPISODE - CLINICAL DIAGNOSIS GROUP (ICD) |
| --- | --- | --- |
| Group Status | Group Repeats | FUNCTION: |
| R | 0..1 | To carry the details of the ICD coded Clinical Diagnoses for the Patient (the Mother). |

| | | | | | |
| --- | --- | --- | --- | --- | --- |
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET) | V |
| M | 1..1 | DATA GROUP: PRIMARY DIAGNOSIS | | | Rules |
| | | M | 1..1 | PRIMARY DIAGNOSIS (ICD) | F H4 |
| R | 0..* | DATA GROUP: SECONDARY DIAGNOSES | | | Rules |
| | | M | 1..1 | SECONDARY DIAGNOSIS (ICD) | F H4 |

| Notation | | DATA GROUP: DELIVERY EPISODE - CLINICAL DIAGNOSIS GROUP (SNOMED CT) |
| --- | --- | --- |
| Group Status | Group Repeats | FUNCTION: |
| R | 0..* | To carry the details of the SNOMED CT coded Clinical Diagnoses for the Patient (the Mother). |

**One of the following DATA GROUPS may be used:**

| | | | | | |
| --- | --- | --- | --- | --- | --- |
| M | 1..1 | DATA GROUP: SNOMED CT DIAGNOSIS | | | Rules |
| | | M | 1..1 | DIAGNOSIS (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | CODED CLINICAL ENTRY SEQUENCE NUMBER | F |
| | | M | 1..1 | CODED DIAGNOSIS TIMESTAMP | F |

**OR**

| | | | | | |
| --- | --- | --- | --- | --- | --- |
| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: DELIVERY EPISODE - COMORBIDITY (SNOMED CT) |
| --- | --- | --- |
| Group Status | Group Repeats | FUNCTION: |
| R | 0..* | To carry the details of the SNOMED CT coded Comorbidities for the Patient (the Mother). |

**One of the following DATA GROUPS may be used:**

| | | | | | |
| --- | --- | --- | --- | --- | --- |
| M | 1..1 | DATA GROUP: SNOMED CT COMORBIDITY | | | Rules |
| | | M | 1..1 | COMORBIDITY (SNOMED CT EXPRESSION) | F |

**OR**

| | | | | | |
| --- | --- | --- | --- | --- | --- |
| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: DELIVERY EPISODE - PROCEDURE GROUP (OPCS) |
| --- | --- | --- |
| | | |

| Group Status | Group Repeats | FUNCTION: |
|---|---|---|
| R | 0..1 | To carry the details of the OPCS coded Procedures for the Patient (the Mother). |

| | | | | | Rules |
|---|---|---|---|---|---|
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | PROCEDURE SCHEME IN USE (COMMISSIONING DATA SET) | V |
| M | 1..1 | DATA GROUP: PRIMARY PROCEDURE | | | Rules |
| | | M | 1..1 | PRIMARY PROCEDURE (OPCS) | F |
| | | R | 0..1 | PROCEDURE DATE | F S13 |
| O | 0..1 | DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | F |
| O | 0..1 | DATA GROUP: RESPONSIBLE ANAESTHETIST | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | F |
| R | 0..* | DATA GROUP: SECONDARY PROCEDURES | | | Rules |
| | | M | 1..1 | PROCEDURE (OPCS) | F |
| | | R | 0..1 | PROCEDURE DATE | F S13 |
| O | 0..1 | DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | F |
| O | 0..1 | DATA GROUP: RESPONSIBLE ANAESTHETIST | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | F |

| Notation | DATA GROUP: DELIVERY EPISODE - PROCEDURE GROUP (SNOMED CT) |
|---|---|

| Group Status | Group Repeats | FUNCTION: |
|---|---|---|
| R | 0..* | To carry the details of the SNOMED CT coded Procedures for the Patient (the Mother). |

One of the following DATA GROUPS may be used:

| | | | | | Rules |
|---|---|---|---|---|---|
| M | 1..1 | DATA GROUP: SNOMED CT PROCEDURE | | | Rules |
| | | M | 1..1 | PROCEDURE (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | CODED CLINICAL ENTRY SEQUENCE NUMBER | F |
| | | M | 1..1 | CODED PROCEDURE TIMESTAMP | F |
| O | 0..1 | DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | F |
| O | 0..1 | DATA GROUP: RESPONSIBLE ANAESTHETIST | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | F |

OR

| | | | | | Rules |
|---|---|---|---|---|---|
| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: DELIVERY EPISODE - OBSERVATION GROUP (SNOMED CT) |
|---|---|

| Group Status | Group Repeats | FUNCTION: |
|---|---|---|
| R | 0..* | To carry the details of the SNOMED CT coded Clinical Observations for the Patient (the Mother). |

One of the following DATA GROUPS may be used:

| M | 1..1 | DATA GROUP: SNOMED CT OBSERVATION | | Rules |
|---|---|---|---|---|
| | | M | 1..1 | OBSERVATION (SNOMED CT EXPRESSION) | F |
| | | R | 0..1 | OBSERVATION VALUE | F |
| | | R | 0..1 | UCUM UNIT OF MEASUREMENT | F |
| | | M | 1..1 | CODED OBSERVATION TIMESTAMP | F |

OR

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | Rules |
|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: DELIVERY EPISODE - FINDING GROUP (SNOMED CT) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| R | 0..* | To carry the details of the SNOMED CT coded Clinical Findings for the Patient (the Mother). |

One of the following DATA GROUPS may be used:

| M | 1..1 | DATA GROUP: SNOMED CT FINDING | | Rules |
|---|---|---|---|---|
| | | M | 1..1 | FINDING (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | CODED FINDING TIMESTAMP | F |

OR

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | Rules |
|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: DELIVERY EPISODE - ASSESSMENT TOOL GROUP (SNOMED CT) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| R | 0..* | To carry the details of the SNOMED CT coded Assessment Tools for the Patient (the Mother). |

One of the following DATA GROUPS may be used:

| M | 1..1 | DATA GROUP: SNOMED CT ASSESSMENT TOOL | | Rules |
|---|---|---|---|---|
| | | M | 1..1 | ASSESSMENT TOOL (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | PERSON SCORE | F |
| | | M | 1..1 | ASSESSMENT TOOL COMPLETION TIMESTAMP | F |

OR

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | Rules |
|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: LOCATION GROUP (AT START OF DELIVERY EPISODE) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| R | 0..1 | To carry the details of the Location at the Start of the Finished Delivery Care Professional Admitted Care Episode. |

| M | 1..1 | Data Element Components | | Rules |
|---|---|---|---|---|
| | | R | 0..1 | ORGANISATION SITE IDENTIFIER (OF TREATMENT) | F |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | O | 0..1 | WARD INTENDED CLINICAL CARE INTENSITY | V |
| | | O | 0..1 | WARD INTENDED AGE GROUP | V |
| | | O | 0..1 | WARD INTENDED SEX OF PATIENTS | V |
| | | O | 0..1 | WARD INTENDED DAY PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD INTENDED NIGHT PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD SECURITY LEVEL | V |

| | | O | 0..1 | WARD CODE | F |
|---|---|---|---|---|---|

| Notation | DATA GROUP: LOCATION GROUP (AT WARD STAY) |
|---|---|
| Group Status R \| Group Repeats 0..97 | FUNCTION: To carry the details of one or more Ward Stays during the Finished Delivery Care Professional Admitted Care Episode. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | ORGANISATION SITE IDENTIFIER (OF TREATMENT) | F |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | O | 0..1 | WARD INTENDED CLINICAL CARE INTENSITY | V |
| | | O | 0..1 | WARD INTENDED AGE GROUP | V |
| | | O | 0..1 | WARD INTENDED SEX OF PATIENTS | V |
| | | O | 0..1 | WARD INTENDED DAY PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD INTENDED NIGHT PERIOD AVAILABILITY | V |
| | | O | 0..1 | START DATE (WARD STAY) | F S13 |
| | | O | 0..1 | START TIME (WARD STAY) | F S14 |
| | | O | 0..1 | END DATE (WARD STAY) | F S13 |
| | | O | 0..1 | END TIME (WARD STAY) | F S14 |
| | | O | 0..1 | WARD SECURITY LEVEL | V |
| | | O | 0..1 | WARD CODE | F |

| Notation | DATA GROUP: LOCATION GROUP (AT END OF DELIVERY EPISODE) |
|---|---|
| Group Status R \| Group Repeats 0..1 | FUNCTION: To carry the details of the Location at the End of the Finished Delivery Care Professional Admitted Care Episode. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | ORGANISATION SITE IDENTIFIER (OF TREATMENT) | F |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | O | 0..1 | WARD INTENDED CLINICAL CARE INTENSITY | V |
| | | O | 0..1 | WARD INTENDED AGE GROUP | V |
| | | O | 0..1 | WARD INTENDED SEX OF PATIENTS | V |
| | | O | 0..1 | WARD INTENDED DAY PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD INTENDED NIGHT PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD SECURITY LEVEL | V |
| | | O | 0..1 | WARD CODE | F |

| Notation | DATA GROUP: LOCATION GROUP - HOME LEAVE |
|---|---|
| Group Status R \| Group Repeats 0..* | FUNCTION: To carry the details of each separate period of Home Leave within the Finished Delivery Care Professional Admitted Care Episode. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | START DATE (HOME LEAVE) | F S13 |
| | | R | 0..1 | START TIME (HOME LEAVE) | F S14 |
| | | R | 0..1 | END DATE (HOME LEAVE) | F S13 |
| | | R | 0..1 | END TIME (HOME LEAVE) | |

| | | | | | F<br>S14 |
|---|---|---|---|---|---|

| Notation | | DATA GROUP: DELIVERY EPISODE - PAEDIATRIC CRITICAL CARE PERIOD | | | |
|---|---|---|---|---|---|
| Group Status<br>R | Group Repeats<br>0..9 | FUNCTION: See CRITICAL CARE PERIOD<br>To carry the details of the first 9 Critical Care Periods for care provided using Paediatric Care facilities. | | | |
| **M** | **1..1** | **DATA GROUP: PAEDIATRIC CRITICAL CARE - ADMISSION CHARACTERISTICS** | | | **Rules** |
| | | **M** | **1..1** | CRITICAL CARE LOCAL IDENTIFIER | F |
| | | **M** | **1..1** | CRITICAL CARE START DATE | F<br>H4<br>S13 |
| | | **M** | **1..1** | CRITICAL CARE START TIME | F<br>S14 |
| | | **M** | **1..1** | CRITICAL CARE UNIT FUNCTION | V<br>H4 |
| **M** | **1..999** | **DATA GROUP: PAEDIATRIC DAILY CARE - ACTIVITY CHARACTERISTICS** | | | **Rules** |
| | | **M** | **1..1** | ACTIVITY DATE (CRITICAL CARE) | F<br>S13 |
| | | **M** | **1..20** | CRITICAL CARE ACTIVITY CODE | F<br>N4 |
| | | R | 0..20 | HIGH COST DRUGS (OPCS) | F<br>N4 |
| R | 0..1 | DATA GROUP: PAEDIATRIC CRITICAL CARE - DISCHARGE CHARACTERISTICS | | | **Rules** |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE DATE | F<br>H4<br>S13 |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE TIME | F<br>S14 |

| Notation | | DATA GROUP: DELIVERY EPISODE - ADULT CRITICAL CARE PERIOD | | | |
|---|---|---|---|---|---|
| Group Status<br>R | Group Repeats<br>0..9 | FUNCTION: See CRITICAL CARE PERIOD<br>To carry the details of the first 9 Critical Care Periods for care provided using Adult Care facilities. | | | |
| **M** | **1..1** | **DATA GROUP: ADULT CRITICAL CARE - ADMISSION CHARACTERISTICS** | | | **Rules** |
| | | **M** | **1..1** | CRITICAL CARE LOCAL IDENTIFIER | F |
| | | **M** | **1..1** | CRITICAL CARE START DATE | F<br>H4<br>S13 |
| | | O | 0..1 | CRITICAL CARE START TIME | F<br>S14 |
| | | **M** | **1..1** | CRITICAL CARE UNIT FUNCTION | V<br>H4 |
| | | O | 0..1 | CRITICAL CARE UNIT BED CONFIGURATION | V |
| | | O | 0..1 | CRITICAL CARE ADMISSION SOURCE | V |
| | | O | 0..1 | CRITICAL CARE SOURCE LOCATION | V |
| | | O | 0..1 | CRITICAL CARE ADMISSION TYPE | V |
| **M** | **1..1** | **DATA GROUP: ADULT CRITICAL CARE - ACTIVITY CHARACTERISTICS** | | | **Rules** |
| | | R | 0..1 | ADVANCED RESPIRATORY SUPPORT DAYS | F<br>H4 |
| | | R | 0..1 | BASIC RESPIRATORY SUPPORT DAYS | F<br>H4 |
| | | R | 0..1 | ADVANCED CARDIOVASCULAR SUPPORT DAYS | |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | F H4 |
| | | R | 0..1 | BASIC CARDIOVASCULAR SUPPORT DAYS | F H4 |
| | | R | 0..1 | RENAL SUPPORT DAYS | F H4 |
| | | R | 0..1 | NEUROLOGICAL SUPPORT DAYS | F H4 |
| | | O | 0..1 | GASTRO-INTESTINAL SUPPORT DAYS | F |
| | | R | 0..1 | DERMATOLOGICAL SUPPORT DAYS | F H4 |
| | | R | 0..1 | LIVER SUPPORT DAYS | F H4 |
| | | O | 0..1 | ORGAN SUPPORT MAXIMUM | V |
| | | R | 0..1 | CRITICAL CARE LEVEL 2 DAYS | F H4 |
| | | R | 0..1 | CRITICAL CARE LEVEL 3 DAYS | F H4 |
| R | 0..* | DATA GROUP: ADULT CRITICAL CARE - DAILY CARE ACTIVITY CHARACTERISTICS | | | Rules |
| | | **M** | **1..1** | ACTIVITY DATE (CRITICAL CARE) | F S13 |
| | | **M** | **1..9** | ORGAN SYSTEM SUPPORTED | V |
| | | **M** | **1..1** | CRITICAL CARE LEVEL | V |
| R | 0..1 | DATA GROUP: ADULT CRITICAL CARE - DISCHARGE CHARACTERISTICS | | | Rules |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE DATE | F H4 S13 |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE TIME | F S14 |
| | | O | 0..1 | CRITICAL CARE DISCHARGE READY DATE | F S13 |
| | | O | 0..1 | CRITICAL CARE DISCHARGE READY TIME | F S14 |
| | | O | 0..1 | CRITICAL CARE DISCHARGE STATUS | V |
| | | O | 0..1 | CRITICAL CARE DISCHARGE DESTINATION | V |
| | | O | 0..1 | CRITICAL CARE DISCHARGE LOCATION | V |

| Notation | | **DATA GROUP: GP REGISTRATION** | | |
|---|---|---|---|---|
| **Group Status R** | **Group Repeats 0..1** | **FUNCTION: To carry the Patient's General Medical Practitioner and the General Practice details.** | | |
| **M** | **1..1** | **Data Element Components** | | **Rules** |
| | | O | 0..1 GENERAL MEDICAL PRACTITIONER (SPECIFIED) | F |
| | | R | 0..1 GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION) | F |

| Notation | | **DATA GROUP: REFERRER** | | |
|---|---|---|---|---|
| **Group Status R** | **Group Repeats 0..1** | **FUNCTION: To carry the details of the Referrer.** | | |
| **M** | **1..1** | **Data Element Components** | | **Rules** |
| | | R | 0..1 REFERRER CODE | F |
| | | R | 0..1 ORGANISATION IDENTIFIER (REFERRING ORGANISATION) | F |

| Notation | DATA GROUP: PREGNANCY - ACTIVITY CHARACTERISTICS | | | |
|---|---|---|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the Pregnancy. | | |
| M | 1..1 | Data Element Components | | Rules |
| | | R | 0..1 | NUMBER OF BABIES INDICATION CODE | V |

| Notation | DATA GROUP: ANTENATAL CARE - ACTIVITY CHARACTERISTICS | | | |
|---|---|---|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the Antenatal Care. | | |
| M | 1..1 | Data Element Components | | Rules |
| | | R | 0..1 | FIRST ANTENATAL ASSESSMENT DATE | F S13 |

| Notation | DATA GROUP: ANTENATAL CARE - PERSON GROUP (RESPONSIBLE CLINICIAN) | | | |
|---|---|---|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the General Medical Practitioner responsible for the Antenatal Care. | | |
| M | 1..1 | Data Element Components | | Rules |
| | | R | 0..1 | GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE) | F |
| | | O | 0..1 | GENERAL MEDICAL PRACTITIONER PRACTICE (PATIENT ANTENATAL CARE) | F |

| Notation | DATA GROUP: ANTENATAL CARE - LOCATION GROUP - DELIVERY PLACE INTENDED | | | |
|---|---|---|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the Intended Delivery Location. | | |
| M | 1..1 | Data Element Components | | Rules |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | R | 0..1 | DELIVERY PLACE CHANGE REASON CODE | V |
| | | R | 0..1 | DELIVERY PLACE TYPE CODE (INTENDED) | V |

| Notation | DATA GROUP: LABOUR/DELIVERY - ACTIVITY CHARACTERISTICS | | | |
|---|---|---|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the Labour/Delivery. | | |
| M | 1..1 | Data Element Components | | Rules |
| | | R | 0..1 | ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY CODE | V |
| | | R | 0..1 | ANAESTHETIC GIVEN POST LABOUR OR DELIVERY CODE | V |
| | | O | 0..1 | GESTATION LENGTH (LABOUR ONSET) | F |
| | | R | 0..1 | LABOUR OR DELIVERY ONSET METHOD CODE | V |
| | | R | 0..1 | DELIVERY TIMESTAMP | F |

| Notation | DATA GROUP: BIRTH OCCURRENCE | | | |
|---|---|---|---|---|
| Group Status R | Group Repeats 0..9 | FUNCTION: To carry the details of up to 9 Birth Occurrences - one per Baby. | | |
| M | 1..1 | DATA GROUP: BIRTH OCCURRENCE - ACTIVITY CHARACTERISTICS | | Rules |
| | | R | 0..1 | BIRTH ORDER | F |
| | | R | 0..1 | DELIVERY METHOD CODE | V |
| | | R | 0..1 | GESTATION LENGTH (ASSESSMENT) | F |
| | | R | 0..1 | RESUSCITATION METHOD CODE | V |

| | | R | 0..1 | STATUS OF PERSON CONDUCTING DELIVERY CODE | V |
|---|---|---|---|---|---|

| Notation | | DATA GROUP: PERSON IDENTITY (BABY) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To carry the Identity of the Patient (the Baby). |
| M | 1..1 | See Note: S3 in Commissioning Data Set Business Rules. |

**One of the following DATA GROUPS must be used:**

| 1..1 | DATA GROUP: WITHHELD IDENTITY STRUCTURE<br>Must be used where the Commissioning Data Set record has been anonymised | | | |
|---|---|---|---|---|
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | NHS NUMBER STATUS INDICATOR CODE (BABY) | V |
| | | R | 0..1 | PERSON BIRTH DATE (BABY) | F<br>S3<br>S12 |
| | | R | 0..1 | WITHHELD IDENTITY REASON | V |

**OR**

| 1..1 | DATA GROUP: VERIFIED IDENTITY STRUCTURE<br>Must be used where the NHS NUMBER STATUS INDICATOR CODE (BABY) National Code = 01 (Number present and verified) | | | | |
|---|---|---|---|---|---|
| O | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | Rules |
| | | M | 1..1 | LOCAL PATIENT IDENTIFIER (EXTENDED (BABY)) | F<br>S3 |
| | | M | 1..1 | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (BABY)) | F |
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | NHS NUMBER (BABY) | F<br>S3 |
| | | M | 1..1 | NHS NUMBER STATUS INDICATOR CODE (BABY) | V |
| | | R | 0..1 | PERSON BIRTH DATE (BABY) | F<br>S3<br>S12 |

**OR**

| 1..1 | DATA GROUP: UNVERIFIED IDENTITY STRUCTURE<br>Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE (BABY) NOT included in the above | | | | |
|---|---|---|---|---|---|
| O | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | Rules |
| | | M | 1..1 | LOCAL PATIENT IDENTIFIER (EXTENDED (BABY)) | F<br>S3 |
| | | M | 1..1 | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (BABY)) | F |
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | NHS NUMBER (BABY) | F<br>S3 |
| | | M | 1..1 | NHS NUMBER STATUS INDICATOR CODE (BABY) | V |
| R | 0..1 | Data Element Components | | | Rules |
| | | R | 0..1 | PERSON BIRTH DATE (BABY) | F<br>S3<br>S12 |

| Notation | | DATA GROUP: BIRTH OCCURRENCE - PERSON CHARACTERISTICS - BABY |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To carry the characteristics of the Baby. |
| R | 0..1 | |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | PERSON PHENOTYPIC SEX | V |
| | | | | | |

| | | R | 0..1 | LIVE OR STILL BIRTH CODE | V |
|---|---|---|---|---|---|
| | | R | 0..1 | BIRTH WEIGHT | F |
| | | R | 0..1 | OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE | V |

| Notation | | DATA GROUP: BIRTH OCCURRENCE - LOCATION GROUP - DELIVERY PLACE ACTUAL | | | |
|---|---|---|---|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the Actual Birth Location. | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | V |
| | | R | 0..1 | DELIVERY PLACE TYPE CODE (ACTUAL) | V |

| Notation | | DATA GROUP: CDS V6-3 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..* | DATA GROUP: CDS V6-3 Type 004 - Commissioning Data Set Message Trailer<br>One per Commissioning Data Set Message submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| Notation | | DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer<br>One per Interchange submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

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**CDS V6-3 TYPE 150 - ADMITTED PATIENT CARE - OTHER BIRTH EVENT CDS**

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Change to Data Set: New Data Set

| CDS V6-3 TYPE 150 - OTHER BIRTH EVENT COMMISSIONING DATA SET |
|---|
| FUNCTION: To support the details for an Other Birth. |

| Notation | | DATA GROUP: CDS V6-3 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 001 - Commissioning Data Set Interchange Header<br>One per Interchange submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| Notation | | DATA GROUP: CDS V6-3 TYPE 003 - COMMISSIONING DATA SET MESSAGE HEADER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..* | DATA GROUP: CDS V6-3 Type 003 - Commissioning Data Set Message Header<br>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. |
|---|---|---|

**ONE OF THE FOLLOWING TWO OPTIONS MUST BE USED:**

| Notation | | DATA GROUP: CDS V6-3 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of the Bulk Replacement Update Mechanism of the Commissioning Data Set Submission Protocol. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol<br>One per Commissioning Data Set record submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

**OR**

| Notation | | DATA GROUP: CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of one of the Net Change Update Mechanism of the Commissioning Data Set Submission Protocol. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol<br>One per Commissioning Data Set record submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| Notation | | | | DATA GROUP: PATIENT PATHWAY | |
|---|---|---|---|---|---|
| Group Status<br>O | Group Repeats<br>0..1 | | | FUNCTION:<br>To carry the details of the Patient Pathway. | |
| M | 1..1 | | | DATA GROUP: PATIENT PATHWAY IDENTITY | Rules |
| | | M<br>*Or*<br>M | 1..1<br><br>1..1 | UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)<br>*Or*<br>PATIENT PATHWAY IDENTIFIER | F<br><br>F<br>I2 |
| | | M | 1..1 | ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER) | F<br>I2 |
| M | 1..1 | | | DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS | Rules |
| | | M | 1..1 | REFERRAL TO TREATMENT PERIOD STATUS | V |
| | | M | 1..1 | WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET) | V |
| | | O | 0..1 | REFERRAL TO TREATMENT PERIOD START DATE | F<br>S13 |
| | | O | 0..1 | REFERRAL TO TREATMENT PERIOD END DATE | F<br>S13 |

| Notation | | DATA GROUP: PATIENT IDENTITY (BABY) |
|---|---|---|
| Group Status<br>M | Group Repeats<br>1..1 | FUNCTION:<br>To carry the Identity of the Patient (the Baby).<br>See Note: S3 in Commissioning Data Set Business Rules. |

**One of the following DATA GROUPS must be used:**

| 1..1 | | DATA GROUP: WITHHELD IDENTITY STRUCTURE<br>Must be used where the Commissioning Data Set record has been anonymised | | | |
|---|---|---|---|---|---|
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | NHS NUMBER STATUS INDICATOR CODE | V |

| | | R | 0..1 | PERSON BIRTH DATE | F<br>S3<br>S12 |
|---|---|---|---|---|---|
| | | R | 0..1 | WITHHELD IDENTITY REASON | V |

**OR**

| 1..1 | **DATA GROUP: VERIFIED IDENTITY STRUCTURE**<br>**Must be used where the NHS NUMBER STATUS INDICATOR CODE National Code = 01 (Number present and verified)** | | | | |
|---|---|---|---|---|---|
| R | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | Rules |
| | | **M** | **1..1** | LOCAL PATIENT IDENTIFIER (EXTENDED) | F<br>S3 |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) | F |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | **M** | **1..1** | NHS NUMBER | F<br>S3 |
| | | **M** | **1..1** | NHS NUMBER STATUS INDICATOR CODE | V |
| | | R | 0..1 | PERSON BIRTH DATE | F<br>S3<br>S12 |

**OR**

| 1..1 | **DATA GROUP: UNVERIFIED IDENTITY STRUCTURE**<br>**Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE NOT included in the above** | | | | |
|---|---|---|---|---|---|
| R | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | Rules |
| | | **M** | **1..1** | LOCAL PATIENT IDENTIFIER (EXTENDED) | F<br>S3 |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) | F |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | NHS NUMBER | F<br>S3 |
| | | **M** | **1..1** | NHS NUMBER STATUS INDICATOR CODE | V |
| R | 0..1 | Data Element Components | | | Rules |
| | | **M**<br>**OR**<br>O<br>and<br>**M**<br>**and**<br>**M**<br>and<br>O<br>and<br>O | **1..1**<br>**OR**<br>0..1<br>and<br>**1..1**<br>**and**<br>**1..1**<br>and<br>0..1<br>and<br>0..1 | PATIENT FULL NAME<br>**OR**<br>PATIENT TITLE<br>and<br>PATIENT GIVEN NAME<br>**and**<br>PATIENT FAMILY NAME<br>and<br>PATIENT NAME SUFFIX<br>and<br>PATIENT INITIALS | F<br>S3<br>I4 |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | PERSON BIRTH DATE | F<br>S3<br>S12 |

| Notation | | **DATA GROUP: PATIENT CHARACTERISTICS** | | | |
|---|---|---|---|---|---|
| **Group Status**<br>**R** | **Group Repeats**<br>**0..1** | **FUNCTION:**<br>**To carry the characteristics of the Patient (the Baby).** | | | |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | PERSON PHENOTYPIC SEX | V<br>H4 |
| | | | | | |

| | | R | 0..1 | ETHNIC CATEGORY | V |
|---|---|---|---|---|---|
| | | X | 0..1 | ETHNIC CATEGORY 2021 | N2 |
| | | R | 0..1 | LIVE OR STILL BIRTH CODE | V |
| | | R | 0..1 | BIRTH WEIGHT | F |

| Notation | DATA GROUP: PATIENT CHARACTERISTICS - SOCIAL AND PERSONAL CIRCUMSTANCES (SNOMED CT) |
|---|---|
| Group Status R | Group Repeats 0..* | FUNCTION: To carry the details of the SNOMED CT coded Social and Personal Circumstances of the Patient (the Baby). |

One of the following DATA GROUPS may be used:

| M | 1..1 | DATA GROUP: SNOMED CT SOCIAL AND PERSONAL CIRCUMSTANCES | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP | F |

OR

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: BIRTH EPISODE - CLINICAL DIAGNOSIS GROUP (SNOMED CT) |
|---|---|
| Group Status R | Group Repeats 0..* | FUNCTION: To carry the details of the SNOMED CT coded Clinical Diagnoses for the Patient (the Baby). |

One of the following DATA GROUPS may be used:

| M | 1..1 | DATA GROUP: SNOMED CT DIAGNOSIS | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | DIAGNOSIS (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | CODED CLINICAL ENTRY SEQUENCE NUMBER | F |
| | | M | 1..1 | CODED DIAGNOSIS TIMESTAMP | F |

OR

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: BIRTH EPISODE - COMORBIDITY (SNOMED CT) |
|---|---|
| Group Status R | Group Repeats 0..* | FUNCTION: To carry the details of the SNOMED CT coded Comorbidities for the Patient (the Baby). |

One of the following DATA GROUPS may be used:

| M | 1..1 | DATA GROUP: SNOMED CT COMORBIDITY | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | COMORBIDITY (SNOMED CT EXPRESSION) | F |

OR

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: BIRTH EPISODE - PROCEDURE GROUP (SNOMED CT) |
|---|---|
| Group Status R | Group Repeats 0..* | FUNCTION: To carry the details of the SNOMED CT coded Procedures for the Patient (the Baby). |

One of the following DATA GROUPS may be used:

| M | 1..1 | DATA GROUP: SNOMED CT PROCEDURE | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | PROCEDURE (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | CODED CLINICAL ENTRY SEQUENCE NUMBER | F |
| | | M | 1..1 | CODED PROCEDURE TIMESTAMP | F |
| O | 0..1 | DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL | | | Rules |

| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
|---|---|---|---|---|---|
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | F |
| O | 0..1 | DATA GROUP: RESPONSIBLE ANAESTHETIST | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: BIRTH EPISODE - OBSERVATION GROUP (SNOMED CT) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To carry the details of the SNOMED CT coded Clinical Observations for the Patient (the baby). |
| R | 0..* | |

**One of the following DATA GROUPS may be used:**

| M | 1..1 | DATA GROUP: SNOMED CT OBSERVATION | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | OBSERVATION (SNOMED CT EXPRESSION) | F |
| | | R | 0..1 | OBSERVATION VALUE | F |
| | | R | 0..1 | UCUM UNIT OF MEASUREMENT | F |
| | | M | 1..1 | CODED OBSERVATION TIMESTAMP | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: BIRTH EPISODE - FINDING GROUP (SNOMED CT) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To carry the details of the SNOMED CT coded Clinical Findings for the Patient (the Baby). |
| R | 0..* | |

**One of the following DATA GROUPS may be used:**

| M | 1..1 | DATA GROUP: SNOMED CT FINDING | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | FINDING (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | CODED FINDING TIMESTAMP | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: BIRTH EPISODE - ASSESSMENT TOOL GROUP (SNOMED CT) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To carry the details of the SNOMED CT coded Assessment Tools for the Patient (the Baby). |
| R | 0..* | |

**One of the following DATA GROUPS may be used:**

| M | 1..1 | DATA GROUP: SNOMED CT ASSESSMENT TOOL | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | ASSESSMENT TOOL (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | PERSON SCORE | F |
| | | M | 1..1 | ASSESSMENT TOOL COMPLETION TIMESTAMP | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: GP REGISTRATION |
|---|---|---|
| | | |

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

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | GENERAL MEDICAL PRACTITIONER (SPECIFIED) | F |
| | | R | 0..1 | GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION) | F |

| Notation | DATA GROUP: PREGNANCY - ACTIVITY CHARACTERISTICS |
|---|---|

| Group Status | Group Repeats | FUNCTION: |
|---|---|---|
| R | 0..1 | To carry the details of the Pregnancy. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | NUMBER OF BABIES INDICATION CODE | V |

| Notation | DATA GROUP: ANTENATAL CARE - ACTIVITY CHARACTERISTICS |
|---|---|

| Group Status | Group Repeats | FUNCTION: |
|---|---|---|
| R | 0..1 | To carry the details of the Antenatal Care. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | FIRST ANTENATAL ASSESSMENT DATE | F<br>S13 |

| Notation | DATA GROUP: ANTENATAL CARE - PERSON GROUP (RESPONSIBLE CLINICIAN) |
|---|---|

| Group Status | Group Repeats | FUNCTION: |
|---|---|---|
| R | 0..1 | To carry the details of the General Medical Practitioner responsible for the Antenatal Care. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE) | F |
| | | O | 0..1 | GENERAL MEDICAL PRACTITIONER PRACTICE (PATIENT ANTENATAL CARE) | F |

| Notation | DATA GROUP: ANTENATAL CARE - LOCATION GROUP - DELIVERY PLACE INTENDED |
|---|---|

| Group Status | Group Repeats | FUNCTION: |
|---|---|---|
| R | 0..1 | To carry the details of the Intended Delivery Location. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | R | 0..1 | DELIVERY PLACE CHANGE REASON CODE | V |
| | | R | 0..1 | DELIVERY PLACE TYPE CODE (INTENDED) | V |

| Notation | DATA GROUP: LABOUR/DELIVERY - ACTIVITY CHARACTERISTICS |
|---|---|

| Group Status | Group Repeats | FUNCTION: |
|---|---|---|
| M | 1..1 | To carry the details of the Labour/Delivery. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY CODE | V |
| | | R | 0..1 | ANAESTHETIC GIVEN POST LABOUR OR DELIVERY CODE | V |
| | | O | 0..1 | GESTATION LENGTH (LABOUR ONSET) | F |
| | | R | 0..1 | LABOUR OR DELIVERY ONSET METHOD CODE | V |
| | | M | 1..1 | DELIVERY TIMESTAMP | F<br>S1<br>S13 |
| | | M | 1..1 | AGE AT CDS ACTIVITY DATE | |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | F<br>H4 |
| | | R | 0..1 | OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE | V |

| Notation | | DATA GROUP: LABOUR/DELIVERY - SERVICE AGREEMENT DETAILS |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| M | 1..1 | To carry the details of the Provider, Commissioners and Service Agreements. |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (CODE OF PROVIDER) | F |
| **M** | **1..*** | **DATA GROUP: COMMISSIONERS** | | | **Rules** |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) | F |
| | | R | 0..1 | START DATE (COMMISSIONER ASSIGNMENT PERIOD) | F<br>S13 |
| | | R | 0..1 | END DATE (COMMISSIONER ASSIGNMENT PERIOD) | F<br>S13 |
| | | R | 0..1 | NHS SERVICE AGREEMENT IDENTIFIER | F |
| | | O | 0..1 | NHS SERVICE AGREEMENT LINE IDENTIFIER | F |
| | | O | 0..1 | PROVIDER REFERENCE IDENTIFIER | F |
| | | R | 0..1 | COMMISSIONER REFERENCE IDENTIFIER | F |
| | | R | 0..1 | SPECIALISED SERVICE CODE | F |

| Notation | | DATA GROUP: DELIVERY OCCURRENCE - ACTIVITY CHARACTERISTICS |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| R | 0..1 | To carry the details of the Birth Occurrence. |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | BIRTH ORDER | F |
| | | R | 0..1 | DELIVERY METHOD CODE | V |
| | | R | 0..1 | GESTATION LENGTH (ASSESSMENT) | F |
| | | R | 0..1 | RESUSCITATION METHOD CODE | V |
| | | R | 0..1 | STATUS OF PERSON CONDUCTING DELIVERY CODE | V |

| Notation | | DATA GROUP: PERSON IDENTITY (MOTHER) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| M | 1..1 | To carry the Identity details of the Baby's mother.<br>See Note: S3 in Commissioning Data Set Business Rules. |

**One of the following DATA GROUPS must be used:**

| | | | | | |
|---|---|---|---|---|---|
| **1..1** | **DATA GROUP: WITHHELD IDENTITY STRUCTURE**<br>**Must be used where the Commissioning Data Set record has been anonymised** | | | | |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | **M** | **1..1** | NHS NUMBER STATUS INDICATOR CODE (MOTHER) | V |
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | WITHHELD IDENTITY REASON | V |

**OR**

| | | | | | |
|---|---|---|---|---|---|
| **1..1** | **DATA GROUP: VERIFIED IDENTITY STRUCTURE**<br>**Must be used where the NHS NUMBER STATUS INDICATOR CODE (MOTHER) National Code = 01 (Number present and verified)** | | | | |
| O | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | **Rules** |
| | | **M** | **1..1** | LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER)) | F<br>S3 |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER)) | F |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | NHS NUMBER (MOTHER) | F S3 |
| | | M | 1..1 | NHS NUMBER STATUS INDICATOR CODE (MOTHER) | V |
| | | M | 1..1 | POSTCODE OF USUAL ADDRESS (MOTHER) | F S3 |
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | PERSON BIRTH DATE (MOTHER) | F S3 S12 |

**OR**

| 1..1 | **DATA GROUP: UNVERIFIED IDENTITY STRUCTURE** Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE (MOTHER) NOT included in the above | | | | |
|---|---|---|---|---|---|
| O | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | Rules |
| | | M | 1..1 | LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER)) | F S3 |
| | | M | 1..1 | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER)) | F |
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | NHS NUMBER (MOTHER) | F S3 |
| | | M | 1..1 | NHS NUMBER STATUS INDICATOR CODE (MOTHER) | V |
| O | 0..1 | Data Element Components | | | Rules |
| | | M OR M | 1..1 OR 2..5 | PATIENT USUAL ADDRESS (UNSTRUCTURED (MOTHER)) OR PATIENT USUAL ADDRESS (STRUCTURED (MOTHER)) | F S3 I5 |
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | POSTCODE OF USUAL ADDRESS (MOTHER) | F S3 |
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | PERSON BIRTH DATE (MOTHER) | F S3 S12 |

| Notation | | **DATA GROUP: DELIVERY OCCURRENCE - OVERSEAS VISITOR CHARGING CATEGORY CDS ACTIVITY DATE** | | | |
|---|---|---|---|---|---|
| Group Status R | Group Repeats 0..1 | **FUNCTION:** To carry the details of the Overseas Visitor Charging Category of the Mother. | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE | V |

| Notation | | **DATA GROUP: BIRTH OCCURRENCE - LOCATION GROUP - DELIVERY PLACE ACTUAL** | | | |
|---|---|---|---|---|---|
| Group Status R | Group Repeats 0..1 | **FUNCTION:** To carry the details of the Actual Delivery Location. | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | R | 0..1 | DELIVERY PLACE TYPE CODE (ACTUAL) | V |

| Notation | | **DATA GROUP: CDS V6-3 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER** |
|---|---|---|
| Group Status | Group Repeats | **FUNCTION:** To define the mandatory identity and addressing information for a Commissioning Data Set submission. |

| | | |
|---|---|---|
| M | 1..* | DATA GROUP: CDS V6-3 Type 004 - Commissioning Data Set Message Trailer<br>One per Commissioning Data Set Message submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| Notation | | DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer<br>One per Interchange submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

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**CDS V6-3 TYPE 160 - ADMITTED PATIENT CARE - OTHER DELIVERY EVENT CDS**

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Change to Data Set: New Data Set

| CDS V6-3 TYPE 160 - OTHER DELIVERY EVENT COMMISSIONING DATA SET |
|---|
| FUNCTION: To support the details for an Other Delivery. |

| Notation | | DATA GROUP: CDS V6-3 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 001 - Commissioning Data Set Interchange Header<br>One per Interchange submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| Notation | | DATA GROUP: CDS V6-3 TYPE 003 - COMMISSIONING DATA SET MESSAGE HEADER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..* | DATA GROUP: CDS V6-3 Type 003 - Commissioning Data Set Message Header<br>One per Commissioning Data Set Message submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

**ONE OF THE FOLLOWING TWO OPTIONS MUST BE USED:**

| Notation | | DATA GROUP: CDS V6-3 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of the Bulk Replacement Update Mechanism of the Commissioning Data Set Submission Protocol. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol<br>One per Commissioning Data Set record submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

**OR**

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

| Group Status | Group Repeats | FUNCTION: To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of one of the Net Change Update Mechanism of the Commissioning Data Set Submission Protocol. |
|---|---|---|
| M | 1..1 | DATA GROUP: CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol<br>One per Commissioning Data Set record submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| Notation | | DATA GROUP: PATIENT PATHWAY | | | |
|---|---|---|---|---|---|
| Group Status<br>O | Group Repeats<br>0..1 | FUNCTION:<br>To carry the details of the Patient Pathway. | | | |
| M | 1..1 | DATA GROUP: PATIENT PATHWAY IDENTITY | | | Rules |
| | M<br>*Or*<br>M | 1..1<br><br>1..1 | UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)<br>*Or*<br>PATIENT PATHWAY IDENTIFIER | | F<br><br>F<br>I2 |
| | M | 1..1 | ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER) | | F<br>I2 |
| M | 1..1 | DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS | | | Rules |
| | M | 1..1 | REFERRAL TO TREATMENT PERIOD STATUS | | V |
| | M | 1..1 | WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET) | | V |
| | O | 0..1 | REFERRAL TO TREATMENT PERIOD START DATE | | F<br>S13 |
| | O | 0..1 | REFERRAL TO TREATMENT PERIOD END DATE | | F<br>S13 |

| Notation | | DATA GROUP: PATIENT IDENTITY (MOTHER) |
|---|---|---|
| Group Status<br>M | Group Repeats<br>1..1 | FUNCTION:<br>To carry the Identity of the Patient (the Mother).<br>See Note: S3 in Commissioning Data Set Business Rules. |

**One of the following DATA GROUPS must be used:**

| 1..1 | DATA GROUP: WITHHELD IDENTITY STRUCTURE<br>Must be used where the Commissioning Data Set record has been anonymised | | | |
|---|---|---|---|---|
| M | 1..1 | Data Element Components | | Rules |
| | | M \| 1..1 | NHS NUMBER STATUS INDICATOR CODE | V |
| | | R \| 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R \| 0..1 | WITHHELD IDENTITY REASON | V |

**OR**

| 1..1 | DATA GROUP: VERIFIED IDENTITY STRUCTURE<br>Must be used where the NHS NUMBER STATUS INDICATOR CODE National Code = 01 (Number present and verified) | | | | |
|---|---|---|---|---|---|
| R | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | Rules |
| | | M | 1..1 | LOCAL PATIENT IDENTIFIER (EXTENDED) | F<br>S3 |
| | | M | 1..1 | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) | F |
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | NHS NUMBER | F<br>S3 |
| | | M | 1..1 | NHS NUMBER STATUS INDICATOR CODE | V |
| | | M | 1..1 | POSTCODE OF USUAL ADDRESS | F<br>S3 |

| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
|---|---|---|---|---|---|
| | | R | 0..1 | PERSON BIRTH DATE | F<br>S3<br>S12 |

**OR**

| 1..1 | **DATA GROUP: UNVERIFIED IDENTITY STRUCTURE**<br>**Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE NOT included in the above** | | | | |
|---|---|---|---|---|---|
| R | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | Rules |
| | | **M** | **1..1** | LOCAL PATIENT IDENTIFIER (EXTENDED) | F<br>S3 |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) | F |
| **M** | **1..1** | **Data Element Components** | | | Rules |
| | | R | 0..1 | NHS NUMBER | F<br>S3 |
| | | **M** | **1..1** | NHS NUMBER STATUS INDICATOR CODE | V |
| R | 0..1 | Data Element Components | | | Rules |
| | | **M**<br>**OR**<br>O<br>and<br>**M**<br>**and**<br>**M**<br>and<br>O<br>and<br>O | **1..1**<br>**OR**<br>0..1<br>and<br>**1..1**<br>**and**<br>**1..1**<br>and<br>0..1<br>and<br>0..1 | PATIENT FULL NAME<br>**OR**<br>PATIENT TITLE<br>and<br>PATIENT GIVEN NAME<br>**and**<br>PATIENT FAMILY NAME<br>and<br>PATIENT NAME SUFFIX<br>and<br>PATIENT INITIALS | F<br>S3<br>I4 |
| R | 0..1 | Data Element Components | | | Rules |
| | | **M**<br>**OR**<br>**M** | **1..1**<br>**OR**<br>**2..5** | PATIENT USUAL ADDRESS (UNSTRUCTURED)<br>**OR**<br>PATIENT USUAL ADDRESS (STRUCTURED) | F<br>S3<br>I5 |
| **M** | **1..1** | **Data Element Components** | | | Rules |
| | | R | 0..1 | POSTCODE OF USUAL ADDRESS | F<br>S3 |
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | PERSON BIRTH DATE | F<br>S3<br>S12 |

| **Notation** | | **DATA GROUP: PATIENT CHARACTERISTICS** |
|---|---|---|
| **Group Status**<br>**R** | **Group Repeats**<br>**0..1** | **FUNCTION:**<br>**To carry the characteristics of the Patient (the Mother).** |

| **M** | **1..1** | **Data Element Components** | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | PERSON STATED GENDER CODE | V<br>H4 |
| | | O | 0..1 | CARER SUPPORT INDICATOR | V |
| | | R | 0..1 | ETHNIC CATEGORY | V |
| | | X | 0..1 | ETHNIC CATEGORY 2021 | N2 |
| | | R | 0..1 | PERSON MARITAL STATUS | V |

| **Notation** | | **DATA GROUP: DELIVERY CHARACTERISTICS** |
|---|---|---|
| | | **FUNCTION:**<br>**To carry the delivery characteristics of the Patient (the Mother).** |

| Group Status | Group Repeats | |
|---|---|---|
| R | 0..1 | |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | NUMBER OF PREVIOUS PREGNANCIES RESULTING IN REGISTRABLE BIRTH | F |

| Notation | DATA GROUP: PATIENT CHARACTERISTICS - SOCIAL AND PERSONAL CIRCUMSTANCES (SNOMED CT) |
|---|---|
| Group Status / R | FUNCTION: |
| Group Repeats / 0..* | To carry the details the SNOMED CT coded Social and Personal Circumstances for the Patient (the Mother). |

One of the following DATA GROUPS may be used:

| M | 1..1 | DATA GROUP: SNOMED CT SOCIAL AND PERSONAL CIRCUMSTANCES | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP | F |

OR

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: DELIVERY EPISODE - CLINICAL DIAGNOSIS GROUP (SNOMED CT) |
|---|---|
| Group Status / R | FUNCTION: |
| Group Repeats / 0..* | To carry the details of the SNOMED CT coded Clinical Diagnoses for the Patient (the Mother). |

One of the following DATA GROUPS may be used:

| M | 1..1 | DATA GROUP: SNOMED CT DIAGNOSIS | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | DIAGNOSIS (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | CODED CLINICAL ENTRY SEQUENCE NUMBER | F |
| | | M | 1..1 | CODED DIAGNOSIS TIMESTAMP | F |

OR

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: DELIVERY EPISODE - COMORBIDITY (SNOMED CT) |
|---|---|
| Group Status / R | FUNCTION: |
| Group Repeats / 0..* | To carry the details of the SNOMED CT coded Comorbidities for the Patient (the Mother). |

One of the following DATA GROUPS may be used:

| M | 1..1 | DATA GROUP: SNOMED CT COMORBIDITY | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | COMORBIDITY (SNOMED CT EXPRESSION) | F |

OR

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: DELIVERY EPISODE - PROCEDURE GROUP (SNOMED CT) |
|---|---|
| Group Status / R | FUNCTION: |
| Group Repeats / 0..* | To carry the details of the SNOMED CT coded Procedures for the Patient (the Mother). |

One of the following DATA GROUPS may be used:

| M | 1..1 | DATA GROUP: SNOMED CT PROCEDURE | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | PROCEDURE (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | CODED CLINICAL ENTRY SEQUENCE NUMBER | F |
| | | M | 1..1 | CODED PROCEDURE TIMESTAMP | F |

| O | 0..1 | DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL | Rules |
|---|---|---|---|
| | | **M** **1..1** PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | **M** **1..1** PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | F |
| O | 0..1 | DATA GROUP: RESPONSIBLE ANAESTHETIST | Rules |
| | | **M** **1..1** PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | **M** **1..1** PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | Rules |
|---|---|---|---|
| | | O 0..1 DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: DELIVERY EPISODE - OBSERVATION GROUP (SNOMED CT) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| R | 0..* | To carry the details of the SNOMED CT coded Clinical Observations for the Patient (the Mother). |

**One of the following DATA GROUPS may be used:**

| **M** | **1..1** | **DATA GROUP: SNOMED CT OBSERVATION** | Rules |
|---|---|---|---|
| | | **M** **1..1** OBSERVATION (SNOMED CT EXPRESSION) | F |
| | | R 0..1 OBSERVATION VALUE | F |
| | | R 0..1 UCUM UNIT OF MEASUREMENT | F |
| | | **M** **1..1** CODED OBSERVATION TIMESTAMP | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | Rules |
|---|---|---|---|
| | | O 0..1 DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: DELIVERY EPISODE - FINDING GROUP (SNOMED CT) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| R | 0..* | To carry the details of the SNOMED CT coded Clinical Findings for the Patient (the Mother). |

**One of the following DATA GROUPS may be used:**

| M | **1..1** | **DATA GROUP: SNOMED CT FINDING** | Rules |
|---|---|---|---|
| | | **M** **1..1** FINDING (SNOMED CT EXPRESSION) | F |
| | | **M** **1..1** CODED FINDING TIMESTAMP | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | Rules |
|---|---|---|---|
| | | O 0..1 DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: DELIVERY EPISODE - ASSESSMENT TOOL GROUP (SNOMED CT) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| R | 0..* | To carry the details of the SNOMED CT coded Assessment Tools for the Patient (the Mother). |

**One of the following DATA GROUPS may be used:**

| **M** | **1..1** | **DATA GROUP: SNOMED CT ASSESSMENT TOOL** | Rules |
|---|---|---|---|
| | | **M** **1..1** ASSESSMENT TOOL (SNOMED CT EXPRESSION) | F |
| | | **M** **1..1** PERSON SCORE | F |
| | | **M** **1..1** ASSESSMENT TOOL COMPLETION TIMESTAMP | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | Rules |
|---|---|---|---|
| | | O 0..1 DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: GP REGISTRATION |
|---|---|

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

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | GENERAL MEDICAL PRACTITIONER (SPECIFIED) | F |
| | | R | 0..1 | GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION) | F |

| Notation | DATA GROUP: PREGNANCY - ACTIVITY CHARACTERISTICS |
|---|---|
| Group Status / Group Repeats | FUNCTION: |
| R / 0..1 | To carry the details of the Pregnancy. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | NUMBER OF BABIES INDICATION CODE | V |

| Notation | DATA GROUP: ANTENATAL CARE - ACTIVITY CHARACTERISTICS |
|---|---|
| Group Status / Group Repeats | FUNCTION: |
| R / 0..1 | To carry the details of the Antenatal Care. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | FIRST ANTENATAL ASSESSMENT DATE | F<br>S13 |

| Notation | DATA GROUP: ANTENATAL CARE - PERSON GROUP (RESPONSIBLE CLINICIAN) |
|---|---|
| Group Status / Group Repeats | FUNCTION: |
| R / 0..1 | To carry the details of the General Medical Practitioner responsible for the Antenatal Care. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE) | F |
| | | O | 0..1 | GENERAL MEDICAL PRACTITIONER PRACTICE (PATIENT ANTENATAL CARE) | F |

| Notation | DATA GROUP: ANTENATAL CARE - LOCATION GROUP - DELIVERY PLACE INTENDED |
|---|---|
| Group Status / Group Repeats | FUNCTION: |
| R / 0..1 | To carry the details of the Intended Delivery Location. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | R | 0..1 | DELIVERY PLACE CHANGE REASON CODE | V |
| | | R | 0..1 | DELIVERY PLACE TYPE CODE (INTENDED) | V |

| Notation | DATA GROUP: LABOUR/DELIVERY - ACTIVITY CHARACTERISTICS |
|---|---|
| Group Status / Group Repeats | FUNCTION: |
| M / 1..1 | To carry the details of the Labour/Delivery. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY CODE | V |
| | | R | 0..1 | ANAESTHETIC GIVEN POST LABOUR OR DELIVERY CODE | V |
| | | O | 0..1 | GESTATION LENGTH (LABOUR ONSET) | F |
| | | R | 0..1 | LABOUR OR DELIVERY ONSET METHOD CODE | V |
| | | **M** | **1..1** | DELIVERY TIMESTAMP | F<br>S1<br>S13 |
| | | **M** | **1..1** | AGE AT CDS ACTIVITY DATE | |

| | | | | | Rules |
|---|---|---|---|---|---|
| | | | | | F<br>H4 |
| | | R | 0..1 | OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE | V |

| Notation | | DATA GROUP: LABOUR/DELIVERY - SERVICE AGREEMENT DETAILS |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| M | 1..1 | To carry the details of the Provider, Commissioners and Service Agreements. |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (CODE OF PROVIDER) | F |
| **M** | **1..*** | **DATA GROUP: COMMISSIONERS** | | | **Rules** |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) | F |
| | | R | 0..1 | START DATE (COMMISSIONER ASSIGNMENT PERIOD) | F<br>S13 |
| | | R | 0..1 | END DATE (COMMISSIONER ASSIGNMENT PERIOD) | F<br>S13 |
| | | R | 0..1 | NHS SERVICE AGREEMENT IDENTIFIER | F |
| | | O | 0..1 | NHS SERVICE AGREEMENT LINE IDENTIFIER | F |
| | | O | 0..1 | PROVIDER REFERENCE IDENTIFIER | F |
| | | R | 0..1 | COMMISSIONER REFERENCE IDENTIFIER | F |
| | | R | 0..1 | SPECIALISED SERVICE CODE | F |

| Notation | | DATA GROUP: BIRTH OCCURRENCE - ACTIVITY CHARACTERISTICS |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| R | 0..9 | To carry the details of up to 9 Birth Occurrences - one per Baby. |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **DATA GROUP: BIRTH OCCURRENCE - ACTIVITY CHARACTERISTICS** | | | **Rules** |
| | | R | 0..1 | BIRTH ORDER | F |
| | | R | 0..1 | DELIVERY METHOD CODE | V |
| | | R | 0..1 | GESTATION LENGTH (ASSESSMENT) | F |
| | | R | 0..1 | RESUSCITATION METHOD CODE | V |
| | | R | 0..1 | STATUS OF PERSON CONDUCTING DELIVERY CODE | V |

| Notation | | DATA GROUP: PERSON IDENTITY (BABY) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| M | 1..1 | To carry the Identity of the Baby.<br>See Note: S3 in Commissioning Data Set Business Rules. |

**One of the following DATA GROUPS must be used:**

| | | | | | |
|---|---|---|---|---|---|
| **1..1** | **DATA GROUP: WITHHELD IDENTITY STRUCTURE**<br>**Must be used where the Commissioning Data Set record has been anonymised** | | | | |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | **M** | **1..1** | NHS NUMBER STATUS INDICATOR CODE (BABY) | V |
| | | R | 0..1 | PERSON BIRTH DATE (BABY) | F<br>S3<br>S12 |
| | | R | 0..1 | WITHHELD IDENTITY REASON | V |

**OR**

| | | | | | |
|---|---|---|---|---|---|
| **1..1** | **DATA GROUP: VERIFIED IDENTITY STRUCTURE**<br>**Must be used where the NHS NUMBER STATUS INDICATOR CODE (BABY) National Code = 01 (Number present and verified)** | | | | |
| O | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | **Rules** |
| | | **M** | **1..1** | LOCAL PATIENT IDENTIFIER (EXTENDED (BABY)) | |

| | | | | | Rules |
|---|---|---|---|---|---|
| | | | | | F<br>S3 |
| | | M | 1..1 | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (BABY)) | F |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | M | 1..1 | NHS NUMBER (BABY) | F<br>S3 |
| | | M | 1..1 | NHS NUMBER STATUS INDICATOR CODE (BABY) | V |
| | | R | 0..1 | PERSON BIRTH DATE (BABY) | F<br>S3<br>S12 |

**OR**

| | | | | | |
|---|---|---|---|---|---|
| **1..1** | **DATA GROUP: UNVERIFIED IDENTITY STRUCTURE**<br>**Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE (BABY) NOT included in the above** | | | | |
| O | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | **Rules** |
| | | M | 1..1 | LOCAL PATIENT IDENTIFIER (EXTENDED (BABY)) | F<br>S3 |
| | | M | 1..1 | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (BABY)) | F |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | NHS NUMBER (BABY) | F<br>S3 |
| | | M | 1..1 | NHS NUMBER STATUS INDICATOR CODE (BABY) | V |
| R | 0..1 | Data Element Components | | | **Rules** |
| | | R | 0..1 | PERSON BIRTH DATE (BABY) | F<br>S3<br>S12 |

| Notation | | DATA GROUP: BIRTH OCCURRENCE - PERSON CHARACTERISTICS - BABY |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| R | 0..1 | To carry the characteristics of the Baby. |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | PERSON PHENOTYPIC SEX | V |
| | | R | 0..1 | LIVE OR STILL BIRTH CODE | V |
| | | R | 0..1 | BIRTH WEIGHT | F |
| | | R | 0..1 | OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE | V |

| Notation | | DATA GROUP: BIRTH OCCURRENCE - LOCATION GROUP - DELIVERY PLACE ACTUAL |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| R | 0..1 | To carry the details of the Actual Birth Location. |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | R | 0..1 | DELIVERY PLACE TYPE CODE (ACTUAL) | V |

| Notation | | DATA GROUP: CDS V6-3 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To define the mandatory identity and addressing information for a Commissioning Data Set submission. |

| | | |
|---|---|---|
| **M** | **1..*** | **DATA GROUP: CDS V6-3 Type 004 - Commissioning Data Set Message Trailer**<br>One per Commissioning Data Set Message submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| Notation | | DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER |
| --- | --- | --- |
| Group Status | Group Repeats | FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer<br>One per Interchange submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

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CDS V6-3 TYPE 180 - ADMITTED PATIENT CARE - UNFINISHED BIRTH EPISODE CDS

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Change to Data Set: New Data Set

| CDS TYPE V6-3 180 - UNFINISHED BIRTH EPISODE COMMISSIONING DATA SET |
| --- |
| FUNCTION: To support the details of an Unfinished Care Professional Admitted Care Birth Episode. |

| Notation | | DATA GROUP: CDS V6-3 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER |
| --- | --- | --- |
| Group Status | Group Repeats | FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 001 - Commissioning Data Set Interchange Header<br>One per Interchange submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| Notation | | DATA GROUP: CDS V6-3 TYPE 003 - COMMISSIONING DATA SET MESSAGE HEADER |
| --- | --- | --- |
| Group Status | Group Repeats | FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 003 - Commissioning Data Set Message Header<br>One per Commissioning Data Set Message submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

**ONE OF THE FOLLOWING TWO OPTIONS MUST BE USED:**

| Notation | | DATA GROUP: CDS V6-3 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL |
| --- | --- | --- |
| Group Status | Group Repeats | FUNCTION: To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of the Bulk Replacement Update Mechanism of the Commissioning Data Set Submission Protocol. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol<br>One per Commissioning Data Set record submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

**OR**

| Notation | | DATA GROUP: CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL |
| --- | --- | --- |
| Group Status | Group Repeats | FUNCTION: To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of one of the Net Change Update Mechanism of the Commissioning Data Set Submission Protocol. |
| M | 1..1 | |

| | | DATA GROUP: CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol<br>One per Commissioning Data Set record submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |
|---|---|---|

| Notation | | DATA GROUP: PATIENT PATHWAY | |
|---|---|---|---|
| Group Status<br>O | Group Repeats<br>0..1 | FUNCTION:<br>To carry the details of the Patient Pathway. | |
| M | 1..1 | DATA GROUP: PATIENT PATHWAY IDENTITY | Rules |
| | M<br>*Or*<br>M | 1..1 UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)<br>*Or*<br>1..1 PATIENT PATHWAY IDENTIFIER | F<br><br>F<br>I2 |
| | M | 1..1 ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER) | F<br>I2 |
| M | 1..1 | DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS | Rules |
| | M | 1..1 REFERRAL TO TREATMENT PERIOD STATUS | V |
| | M | 1..1 WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET) | V |
| | O | 0..1 REFERRAL TO TREATMENT PERIOD START DATE | F<br>S13 |
| | O | 0..1 REFERRAL TO TREATMENT PERIOD END DATE | F<br>S13 |

| Notation | | DATA GROUP: PATIENT IDENTITY (BABY) |
|---|---|---|
| Group Status<br>M | Group Repeats<br>1..1 | FUNCTION:<br>To carry the Identity of the Patient (the Baby).<br>See Note: S3 in Commissioning Data Set Business Rules. |

**One of the following DATA GROUPS must be used:**

| 1..1 | DATA GROUP: WITHHELD IDENTITY STRUCTURE<br>Must be used where the Commissioning Data Set record has been anonymised | | | |
|---|---|---|---|---|
| M | 1..1 | Data Element Components | | Rules |
| | | M | 1..1 NHS NUMBER STATUS INDICATOR CODE | V |
| | | R | 0..1 PERSON BIRTH DATE | F<br>S3<br>S12 |
| | | R | 0..1 WITHHELD IDENTITY REASON | V |

**OR**

| 1..1 | DATA GROUP: VERIFIED IDENTITY STRUCTURE<br>Must be used where the NHS NUMBER STATUS INDICATOR CODE National Code = 01 (Number present and verified) | | | |
|---|---|---|---|---|
| R | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | Rules |
| | | M | 1..1 LOCAL PATIENT IDENTIFIER (EXTENDED) | F<br>S3 |
| | | M | 1..1 ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) | F |
| M | 1..1 | Data Element Components | | Rules |
| | | M | 1..1 NHS NUMBER | F<br>S3 |
| | | M | 1..1 NHS NUMBER STATUS INDICATOR CODE | V |
| | | R | 0..1 PERSON BIRTH DATE | F<br>S3<br>S12 |

**OR**

| | | |
|---|---|---|
| **1..1** | **DATA GROUP: UNVERIFIED IDENTITY STRUCTURE**<br>**Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE NOT included in the above** | |

| | | | | | |
|---|---|---|---|---|---|
| R | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | **Rules** |
| | | **M** | **1..1** | LOCAL PATIENT IDENTIFIER (EXTENDED) | F<br>S3 |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) | F |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | NHS NUMBER | F<br>S3 |
| | | **M** | **1..1** | NHS NUMBER STATUS INDICATOR CODE | V |
| R | 0..1 | Data Element Components | | | **Rules** |
| | | **M**<br>**OR**<br>O<br>and<br>**M**<br>**and**<br>**M**<br>and<br>O<br>and<br>O | **1..1**<br>**OR**<br>0..1<br>and<br>**1..1**<br>**and**<br>**1..1**<br>and<br>0..1<br>and<br>0..1 | PATIENT FULL NAME<br>**OR**<br>PATIENT TITLE<br>and<br>PATIENT GIVEN NAME<br>**and**<br>PATIENT FAMILY NAME<br>and<br>PATIENT NAME SUFFIX<br>and<br>PATIENT INITIALS | F<br>S3<br>I4 |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | PERSON BIRTH DATE | F<br>S3<br>S12 |

| **Notation** | | **DATA GROUP: PATIENT CHARACTERISTICS** |
|---|---|---|
| **Group Status**<br>**R** | **Group Repeats**<br>**0..1** | **FUNCTION:**<br>**To carry the characteristics of the Patient (the Baby).** |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | PERSON PHENOTYPIC SEX | V |
| | | R | 0..1 | ETHNIC CATEGORY | V |
| | | X | 0..1 | ETHNIC CATEGORY 2021 | N2 |
| | | R | 0..1 | LIVE OR STILL BIRTH CODE | V |
| | | R | 0..1 | BIRTH WEIGHT | F |

| **Notation** | | **DATA GROUP: PATIENT CHARACTERISTICS - SOCIAL AND PERSONAL CIRCUMSTANCES (SNOMED CT)** |
|---|---|---|
| **Group Status**<br>**R** | **Group Repeats**<br>**0..*** | **FUNCTION:**<br>**To carry the details of the SNOMED CT coded Social and Personal Circumstances for the Patient (the Baby).** |

**One of the following DATA GROUPS may be used:**

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **DATA GROUP: SNOMED CT SOCIAL AND PERSONAL CIRCUMSTANCES** | | | **Rules** |
| | | **M** | **1..1** | SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION) | F |
| | | **M** | **1..1** | SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP | F |

**OR**

| | | | | | |
|---|---|---|---|---|---|
| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | **Rules** |
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| **Notation** | | **DATA GROUP: HOSPITAL PROVIDER SPELL - ADMISSION CHARACTERISTICS** |
|---|---|---|
| | | |

| Group Status | Group Repeats | FUNCTION: | |
|---|---|---|---|
| M | 1..1 | To carry the admission details of the Hospital Provider Spell containing the Unfinished Birth Care Professional Admitted Care Episode. | |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | HOSPITAL PROVIDER SPELL IDENTIFIER | F |
| | | R | 0..1 | ADMINISTRATIVE CATEGORY CODE (ON ADMISSION) | V |
| | | R | 0..1 | PATIENT CLASSIFICATION CODE | V |
| | | R | 0..1 | METHOD OF ADMISSION (HOSPITAL PROVIDER SPELL) | V |
| | | R | 0..1 | ADMISSION SOURCE (HOSPITAL PROVIDER SPELL) | V |
| | | **M** | **1..1** | START DATE (HOSPITAL PROVIDER SPELL) | F<br>S13 |
| | | O | 0..1 | START TIME (HOSPITAL PROVIDER SPELL) | F<br>S14 |
| | | **M** | **1..1** | AGE ON ADMISSION | F |

| Notation | DATA GROUP: HOSPITAL PROVIDER SPELL - DISCHARGE CHARACTERISTICS |
|---|---|

| Group Status | Group Repeats | FUNCTION: |
|---|---|---|
| R | 0..1 | To carry the discharge details of the Hospital Provider Spell containing the Unfinished Birth Care Professional Admitted Care Episode. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | DESTINATION OF DISCHARGE (HOSPITAL PROVIDER SPELL) | V |
| | | R | 0..1 | METHOD OF DISCHARGE (HOSPITAL PROVIDER SPELL) | V |
| | | R | 0..1 | DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL) | F<br>S13 |
| | | R | 0..1 | DISCHARGE DATE (HOSPITAL PROVIDER SPELL) | F<br>S13 |
| | | O | 0..1 | DISCHARGE TIME (HOSPITAL PROVIDER SPELL) | F<br>S14 |
| | | R | 0..1 | DISCHARGED TO NHS AT HOME SERVICE INDICATOR | V |

| Notation | DATA GROUP: BIRTH EPISODE - ACTIVITY CHARACTERISTICS |
|---|---|

| Group Status | Group Repeats | FUNCTION: |
|---|---|---|
| M | 1..1 | To carry the details of the Unfinished Birth Care Professional Admitted Care Episode. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | EPISODE NUMBER | F |
| | | R | 0..1 | LAST EPISODE IN SPELL INDICATOR CODE | V |
| | | R | 0..1 | NEONATAL LEVEL OF CARE CODE | V |
| | | **M** | **1..1** | START DATE (EPISODE) | F<br>S1<br>S13 |
| | | O | 0..1 | START TIME (EPISODE) | F<br>S14 |
| | | R | 0..1 | END DATE (EPISODE) | F<br>S13 |
| | | O | 0..1 | END TIME (EPISODE) | F<br>S14 |
| | | **M** | **1..1** | AGE AT CDS ACTIVITY DATE | F |

| Notation | DATA GROUP: BIRTH EPISODE- OVERSEAS VISITOR CHARGING CATEGORY |
|---|---|

| Group Status | Group Repeats | FUNCTION: |
|---|---|---|
| R | 0..5 | To carry the details of the Overseas Visitor Charging Categories of the Patient (the Baby) during the Unfinished Birth Care Professional Admitted Care Episode. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | OVERSEAS VISITOR CHARGING CATEGORY | V |
| | | M | 1..1 | OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE FROM DATE | F S13 |
| | | R | 0..1 | OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE END DATE | F S13 |

| Notation | | DATA GROUP: BIRTH EPISODE - SERVICE AGREEMENT DETAILS | | | |
|---|---|---|---|---|---|
| Group Status M | Group Repeats 1..1 | FUNCTION: To carry the details of the Provider, Commissioners and Service Agreements. | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | ORGANISATION IDENTIFIER (CODE OF PROVIDER) | F |
| M | 1..* | DATA GROUP: COMMISSIONERS | | | Rules |
| | | M | 1..1 | ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) | F |
| | | R | 0..1 | START DATE (COMMISSIONER ASSIGNMENT PERIOD) | F S13 |
| | | R | 0..1 | END DATE (COMMISSIONER ASSIGNMENT PERIOD) | F S13 |
| | | R | 0..1 | NHS SERVICE AGREEMENT IDENTIFIER | F |
| | | O | 0..1 | NHS SERVICE AGREEMENT LINE IDENTIFIER | F |
| | | O | 0..1 | PROVIDER REFERENCE IDENTIFIER | F |
| | | R | 0..1 | COMMISSIONER REFERENCE IDENTIFIER | F |
| | | R | 0..1 | SPECIALISED SERVICE CODE | F |

| Notation | | DATA GROUP: CARE EPISODE - PERSON GROUP (CARE PROFESSIONAL) | | | |
|---|---|---|---|---|---|
| Group Status R | Group Repeats 0..* | FUNCTION: To carry the details of the Care Professionals active during the Unfinished Birth Care Professional Admitted Care Episode. | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER | F |
| | | M | 1..1 | CARE PROFESSIONAL MAIN SPECIALTY CODE | F H4 |
| | | M | 1..1 | ACTIVITY TREATMENT FUNCTION CODE | F H4 |
| | | O | 0..1 | LOCAL SUB-SPECIALTY CODE | F |
| | | M | 1..1 | RESPONSIBLE CARE PROFESSIONAL INDICATOR | V |

| Notation | | DATA GROUP: BIRTH EPISODE - CLINICAL DIAGNOSIS GROUP (ICD) | | | |
|---|---|---|---|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the ICD coded Clinical Diagnoses for the Patient (the Baby). | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET) | V |
| M | 1..1 | DATA GROUP: PRIMARY DIAGNOSIS | | | Rules |
| | | M | 1..1 | PRIMARY DIAGNOSIS (ICD) | F |
| R | 0..* | DATA GROUP: SECONDARY DIAGNOSES | | | Rules |
| | | M | 1..1 | SECONDARY DIAGNOSIS (ICD) | F |

| Notation | | DATA GROUP: BIRTH EPISODE - CLINICAL DIAGNOSIS GROUP (SNOMED CT) |
|---|---|---|
| | | |

| Group Status | Group Repeats | FUNCTION: |
|---|---|---|
| R | 0..* | To carry the details of the SNOMED CT coded Clinical Diagnoses for the Patient (the Baby). |

**One of the following DATA GROUPS may be used:**

| M | 1..1 | **DATA GROUP: SNOMED CT DIAGNOSIS** | | | **Rules** |
|---|---|---|---|---|---|
| | | **M** | **1..1** | DIAGNOSIS (SNOMED CT EXPRESSION) | F |
| | | **M** | **1..1** | CODED CLINICAL ENTRY SEQUENCE NUMBER | F |
| | | **M** | **1..1** | CODED DIAGNOSIS TIMESTAMP | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | **Rules** |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: BIRTH EPISODE - COMORBIDITY (SNOMED CT) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| R | 0..* | To carry the details of the SNOMED CT coded Comorbidities for the Patient (the Baby). |

**One of the following DATA GROUPS may be used:**

| M | 1..1 | **DATA GROUP: SNOMED CT COMORBIDITY** | | | **Rules** |
|---|---|---|---|---|---|
| | | **M** | **1..1** | COMORBIDITY (SNOMED CT EXPRESSION) | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | **Rules** |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: BIRTH EPISODE - PROCEDURE GROUP (OPCS) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| R | 0..1 | To carry the details of the OPCS coded Procedures for the Patient (the Baby). |

| M | 1..1 | **Data Element Components** | | | **Rules** |
|---|---|---|---|---|---|
| | | **M** | **1..1** | PROCEDURE SCHEME IN USE (COMMISSIONING DATA SET) | V |
| **M** | **1..1** | **DATA GROUP: PRIMARY PROCEDURE** | | | **Rules** |
| | | **M** | **1..1** | PRIMARY PROCEDURE (OPCS) | F |
| | | R | 0..1 | PROCEDURE DATE | F<br>S13 |
| O | 0..1 | DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL | | | **Rules** |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | F |
| O | 0..1 | DATA GROUP: RESPONSIBLE ANAESTHETIST | | | **Rules** |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | F |
| R | 0..* | DATA GROUP: SECONDARY PROCEDURES | | | **Rules** |
| | | **M** | **1..1** | PROCEDURE (OPCS) | F |
| | | R | 0..1 | PROCEDURE DATE | F<br>S13 |
| O | 0..1 | DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL | | | **Rules** |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | F |
| O | 0..1 | DATA GROUP: RESPONSIBLE ANAESTHETIST | | | **Rules** |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | **M** | **1..1** | | F |

| | | | | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | |
|---|---|---|---|---|---|

| Notation | DATA GROUP: BIRTH EPISODE - PROCEDURE GROUP (SNOMED CT) |
|---|---|
| Group Status<br>R \| Group Repeats<br>0..* | FUNCTION:<br>To carry the details of the SNOMED CT coded Procedures for the Patient (the Baby). |

One of the following DATA GROUPS may be used:

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **DATA GROUP: SNOMED CT PROCEDURE** | | | **Rules** |
| | | **M** | **1..1** | PROCEDURE (SNOMED CT EXPRESSION) | F |
| | | **M** | **1..1** | CODED CLINICAL ENTRY SEQUENCE NUMBER | F |
| | | **M** | **1..1** | CODED PROCEDURE TIMESTAMP | F |
| O | 0..1 | DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL | | | **Rules** |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | F |
| O | 0..1 | DATA GROUP: RESPONSIBLE ANAESTHETIST | | | **Rules** |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | F |

**OR**

| | | | | | |
|---|---|---|---|---|---|
| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | **Rules** |
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: BIRTH EPISODE - OBSERVATION GROUP (SNOMED CT) |
|---|---|
| Group Status<br>R \| Group Repeats<br>0..* | FUNCTION:<br>To carry the details of the SNOMED CT coded Clinical Observations for the Patient (the baby). |

One of the following DATA GROUPS may be used:

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **DATA GROUP: SNOMED CT OBSERVATION** | | | **Rules** |
| | | **M** | **1..1** | OBSERVATION (SNOMED CT EXPRESSION) | F |
| | | R | 0..1 | OBSERVATION VALUE | F |
| | | R | 0..1 | UCUM UNIT OF MEASUREMENT | F |
| | | **M** | **1..1** | CODED OBSERVATION TIMESTAMP | F |

**OR**

| | | | | | |
|---|---|---|---|---|---|
| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | **Rules** |
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: BIRTH EPISODE - FINDING GROUP (SNOMED CT) |
|---|---|
| Group Status<br>R \| Group Repeats<br>0..* | FUNCTION:<br>To carry the details of the SNOMED CT coded Clinical Findings for the Patient (the Baby). |

One of the following DATA GROUPS may be used:

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **DATA GROUP: SNOMED CT FINDING** | | | **Rules** |
| | | **M** | **1..1** | FINDING (SNOMED CT EXPRESSION) | F |
| | | **M** | **1..1** | CODED FINDING TIMESTAMP | F |

**OR**

| | | | | | |
|---|---|---|---|---|---|
| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | **Rules** |
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: BIRTH EPISODE - ASSESSMENT TOOL GROUP (SNOMED CT) |
|---|---|
| | |

| Group Status | Group Repeats | FUNCTION: |
| --- | --- | --- |
| R | 0..* | To carry the details of the SNOMED CT coded Assessment Tools for the Patient (the Baby). |

One of the following DATA GROUPS may be used:

| | | | | | Rules |
| --- | --- | --- | --- | --- | --- |
| M | 1..1 | DATA GROUP: SNOMED CT ASSESSMENT TOOL | | | Rules |
| | | M | 1..1 | ASSESSMENT TOOL (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | PERSON SCORE | F |
| | | M | 1..1 | ASSESSMENT TOOL COMPLETION TIMESTAMP | F |

OR

| | | | | | Rules |
| --- | --- | --- | --- | --- | --- |
| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: LOCATION GROUP (AT START OF BIRTH EPISODE) |
| --- | --- | --- |
| Group Status | Group Repeats | FUNCTION: |
| R | 0..1 | To carry the details of the Location at the Start of the Unfinished Birth Care Professional Admitted Care Episode. |

| | | | | | Rules |
| --- | --- | --- | --- | --- | --- |
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | ORGANISATION SITE IDENTIFIER (OF TREATMENT) | F |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | O | 0..1 | WARD INTENDED CLINICAL CARE INTENSITY | V |
| | | O | 0..1 | WARD INTENDED AGE GROUP | V |
| | | O | 0..1 | WARD INTENDED SEX OF PATIENTS | V |
| | | O | 0..1 | WARD INTENDED DAY PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD INTENDED NIGHT PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD SECURITY LEVEL | V |
| | | O | 0..1 | WARD CODE | F |

| Notation | | DATA GROUP: LOCATION GROUP (AT WARD STAY) |
| --- | --- | --- |
| Group Status | Group Repeats | FUNCTION: |
| R | 0..97 | To carry the details of one or more Ward Stays during the Unfinished Birth Care Professional Admitted Care Episode. |

| | | | | | Rules |
| --- | --- | --- | --- | --- | --- |
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | ORGANISATION SITE IDENTIFIER (OF TREATMENT) | F |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | O | 0..1 | WARD INTENDED CLINICAL CARE INTENSITY | V |
| | | O | 0..1 | WARD INTENDED AGE GROUP | V |
| | | O | 0..1 | WARD INTENDED SEX OF PATIENTS | V |
| | | O | 0..1 | WARD INTENDED DAY PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD INTENDED NIGHT PERIOD AVAILABILITY | V |
| | | O | 0..1 | START DATE (WARD STAY) | F<br>S13 |
| | | O | 0..1 | START TIME (WARD STAY) | F<br>S14 |
| | | O | 0..1 | END DATE (WARD STAY) | F<br>S13 |
| | | O | 0..1 | END TIME (WARD STAY) | F<br>S14 |
| | | O | 0..1 | WARD SECURITY LEVEL | V |
| | | O | 0..1 | WARD CODE | F |

| Notation | | DATA GROUP: LOCATION GROUP (AT END OF BIRTH EPISODE) |
| --- | --- | --- |
| | | |

| Group Status | Group Repeats | FUNCTION: | |
|---|---|---|---|
| R | 0..1 | To carry the details of the Location at the End of the Unfinished Birth Care Professional Admitted Care Episode. | |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | ORGANISATION SITE IDENTIFIER (OF TREATMENT) | F |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | O | 0..1 | WARD INTENDED CLINICAL CARE INTENSITY | V |
| | | O | 0..1 | WARD INTENDED AGE GROUP | V |
| | | O | 0..1 | WARD INTENDED SEX OF PATIENTS | V |
| | | O | 0..1 | WARD INTENDED DAY PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD INTENDED NIGHT PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD SECURITY LEVEL | V |
| | | O | 0..1 | WARD CODE | F |

| Notation | DATA GROUP: LOCATION GROUP - HOME LEAVE |
|---|---|
| **Group Status** / **Group Repeats** | **FUNCTION:** |
| **R** / **0..*** | **To carry the details of each separate period of Home Leave within the Unfinished Birth Care Professional Admitted Care Episode.** |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | **M** | **1..1** | START DATE (HOME LEAVE) | F S13 |
| | | R | 0..1 | START TIME (HOME LEAVE) | F S14 |
| | | R | 0..1 | END DATE (HOME LEAVE) | F S13 |
| | | R | 0..1 | END TIME (HOME LEAVE) | F S14 |

| Notation | DATA GROUP: BIRTH EPISODE - NEONATAL CRITICAL CARE PERIOD |
|---|---|
| **Group Status** / **Group Repeats** | **FUNCTION: See CRITICAL CARE PERIOD** |
| **R** / **0..9** | **To carry the details of the first 9 Critical Care Periods for care provided using Neonatal Care facilities.** |

| M | 1..1 | DATA GROUP: NEONATAL CARE - ADMISSION CHARACTERISTICS | | | Rules |
|---|---|---|---|---|---|
| | | **M** | **1..1** | CRITICAL CARE LOCAL IDENTIFIER | F |
| | | **M** | **1..1** | CRITICAL CARE START DATE | F S13 |
| | | **M** | **1..1** | CRITICAL CARE START TIME | F S14 |
| | | **M** | **1..1** | CRITICAL CARE UNIT FUNCTION | V |
| | | **M** | **1..1** | GESTATION LENGTH (AT DELIVERY) | V |
| **M** | **1..999** | **DATA GROUP: NEONATAL DAILY CARE - ACTIVITY CHARACTERISTICS** | | | **Rules** |
| | | **M** | **1..1** | ACTIVITY DATE (CRITICAL CARE) | F S13 |
| | | R | 0..1 | PERSON WEIGHT | F |
| | | **M** | **1..20** | CRITICAL CARE ACTIVITY CODE | F N4 |
| | | R | 0..20 | HIGH COST DRUGS (OPCS) | F N4 |
| R | 0..1 | DATA GROUP: NEONATAL CARE - DISCHARGE CHARACTERISTICS | | | **Rules** |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE DATE | F S13 |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE TIME | |

| | | | | | F<br>S14 |
|---|---|---|---|---|---|

| Notation | | DATA GROUP: BIRTH EPISODE - PAEDIATRIC CRITICAL CARE PERIOD | | | |
|---|---|---|---|---|---|
| Group Status<br>R | Group Repeats<br>0..9 | FUNCTION: See CRITICAL CARE PERIOD<br>To carry the details of the first 9 Critical Care Periods for care provided using Paediatric Care facilities. | | | |
| M | 1..1 | DATA GROUP: PAEDIATRIC CRITICAL CARE - ADMISSION CHARACTERISTICS | | | Rules |
| | | M | 1..1 | CRITICAL CARE LOCAL IDENTIFIER | F |
| | | M | 1..1 | CRITICAL CARE START DATE | F<br>S13 |
| | | M | 1..1 | CRITICAL CARE START TIME | F<br>S14 |
| | | M | 1..1 | CRITICAL CARE UNIT FUNCTION | V |
| M | 1..999 | DATA GROUP: PAEDIATRIC DAILY CARE - ACTIVITY CHARACTERISTICS | | | Rules |
| | | M | 1..1 | ACTIVITY DATE (CRITICAL CARE) | F<br>S13 |
| | | M | 1..20 | CRITICAL CARE ACTIVITY CODE | F<br>N4 |
| | | R | 0..20 | HIGH COST DRUGS (OPCS) | F<br>N4 |
| R | 0..1 | DATA GROUP: PAEDIATRIC CRITICAL CARE - DISCHARGE CHARACTERISTICS | | | Rules |
| | | M | 1..1 | CRITICAL CARE DISCHARGE DATE | F<br>S13 |
| | | M | 1..1 | CRITICAL CARE DISCHARGE TIME | F<br>S14 |

| Notation | | DATA GROUP: BIRTH EPISODE - ADULT CRITICAL CARE PERIOD | | | |
|---|---|---|---|---|---|
| Group Status<br>R | Group Repeats<br>0..9 | FUNCTION: See CRITICAL CARE PERIOD<br>To carry the details of the first 9 Critical Care Periods for care provided using Adult Care facilities. | | | |
| M | 1..1 | DATA GROUP: ADULT CRITICAL CARE - ADMISSION CHARACTERISTICS | | | Rules |
| | | M | 1..1 | CRITICAL CARE LOCAL IDENTIFIER | F |
| | | M | 1..1 | CRITICAL CARE START DATE | F<br>S13 |
| | | O | 0..1 | CRITICAL CARE START TIME | F<br>S14 |
| | | M | 1..1 | CRITICAL CARE UNIT FUNCTION | V |
| | | O | 0..1 | CRITICAL CARE UNIT BED CONFIGURATION | V |
| | | O | 0..1 | CRITICAL CARE ADMISSION SOURCE | V |
| | | O | 0..1 | CRITICAL CARE SOURCE LOCATION | V |
| | | O | 0..1 | CRITICAL CARE ADMISSION TYPE | V |
| M | 1..1 | DATA GROUP: ADULT CRITICAL CARE - ACTIVITY CHARACTERISTICS | | | Rules |
| | | R | 0..1 | ADVANCED RESPIRATORY SUPPORT DAYS | F |
| | | R | 0..1 | BASIC RESPIRATORY SUPPORT DAYS | F |
| | | R | 0..1 | ADVANCED CARDIOVASCULAR SUPPORT DAYS | F |
| | | R | 0..1 | BASIC CARDIOVASCULAR SUPPORT DAYS | F |
| | | R | 0..1 | RENAL SUPPORT DAYS | F |
| | | R | 0..1 | NEUROLOGICAL SUPPORT DAYS | F |
| | | O | 0..1 | GASTRO-INTESTINAL SUPPORT DAYS | F |
| | | R | 0..1 | DERMATOLOGICAL SUPPORT DAYS | F |
| | | R | 0..1 | LIVER SUPPORT DAYS | F |

| | | | | | |
|---|---|---|---|---|---|
| | | O | 0..1 | ORGAN SUPPORT MAXIMUM | V |
| | | R | 0..1 | CRITICAL CARE LEVEL 2 DAYS | F |
| | | R | 0..1 | CRITICAL CARE LEVEL 3 DAYS | F |
| R | 0..* | DATA GROUP: ADULT CRITICAL CARE - DAILY CARE ACTIVITY CHARACTERISTICS | | | Rules |
| | | **M** | **1..1** | ACTIVITY DATE (CRITICAL CARE) | F S13 |
| | | **M** | **1..9** | ORGAN SYSTEM SUPPORTED | V |
| | | **M** | **1..1** | CRITICAL CARE LEVEL | V |
| R | 0..1 | DATA GROUP: ADULT CRITICAL CARE - DISCHARGE CHARACTERISTICS | | | Rules |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE DATE | F S13 |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE TIME | F S14 |
| | | O | 0..1 | CRITICAL CARE DISCHARGE READY DATE | F S13 |
| | | O | 0..1 | CRITICAL CARE DISCHARGE READY TIME | F S14 |
| | | O | 0..1 | CRITICAL CARE DISCHARGE STATUS | V |
| | | O | 0..1 | CRITICAL CARE DISCHARGE DESTINATION | V |
| | | O | 0..1 | CRITICAL CARE DISCHARGE LOCATION | V |

| Notation | | DATA GROUP: GP REGISTRATION |
|---|---|---|
| **Group Status** | **Group Repeats** | **FUNCTION:** To carry the Patient's General Medical Practitioner and the General Practice details. |
| **R** | **0..1** | |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | O | 0..1 | GENERAL MEDICAL PRACTITIONER (SPECIFIED) | F |
| | | R | 0..1 | GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION) | F |

| Notation | | DATA GROUP: REFERRER |
|---|---|---|
| **Group Status** | **Group Repeats** | **FUNCTION:** To carry the details of the Referrer. |
| **R** | **0..1** | |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | REFERRER CODE | F |
| | | R | 0..1 | ORGANISATION IDENTIFIER (REFERRING ORGANISATION) | F |

| Notation | | DATA GROUP: PREGNANCY - ACTIVITY CHARACTERISTICS |
|---|---|---|
| **Group Status** | **Group Repeats** | **FUNCTION:** To carry the details of the Pregnancy. |
| **R** | **0..1** | |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | NUMBER OF BABIES INDICATION CODE | V |

| Notation | | DATA GROUP: ANTENATAL CARE - ACTIVITY CHARACTERISTICS |
|---|---|---|
| **Group Status** | **Group Repeats** | **FUNCTION:** To carry the details of the Antenatal Care. |
| **R** | **0..1** | |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | FIRST ANTENATAL ASSESSMENT DATE | F S13 |

| Notation | DATA GROUP: ANTENATAL CARE - PERSON GROUP (RESPONSIBLE CLINICIAN) | | | |
|---|---|---|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the General Medical Practitioner responsible for the Antenatal Care. | | |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE) | F |
| | | O | 0..1 | GENERAL MEDICAL PRACTITIONER PRACTICE (PATIENT ANTENATAL CARE) | F |

| Notation | DATA GROUP: ANTENATAL CARE - LOCATION GROUP - DELIVERY PLACE INTENDED | |
|---|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the Intended Delivery Location. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | R | 0..1 | DELIVERY PLACE CHANGE REASON CODE | V |
| | | R | 0..1 | DELIVERY PLACE TYPE CODE (INTENDED) | V |

| Notation | DATA GROUP: LABOUR/DELIVERY - ACTIVITY CHARACTERISTICS | |
|---|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the Labour/Delivery. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY CODE | V |
| | | R | 0..1 | ANAESTHETIC GIVEN POST LABOUR OR DELIVERY CODE | V |
| | | O | 0..1 | GESTATION LENGTH (LABOUR ONSET) | F |
| | | R | 0..1 | LABOUR OR DELIVERY ONSET METHOD CODE | V |
| | | R | 0..1 | DELIVERY TIMESTAMP | F |

| Notation | DATA GROUP: DELIVERY OCCURRENCE - ACTIVITY CHARACTERISTICS | |
|---|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the Delivery of the Baby. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | BIRTH ORDER | F |
| | | R | 0..1 | DELIVERY METHOD CODE | V |
| | | R | 0..1 | GESTATION LENGTH (ASSESSMENT) | F |
| | | R | 0..1 | RESUSCITATION METHOD CODE | V |
| | | R | 0..1 | STATUS OF PERSON CONDUCTING DELIVERY CODE | V |

| Notation | DATA GROUP: PERSON IDENTITY (MOTHER) | |
|---|---|---|
| Group Status M | Group Repeats 1..1 | FUNCTION: To carry the Identity details of the Baby's mother. See Note: S3 in Commissioning Data Set Business Rules. |

One of the following DATA GROUPS must be used:

| 1..1 | DATA GROUP: WITHHELD IDENTITY STRUCTURE<br>Must be used where the Commissioning Data Set record has been anonymised | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | **M** | **1..1** | NHS NUMBER STATUS INDICATOR CODE (MOTHER) | V |
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | WITHHELD IDENTITY REASON | V |

OR

| | | | | | Rules |
|---|---|---|---|---|---|
| 1..1 | **DATA GROUP: VERIFIED IDENTITY STRUCTURE**<br>**Must be used where the NHS NUMBER STATUS INDICATOR CODE (MOTHER) National Code = 01 (Number present and verified)** | | | | |
| O | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | Rules |
| | | **M** | **1..1** | LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER)) | F<br>S3 |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER)) | F |
| **M** | **1..1** | **Data Element Components** | | | Rules |
| | | **M** | **1..1** | NHS NUMBER (MOTHER) | F<br>S3 |
| | | **M** | **1..1** | NHS NUMBER STATUS INDICATOR CODE (MOTHER) | V |
| | | **M** | **1..1** | POSTCODE OF USUAL ADDRESS (MOTHER) | F<br>S3 |
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | PERSON BIRTH DATE (MOTHER) | F<br>S3<br>S12 |

**OR**

| | | | | | Rules |
|---|---|---|---|---|---|
| 1..1 | **DATA GROUP: UNVERIFIED IDENTITY STRUCTURE**<br>**Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE (MOTHER) NOT included in the above** | | | | |
| O | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | Rules |
| | | **M** | **1..1** | LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER)) | F<br>S3 |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER)) | F |
| **M** | **1..1** | **Data Element Components** | | | Rules |
| | | R | 0..1 | NHS NUMBER (MOTHER) | F<br>S3 |
| | | **M** | **1..1** | NHS NUMBER STATUS INDICATOR CODE (MOTHER) | V |
| O | 0..1 | Data Element Components | | | Rules |
| | | **M**<br>**OR**<br>**M** | **1..1**<br>**OR**<br>**2..5** | PATIENT USUAL ADDRESS (UNSTRUCTURED (MOTHER))<br>**OR**<br>PATIENT USUAL ADDRESS (STRUCTURED (MOTHER)) | F<br>S3<br>I5 |
| **M** | **1..1** | **Data Element Components** | | | Rules |
| | | R | 0..1 | POSTCODE OF USUAL ADDRESS (MOTHER) | F<br>S3 |
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | PERSON BIRTH DATE (MOTHER) | F<br>S3<br>S12 |

| Notation | | **DATA GROUP: DELIVERY OCCURRENCE - OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE** | | | |
|---|---|---|---|---|---|
| Group Status<br>R | Group Repeats<br>0..1 | **FUNCTION:**<br>**To carry the details of the Overseas Visitor Charging Category of the Mother.** | | | |
| **M** | **1..1** | **Data Element Components** | | | Rules |
| | | R | 0..1 | OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE | V |

| Notation | | **DATA GROUP: DELIVERY OCCURRENCE - LOCATION GROUP - DELIVERY PLACE ACTUAL** | | | |
|---|---|---|---|---|---|
| Group Status<br>R | Group Repeats<br>0..1 | **FUNCTION:**<br>**To carry the details of the Actual Delivery Location.** | | | |
| **M** | **1..1** | **Data Element Components** | | | Rules |

| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
|---|---|---|---|---|---|
| | | R | 0..1 | DELIVERY PLACE TYPE CODE (ACTUAL) | V |

| Notation | | DATA GROUP: CDS V6-3 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..* | DATA GROUP: CDS V6-3 Type 004 - Commissioning Data Set Message Trailer<br>One per Commissioning Data Set Message submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| Notation | | DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer<br>One per Interchange submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

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#### CDS V6-3 TYPE 190 - ADMITTED PATIENT CARE - UNFINISHED GENERAL EPISODE CDS

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Change to Data Set: New Data Set

| CDS V6-3 TYPE 190 - UNFINISHED GENERAL EPISODE COMMISSIONING DATA SET |
|---|
| FUNCTION: To support the details of an Unfinished Care Professional Admitted Care General Episode. |

| Notation | | DATA GROUP: CDS V6-3 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 001 - Commissioning Data Set Interchange Header<br>One per Interchange submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| Notation | | DATA GROUP: CDS V6-3 TYPE 003 - COMMISSIONING DATA SET MESSAGE HEADER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..* | DATA GROUP: CDS V6-3 Type 003 - Commissioning Data Set Message Header<br>One per Commissioning Data Set Message submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

**ONE OF THE FOLLOWING TWO OPTIONS MUST BE USED:**

| Notation | | DATA GROUP: CDS V6-3 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL |
|---|---|---|
| Group Status | Group Repeats | FUNCTION:<br>To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of the Bulk Replacement Update Mechanism of the Commissioning Data Set Submission Protocol. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol |

| | | |
|---|---|---|
| | | One per Commissioning Data Set record submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

**OR**

| Notation | | **DATA GROUP: CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL** |
|---|---|---|
| **Group Status** | **Group Repeats** | **FUNCTION:**<br>**To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of one of the Net Change Update Mechanism of the Commissioning Data Set Submission Protocol.** |
| **M** | **1..1** | **DATA GROUP: CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol**<br>One per Commissioning Data Set record submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| Notation | | | | | **DATA GROUP: PATIENT PATHWAY** |
|---|---|---|---|---|---|
| **Group Status**<br>**R** | **Group Repeats**<br>**0..1** | **FUNCTION:**<br>**To carry the details of the Patient Pathway.**<br>**This Group must be present if the record relates to a Referral To Treatment Period Included In 18 Weeks Target.** | | | |
| **M** | **1..1** | **DATA GROUP: PATIENT PATHWAY IDENTITY** | | | **Rules** |
| | **M**<br>*Or*<br>**M** | **1..1**<br><br>**1..1** | UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)<br>*Or*<br>PATIENT PATHWAY IDENTIFIER | | F<br><br>F<br>I2 |
| | **M** | **1..1** | ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER) | | F<br>I2 |
| **M** | **1..1** | **DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS** | | | **Rules** |
| | **M** | **1..1** | REFERRAL TO TREATMENT PERIOD STATUS | | V |
| | **M** | **1..1** | WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET) | | V |
| | O | 0..1 | REFERRAL TO TREATMENT PERIOD START DATE | | F<br>S13 |
| | O | 0..1 | REFERRAL TO TREATMENT PERIOD END DATE | | F<br>S13 |

| Notation | | **DATA GROUP: PATIENT IDENTITY** |
|---|---|---|
| **Group Status**<br>**M** | **Group Repeats**<br>**1..1** | **FUNCTION:**<br>**To carry the Identity of the Patient.**<br>**See Note: S3 in Commissioning Data Set Business Rules.** |

**One of the following DATA GROUPS must be used:**

| **1..1** | **DATA GROUP: WITHHELD IDENTITY STRUCTURE**<br>**Must be used where the Commissioning Data Set record has been anonymised** | | | |
|---|---|---|---|---|
| **M** | **1..1** | **Data Element Components** | | **Rules** |
| | | **M** | **1..1** | NHS NUMBER STATUS INDICATOR CODE | V |
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | WITHHELD IDENTITY REASON | V |

**OR**

| **1..1** | **DATA GROUP: VERIFIED IDENTITY STRUCTURE**<br>**Must be used where the NHS NUMBER STATUS INDICATOR CODE National Code = 01 (Number present and verified)** | | | | |
|---|---|---|---|---|---|
| R | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | **Rules** |
| | | **M** | **1..1** | LOCAL PATIENT IDENTIFIER (EXTENDED) | F<br>S3 |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) | F |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | **M** | **1..1** | NHS NUMBER | F<br>S3 |
| | | **M** | **1..1** | NHS NUMBER STATUS INDICATOR CODE | V |
| | | **M** | **1..1** | POSTCODE OF USUAL ADDRESS | F<br>S3 |
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | PERSON BIRTH DATE | F<br>S3<br>S12 |

**OR**

| | | | | | |
|---|---|---|---|---|---|
| **1..1** | **DATA GROUP: UNVERIFIED IDENTITY STRUCTURE**<br>**Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE NOT included in the above** | | | | |
| R | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | **Rules** |
| | | **M** | **1..1** | LOCAL PATIENT IDENTIFIER (EXTENDED) | F<br>S3 |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) | F |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | NHS NUMBER | F<br>S3 |
| | | **M** | **1..1** | NHS NUMBER STATUS INDICATOR CODE | V |
| R | 0..1 | Data Element Components | | | **Rules** |
| | | **M**<br>**OR**<br>O<br>and<br>**M**<br>**and**<br>**M**<br>and<br>O<br>and<br>O | **1..1**<br>**OR**<br>0..1<br>and<br>**1..1**<br>**and**<br>**1..1**<br>and<br>0..1<br>and<br>0..1 | PATIENT FULL NAME<br>**OR**<br>PATIENT TITLE<br>and<br>PATIENT GIVEN NAME<br>**and**<br>PATIENT FAMILY NAME<br>and<br>PATIENT NAME SUFFIX<br>and<br>PATIENT INITIALS | F<br>S3<br>I4 |
| R | 0..1 | Data Element Components | | | **Rules** |
| | | **M**<br>**OR**<br>**M** | **1..1**<br>**OR**<br>**2..5** | PATIENT USUAL ADDRESS (UNSTRUCTURED)<br>**OR**<br>PATIENT USUAL ADDRESS (STRUCTURED) | F<br>S3<br>I5 |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | POSTCODE OF USUAL ADDRESS | F<br>S3 |
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | PERSON BIRTH DATE | F<br>S3<br>S12 |

| **Notation** | | **DATA GROUP: PATIENT CHARACTERISTICS** | | | |
|---|---|---|---|---|---|
| **Group Status** | **Group Repeats** | **FUNCTION:**<br>**To carry the characteristics of the Patient.** | | | |
| **R** | **0..1** | | | | |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | PERSON STATED GENDER CODE | V |
| | | O | 0..1 | CARER SUPPORT INDICATOR | V |
| | | R | 0..1 | ETHNIC CATEGORY | V |
| | | X | 0..1 | ETHNIC CATEGORY 2021 | N2 |

| | | R | 0..1 | PERSON MARITAL STATUS | V |
|---|---|---|---|---|---|
| | | R | 0..1 | MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION) | F |

| Notation | DATA GROUP: PATIENT CHARACTERISTICS - SOCIAL AND PERSONAL CIRCUMSTANCES (SNOMED CT) |
|---|---|
| Group Status R / Group Repeats 0..* | FUNCTION: To carry the details of the SNOMED CT coded Social and Personal Circumstances for the Patient. |

One of the following DATA GROUPS may be used:

| M | 1..1 | DATA GROUP: SNOMED CT SOCIAL AND PERSONAL CIRCUMSTANCES | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP | F |

OR

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: HOSPITAL PROVIDER SPELL - ADMISSION CHARACTERISTICS |
|---|---|
| Group Status M / Group Repeats 1..1 | FUNCTION: To carry the admission details of the Hospital Provider Spell containing the Unfinished General Care Professional Admitted Care Episode. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | HOSPITAL PROVIDER SPELL IDENTIFIER | F |
| | | R | 0..1 | ADMINISTRATIVE CATEGORY CODE (ON ADMISSION) | V |
| | | R | 0..1 | PATIENT CLASSIFICATION CODE | V |
| | | R | 0..1 | METHOD OF ADMISSION (HOSPITAL PROVIDER SPELL) | V |
| | | R | 0..1 | ADMISSION SOURCE (HOSPITAL PROVIDER SPELL) | V |
| | | M | 1..1 | START DATE (HOSPITAL PROVIDER SPELL) | F S13 |
| | | O | 0..1 | START TIME (HOSPITAL PROVIDER SPELL) | F S14 |
| | | M | 1..1 | AGE ON ADMISSION | F |
| | | R | 0..1 | AMBULANCE CALL IDENTIFIER | F |
| | | R | 0..1 | ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST) | F |
| | | R | 0..1 | CARE CONTACT IDENTIFIER (AMBULANCE SERVICE) | F |

| Notation | DATA GROUP: HOSPITAL PROVIDER SPELL - DISCHARGE CHARACTERISTICS |
|---|---|
| Group Status R / Group Repeats 0..1 | FUNCTION: To carry the discharge details of the Hospital Provider Spell containing the Unfinished General Care Professional Admitted Care Episode. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | DESTINATION OF DISCHARGE (HOSPITAL PROVIDER SPELL) | V |
| | | R | 0..1 | METHOD OF DISCHARGE (HOSPITAL PROVIDER SPELL) | V |
| | | R | 0..1 | DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL) | F S13 |
| | | R | 0..1 | DISCHARGE DATE (HOSPITAL PROVIDER SPELL) | F S13 |
| | | O | 0..1 | DISCHARGE TIME (HOSPITAL PROVIDER SPELL) | F S14 |
| | | R | 0..1 | DISCHARGED TO NHS AT HOME SERVICE INDICATOR | V |

| Notation | DATA GROUP: CARE EPISODE - ACTIVITY CHARACTERISTICS |
|---|---|

| Group Status | Group Repeats | FUNCTION: |
| --- | --- | --- |
| M | 1..1 | To carry the details of the Patient's Unfinished General Care Professional Admitted Care Episode. |

| M | 1..1 | Data Element Components | | | Rules |
| --- | --- | --- | --- | --- | --- |
| | | R | 0..1 | EPISODE NUMBER | F |
| | | R | 0..1 | LAST EPISODE IN SPELL INDICATOR CODE | V |
| | | R | 0..1 | NEONATAL LEVEL OF CARE CODE | V |
| | | O | 0..1 | FIRST REGULAR DAY OR NIGHT ADMISSION CODE | V |
| | | R | 0..1 | PSYCHIATRIC PATIENT STATUS CODE | V |
| | | **M** | **1..1** | START DATE (EPISODE) | F S1 S13 |
| | | O | 0..1 | START TIME (EPISODE) | F S14 |
| | | R | 0..1 | END DATE (EPISODE) | F S13 |
| | | O | 0..1 | END TIME (EPISODE) | F S14 |
| | | **M** | **1..1** | AGE AT CDS ACTIVITY DATE | F S8 |
| | | O | 0..1 | REHABILITATION ASSESSMENT TEAM TYPE | V N3 |

| Notation | | DATA GROUP: CARE EPISODE - LENGTH OF STAY ADJUSTMENT |
| --- | --- | --- |
| Group Status | Group Repeats | FUNCTION: |
| R | 0..1 | To carry details of length of stay adjustments to the Unfinished General Care Professional Admitted Care Episode . |

| M | 1..1 | Data Element Components | | | Rules |
| --- | --- | --- | --- | --- | --- |
| | | R | 0..1 | LENGTH OF STAY ADJUSTMENT (REHABILITATION) | F |
| | | R | 0..1 | LENGTH OF STAY ADJUSTMENT (SPECIALIST PALLIATIVE CARE) | F |

| Notation | | DATA GROUP: CARE EPISODE- OVERSEAS VISITOR CHARGING CATEGORY |
| --- | --- | --- |
| Group Status | Group Repeats | FUNCTION: |
| R | 0..5 | To carry the details of the Overseas Visitor Charging Categories of the Patient during the Unfinished General Care Professional Admitted Care Episode. |

| M | 1..1 | Data Element Components | | | Rules |
| --- | --- | --- | --- | --- | --- |
| | | **M** | **1..1** | OVERSEAS VISITOR CHARGING CATEGORY | V |
| | | **M** | **1..1** | OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE FROM DATE | F S13 |
| | | R | 0..1 | OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE END DATE | F S13 |

| Notation | | DATA GROUP: CARE EPISODE - SERVICE AGREEMENT DETAILS |
| --- | --- | --- |
| Group Status | Group Repeats | FUNCTION: |
| M | 1..1 | To carry the details of the Provider, Commissioners and Service Agreements. |

| M | 1..1 | Data Element Components | | | Rules |
| --- | --- | --- | --- | --- | --- |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (CODE OF PROVIDER) | F |
| **M** | **1..*** | **DATA GROUP: COMMISSIONERS** | | | **Rules** |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) | F |
| | | R | 0..1 | START DATE (COMMISSIONER ASSIGNMENT PERIOD) | F S13 |
| | | R | 0..1 | END DATE (COMMISSIONER ASSIGNMENT PERIOD) | |

| | | | | | Rules |
|---|---|---|---|---|---|
| | | | | | F<br>S13 |
| | | R | 0..1 | NHS SERVICE AGREEMENT IDENTIFIER | F |
| | | O | 0..1 | NHS SERVICE AGREEMENT LINE IDENTIFIER | F |
| | | O | 0..1 | PROVIDER REFERENCE IDENTIFIER | F |
| | | R | 0..1 | COMMISSIONER REFERENCE IDENTIFIER | F |
| | | R | 0..1 | SPECIALISED SERVICE CODE | F |

| Notation | | DATA GROUP: CARE EPISODE - PERSON GROUP (CARE PROFESSIONAL) |
|---|---|---|
| Group Status<br>R | Group Repeats<br>0..* | FUNCTION:<br>To carry the details of the Care Professionals active during the Unfinished General Care Professional Admitted Care Episode. |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER | F |
| | | **M** | **1..1** | CARE PROFESSIONAL MAIN SPECIALTY CODE | F<br>H4 |
| | | **M** | **1..1** | ACTIVITY TREATMENT FUNCTION CODE | F<br>H4 |
| | | O | 0..1 | LOCAL SUB-SPECIALTY CODE | F |
| | | **M** | **1..1** | RESPONSIBLE CARE PROFESSIONAL INDICATOR | V |

| Notation | | DATA GROUP: CARE EPISODE - CLINICAL DIAGNOSIS GROUP (ICD) |
|---|---|---|
| Group Status<br>R | Group Repeats<br>0..1 | FUNCTION:<br>To carry the details of the ICD coded Clinical Diagnoses for the Patient. |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | **M** | **1..1** | DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET) | V |
| **M** | **1..1** | **DATA GROUP: PRIMARY DIAGNOSIS** | | | **Rules** |
| | | **M** | **1..1** | PRIMARY DIAGNOSIS (ICD) | F<br>H4 |
| | | O | 0..1 | PRESENT ON ADMISSION INDICATOR | V |
| R | 0..* | DATA GROUP: SECONDARY DIAGNOSES | | | **Rules** |
| | | **M** | **1..1** | SECONDARY DIAGNOSIS (ICD) | F<br>H4 |
| | | O | 0..1 | PRESENT ON ADMISSION INDICATOR | V |

| Notation | | DATA GROUP: CARE EPISODE - CLINICAL DIAGNOSIS GROUP (SNOMED CT) |
|---|---|---|
| Group Status<br>R | Group Repeats<br>0..* | FUNCTION:<br>To carry the details of the SNOMED CT coded Clinical Diagnoses for the Patient. |

**One of the following DATA GROUPS may be used:**

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **DATA GROUP: SNOMED CT DIAGNOSIS** | | | **Rules** |
| | | **M** | **1..1** | DIAGNOSIS (SNOMED CT EXPRESSION) | F |
| | | **M** | **1..1** | CODED CLINICAL ENTRY SEQUENCE NUMBER | F |
| | | **M** | **1..1** | CODED DIAGNOSIS TIMESTAMP | F |

**OR**

| | | | | | |
|---|---|---|---|---|---|
| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | **Rules** |
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: CARE EPISODE - COMORBIDITY (SNOMED CT) |
|---|---|---|
| | | |

| Group Status | Group Repeats | FUNCTION: |
|---|---|---|
| R | 0..* | To carry the details of the SNOMED CT coded Comorbidities for the Patient. |

**One of the following DATA GROUPS may be used:**

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **DATA GROUP: SNOMED CT COMORBIDITY** | | | **Rules** |
| | | **M** | **1..1** | COMORBIDITY (SNOMED CT EXPRESSION) | F |

**OR**

| | | | | | |
|---|---|---|---|---|---|
| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | **Rules** |
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: CARE EPISODE - EMED3 FIT NOTE |
|---|---|

| Group Status | Group Repeats | FUNCTION: |
|---|---|---|
| R | 0..1 | To carry the details of the EMED3 Fit Note issued. |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | EMED3 FIT NOTE ASSESSMENT DATE | F<br>S13 |
| | | R | 0..1 | EMED3 FIT NOTE CONDITION (SNOMED CT EXPRESSION) | F |
| | | R | 0..1 | EMED3 FIT NOTE DIAGNOSIS (ICD) | F |
| | | R | 0..1 | EMED3 FIT NOTE START DATE | F<br>S13 |
| | | R | 0..1 | EMED3 FIT NOTE END DATE | F<br>S13 |
| | | R | 0..1 | EMED3 FIT NOTE DURATION | F |
| | | R | 0..1 | EMED3 FIT NOTE RECORDED DATE | F<br>S13 |
| | | R | 0..1 | EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR | V |

| Notation | DATA GROUP: CARE EPISODE - PROCEDURE GROUP (OPCS) |
|---|---|

| Group Status | Group Repeats | FUNCTION: |
|---|---|---|
| R | 0..1 | To carry the details of the OPCS coded Procedures for the Patient. |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | **M** | **1..1** | PROCEDURE SCHEME IN USE (COMMISSIONING DATA SET) | V |
| **M** | **1..1** | **DATA GROUP: PRIMARY PROCEDURE** | | | **Rules** |
| | | **M** | **1..1** | PRIMARY PROCEDURE (OPCS) | F |
| | | R | 0..1 | PROCEDURE DATE | F<br>S13 |
| O | 0..1 | DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL | | | **Rules** |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | F |
| O | 0..1 | DATA GROUP: RESPONSIBLE ANAESTHETIST | | | **Rules** |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | F |
| R | 0..* | DATA GROUP: SECONDARY PROCEDURES | | | **Rules** |
| | | **M** | **1..1** | PROCEDURE (OPCS) | F |
| | | R | 0..1 | PROCEDURE DATE | F<br>S13 |
| O | 0..1 | DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL | | | **Rules** |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ISSUER CODE | V |

| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | F |
|---|---|---|---|---|---|
| O | 0..1 | DATA GROUP: RESPONSIBLE ANAESTHETIST | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | F |

| Notation | DATA GROUP: CARE EPISODE - PROCEDURE GROUP (SNOMED CT) |
|---|---|
| Group Status R / Group Repeats 0..* | FUNCTION: To carry the details of the SNOMED CT coded Procedures for the Patient. |

**One of the following DATA GROUPS may be used:**

| M | 1..1 | **DATA GROUP: SNOMED CT PROCEDURE** | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | PROCEDURE (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | CODED CLINICAL ENTRY SEQUENCE NUMBER | F |
| | | M | 1..1 | CODED PROCEDURE TIMESTAMP | F |
| O | 0..1 | DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | F |
| O | 0..1 | DATA GROUP: RESPONSIBLE ANAESTHETIST | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: CARE EPISODE - OBSERVATION GROUP (SNOMED CT) |
|---|---|
| Group Status R / Group Repeats 0..* | FUNCTION: To carry the details of the SNOMED CT coded Clinical Observations for the Patient. |

**One of the following DATA GROUPS may be used:**

| M | 1..1 | **DATA GROUP: SNOMED CT OBSERVATION** | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | OBSERVATION (SNOMED CT EXPRESSION) | F |
| | | R | 0..1 | OBSERVATION VALUE | F |
| | | R | 0..1 | UCUM UNIT OF MEASUREMENT | F |
| | | M | 1..1 | CODED OBSERVATION TIMESTAMP | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: CARE EPISODE - FINDING GROUP (SNOMED CT) |
|---|---|
| Group Status R / Group Repeats 0..* | FUNCTION: To carry the details of the SNOMED CT coded Clinical Findings for the Patient. |

**One of the following DATA GROUPS may be used:**

| M | 1..1 | **DATA GROUP: SNOMED CT FINDING** | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | FINDING (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | CODED FINDING TIMESTAMP | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|

| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |
|---|---|---|---|---|---|

| Notation | DATA GROUP: CARE EPISODE - ASSESSMENT TOOL GROUP (SNOMED CT) |
|---|---|
| Group Status R | Group Repeats 0..* | FUNCTION: To carry the details of the SNOMED CT coded Assessment Tools for the Patient. |

**One of the following DATA GROUPS may be used:**

| M | 1..1 | DATA GROUP: SNOMED CT ASSESSMENT TOOL | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | ASSESSMENT TOOL (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | PERSON SCORE | F |
| | | M | 1..1 | ASSESSMENT TOOL COMPLETION TIMESTAMP | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: LOCATION GROUP (AT START OF CARE EPISODE) |
|---|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the Location at the Start of the Unfinished General Care Professional Admitted Care Episode. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | ORGANISATION SITE IDENTIFIER (OF TREATMENT) | F |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | O | 0..1 | WARD INTENDED CLINICAL CARE INTENSITY | V |
| | | O | 0..1 | WARD INTENDED AGE GROUP | V |
| | | O | 0..1 | WARD INTENDED SEX OF PATIENTS | V |
| | | O | 0..1 | WARD INTENDED DAY PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD INTENDED NIGHT PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD SECURITY LEVEL | V |
| | | O | 0..1 | WARD CODE | F |

| Notation | | DATA GROUP: LOCATION GROUP (AT WARD STAY) |
|---|---|---|
| Group Status R | Group Repeats 0..97 | FUNCTION: To carry the details of one or more Ward Stays during the Unfinished General Care Professional Admitted Care Episode. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | ORGANISATION SITE IDENTIFIER (OF TREATMENT) | F |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | O | 0..1 | WARD INTENDED CLINICAL CARE INTENSITY | V |
| | | O | 0..1 | WARD INTENDED AGE GROUP | V |
| | | O | 0..1 | WARD INTENDED SEX OF PATIENTS | V |
| | | O | 0..1 | WARD INTENDED DAY PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD INTENDED NIGHT PERIOD AVAILABILITY | V |
| | | O | 0..1 | START DATE (WARD STAY) | F S13 |
| | | O | 0..1 | START TIME (WARD STAY) | F S14 |
| | | O | 0..1 | END DATE (WARD STAY) | F S13 |
| | | O | 0..1 | END TIME (WARD STAY) | F S14 |
| | | O | 0..1 | WARD SECURITY LEVEL | V |
| | | O | 0..1 | WARD CODE | F |

| Notation | | DATA GROUP: LOCATION GROUP (AT END OF CARE EPISODE) | |
|---|---|---|---|
| Group Status | Group Repeats | FUNCTION: To carry the details of the Location at the End of the Unfinished General Care Professional Admitted Care Episode. | |
| R | 0..1 | | |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | ORGANISATION SITE IDENTIFIER (OF TREATMENT) | F |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | O | 0..1 | WARD INTENDED CLINICAL CARE INTENSITY | V |
| | | O | 0..1 | WARD INTENDED AGE GROUP | V |
| | | O | 0..1 | WARD INTENDED SEX OF PATIENTS | V |
| | | O | 0..1 | WARD INTENDED DAY PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD INTENDED NIGHT PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD SECURITY LEVEL | V |
| | | O | 0..1 | WARD CODE | F |

| Notation | | DATA GROUP: LOCATION GROUP - HOME LEAVE | |
|---|---|---|---|
| Group Status | Group Repeats | FUNCTION: To carry the details of each separate period of Home Leave within the Unfinished General Care Professional Admitted Care Episode. | |
| R | 0..* | | |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | START DATE (HOME LEAVE) | F S13 |
| | | R | 0..1 | START TIME (HOME LEAVE) | F S14 |
| | | R | 0..1 | END DATE (HOME LEAVE) | F S13 |
| | | R | 0..1 | END TIME (HOME LEAVE) | F S14 |

| Notation | | DATA GROUP: CARE EPISODE - NEONATAL CRITICAL CARE PERIOD | |
|---|---|---|---|
| Group Status | Group Repeats | FUNCTION: See CRITICAL CARE PERIOD To carry the details of the first 9 Critical Care Periods for care provided using Neonatal Care facilities. | |
| R | 0..9 | | |

| M | 1..1 | DATA GROUP: NEONATAL CARE - ADMISSION CHARACTERISTICS | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | CRITICAL CARE LOCAL IDENTIFIER | F |
| | | M | 1..1 | CRITICAL CARE START DATE | F S13 |
| | | M | 1..1 | CRITICAL CARE START TIME | F S14 |
| | | M | 1..1 | CRITICAL CARE UNIT FUNCTION | V |
| | | M | 1..1 | GESTATION LENGTH (AT DELIVERY) | V |
| **M** | **1..999** | **DATA GROUP: NEONATAL DAILY CARE - ACTIVITY CHARACTERISTICS** | | | **Rules** |
| | | M | 1..1 | ACTIVITY DATE (CRITICAL CARE) | F S13 |
| | | R | 0..1 | PERSON WEIGHT | F |
| | | M | 1..20 | CRITICAL CARE ACTIVITY CODE | F N4 |
| | | R | 0..20 | HIGH COST DRUGS (OPCS) | F N4 |
| R | 0..1 | DATA GROUP: NEONATAL CARE - DISCHARGE CHARACTERISTICS | | | Rules |
| | | M | 1..1 | CRITICAL CARE DISCHARGE DATE | |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | F S13 |
| | | M | 1..1 | CRITICAL CARE DISCHARGE TIME | F S14 |

| Notation | DATA GROUP: CARE EPISODE - PAEDIATRIC CRITICAL CARE PERIOD |
|---|---|
| Group Status R / Group Repeats 0..9 | FUNCTION: See CRITICAL CARE PERIOD<br>To carry the details of the first 9 Critical Care Periods for care provided using Paediatric Care facilities. |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **DATA GROUP: PAEDIATRIC CRITICAL CARE - ADMISSION CHARACTERISTICS** | | | **Rules** |
| | | **M** | **1..1** | CRITICAL CARE LOCAL IDENTIFIER | F |
| | | **M** | **1..1** | CRITICAL CARE START DATE | F S13 |
| | | **M** | **1..1** | CRITICAL CARE START TIME | F S14 |
| | | **M** | **1..1** | CRITICAL CARE UNIT FUNCTION | V |
| **M** | **1..999** | **DATA GROUP: PAEDIATRIC DAILY CARE - ACTIVITY CHARACTERISTICS** | | | **Rules** |
| | | **M** | **1..1** | ACTIVITY DATE (CRITICAL CARE) | F S13 |
| | | **M** | **1..20** | CRITICAL CARE ACTIVITY CODE | F N4 |
| | | R | 0..20 | HIGH COST DRUGS (OPCS) | F N4 |
| R | 0..1 | DATA GROUP: PAEDIATRIC CRITICAL CARE - DISCHARGE CHARACTERISTICS | | | **Rules** |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE DATE | F S13 |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE TIME | F S14 |

| Notation | DATA GROUP: CARE EPISODE - ADULT CRITICAL CARE PERIOD |
|---|---|
| Group Status R / Group Repeats 0..9 | FUNCTION: See CRITICAL CARE PERIOD<br>To carry the details of the first 9 Critical Care Periods for care provided using Adult Care facilities. |

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **DATA GROUP: ADULT CRITICAL CARE - ADMISSION CHARACTERISTICS** | | | **Rules** |
| | | **M** | **1..1** | CRITICAL CARE LOCAL IDENTIFIER | F |
| | | **M** | **1..1** | CRITICAL CARE START DATE | F S13 |
| | | O | 0..1 | CRITICAL CARE START TIME | F S14 |
| | | **M** | **1..1** | CRITICAL CARE UNIT FUNCTION | V |
| | | O | 0..1 | CRITICAL CARE UNIT BED CONFIGURATION | V |
| | | O | 0..1 | CRITICAL CARE ADMISSION SOURCE | V |
| | | O | 0..1 | CRITICAL CARE SOURCE LOCATION | V |
| | | O | 0..1 | CRITICAL CARE ADMISSION TYPE | V |
| **M** | **1..1** | **DATA GROUP: ADULT CRITICAL CARE - ACTIVITY CHARACTERISTICS** | | | **Rules** |
| | | R | 0..1 | ADVANCED RESPIRATORY SUPPORT DAYS | F |
| | | R | 0..1 | BASIC RESPIRATORY SUPPORT DAYS | F |
| | | R | 0..1 | ADVANCED CARDIOVASCULAR SUPPORT DAYS | F |
| | | R | 0..1 | BASIC CARDIOVASCULAR SUPPORT DAYS | F |
| | | R | 0..1 | RENAL SUPPORT DAYS | F |
| | | R | 0..1 | NEUROLOGICAL SUPPORT DAYS | F |
| | | O | 0..1 | GASTRO-INTESTINAL SUPPORT DAYS | F |

| | | | | | |
|---|---|---|---|---|---|
| | | R | 0..1 | DERMATOLOGICAL SUPPORT DAYS | F |
| | | R | 0..1 | LIVER SUPPORT DAYS | F |
| | | O | 0..1 | ORGAN SUPPORT MAXIMUM | V |
| | | R | 0..1 | CRITICAL CARE LEVEL 2 DAYS | F |
| | | R | 0..1 | CRITICAL CARE LEVEL 3 DAYS | F |
| R | 0..* | DATA GROUP: ADULT CRITICAL CARE - DAILY CARE ACTIVITY CHARACTERISTICS | | | Rules |
| | | **M** | **1..1** | ACTIVITY DATE (CRITICAL CARE) | F<br>S13 |
| | | **M** | **1..9** | ORGAN SYSTEM SUPPORTED | V |
| | | **M** | **1..1** | CRITICAL CARE LEVEL | V |
| R | 0..1 | DATA GROUP: ADULT CRITICAL CARE - DISCHARGE CHARACTERISTICS | | | Rules |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE DATE | F<br>S13 |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE TIME | F<br>S14 |
| | | O | 0..1 | CRITICAL CARE DISCHARGE READY DATE | F<br>S13 |
| | | O | 0..1 | CRITICAL CARE DISCHARGE READY TIME | F<br>S14 |
| | | O | 0..1 | CRITICAL CARE DISCHARGE STATUS | V |
| | | O | 0..1 | CRITICAL CARE DISCHARGE DESTINATION | V |
| | | O | 0..1 | CRITICAL CARE DISCHARGE LOCATION | V |

| **Notation** | | **DATA GROUP: GP REGISTRATION** | | | |
|---|---|---|---|---|---|
| **Group Status** | **Group Repeats** | **FUNCTION:**<br>**To carry the Patient's General Medical Practitioner and the General Practice details.** | | | |
| **R** | **0..1** | | | | |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | O | 0..1 | GENERAL MEDICAL PRACTITIONER (SPECIFIED) | F |
| | | R | 0..1 | GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION) | F |

| **Notation** | | **DATA GROUP: REFERRER** | | | |
|---|---|---|---|---|---|
| **Group Status** | **Group Repeats** | **FUNCTION:**<br>**To carry the details of the Referrer.** | | | |
| **R** | **0..1** | | | | |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | R | 0..1 | REFERRER CODE | F |
| | | R | 0..1 | ORGANISATION IDENTIFIER (REFERRING ORGANISATION) | F |

| **Notation** | | **DATA GROUP: REFERRAL** | | | |
|---|---|---|---|---|---|
| **Group Status** | **Group Repeats** | **FUNCTION:**<br>**To carry the details of the Referral.** | | | |
| **O** | **0..1** | | | | |
| **M** | **1..1** | Data Element Components | | | **Rules** |
| | | O | 0..1 | DIRECT ACCESS REFERRAL INDICATOR | V |

| **Notation** | | **DATA GROUP: ELECTIVE ADMISSION LIST ENTRY** | | | |
|---|---|---|---|---|---|
| **Group Status** | **Group Repeats** | **FUNCTION:**<br>**To carry the details of the Elective Admission List Entry.** | | | |
| **R** | **0..1** | | | | |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |

| | | R | 0..1 | DURATION OF ELECTIVE WAIT | F |
|---|---|---|---|---|---|
| | | R | 0..1 | INTENDED MANAGEMENT CODE | V |
| | | R | 0..1 | DECIDED TO ADMIT DATE | F S13 |
| | | R | 0..1 | EARLIEST REASONABLE OFFER DATE | F S13 |
| | | R | 0..1 | EARLIEST CLINICALLY APPROPRIATE DATE | F S13 |
| | | R | 0..1 | LATEST CLINICALLY APPROPRIATE DATE | F S13 |

| Notation | | DATA GROUP: CDS V6-3 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..* | DATA GROUP: CDS V6-3 Type 004 - Commissioning Data Set Message Trailer<br>One per Commissioning Data Set Message submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| Notation | | DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer<br>One per Interchange submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

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**CDS V6-3 TYPE 200 - ADMITTED PATIENT CARE - UNFINISHED DELIVERY EPISODE CDS**

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Change to Data Set: New Data Set

| CDS V6-3 TYPE 200 - UNFINISHED DELIVERY EPISODE COMMISSIONING DATA SET |
|---|
| FUNCTION: To support the details of an Unfinished Care Professional Admitted Care Delivery Episode. |

| Notation | | DATA GROUP: CDS V6-3 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 001 - Commissioning Data Set Interchange Header<br>One per Interchange submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| Notation | | DATA GROUP: CDS V6-3 TYPE 003 - COMMISSIONING DATA SET MESSAGE HEADER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..* | DATA GROUP: CDS V6-3 Type 003 - Commissioning Data Set Message Header<br>One per Commissioning Data Set Message submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

ONE OF THE FOLLOWING TWO OPTIONS MUST BE USED:

| Notation | | DATA GROUP: CDS V6-3 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of the Bulk Replacement Update Mechanism of the Commissioning Data Set Submission Protocol. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol<br>One per Commissioning Data Set record submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

OR

| Notation | | DATA GROUP: CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of one of the Net Change Update Mechanism of the Commissioning Data Set Submission Protocol. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol<br>One per Commissioning Data Set record submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| Notation | | DATA GROUP: PATIENT PATHWAY | | | |
|---|---|---|---|---|---|
| Group Status<br>O | Group Repeats<br>0..1 | FUNCTION:<br>To carry the details of the Patient Pathway. | | | |
| M | 1..1 | DATA GROUP: PATIENT PATHWAY IDENTITY | | | Rules |
| | | M<br>*Or*<br>M | 1..1<br><br>1..1 | UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)<br>*Or*<br>PATIENT PATHWAY IDENTIFIER | F<br><br>F |
| | | M | 1..1 | ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER) | F<br>I2 |
| M | 1..1 | DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS | | | Rules |
| | | M | 1..1 | REFERRAL TO TREATMENT PERIOD STATUS | V |
| | | M | 1..1 | WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET) | V |
| | | O | 0..1 | REFERRAL TO TREATMENT PERIOD START DATE | F<br>S13 |
| | | O | 0..1 | REFERRAL TO TREATMENT PERIOD END DATE | F<br>S13 |

| Notation | | DATA GROUP: PATIENT IDENTITY (MOTHER) |
|---|---|---|
| Group Status<br>M | Group Repeats<br>1..1 | FUNCTION:<br>To carry the Identity of the Patient (the Mother).<br>See Note: S3 in Commissioning Data Set Business Rules. |

One of the following DATA GROUPS must be used:

| 1..1 | DATA GROUP: WITHHELD IDENTITY STRUCTURE<br>Must be used where the Commissioning Data Set record has been anonymised | | | | |
|---|---|---|---|---|---|
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | NHS NUMBER STATUS INDICATOR CODE | V |
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | WITHHELD IDENTITY REASON | V |

OR

| | | | | |
|---|---|---|---|---|
| **1..1** | **DATA GROUP: VERIFIED IDENTITY STRUCTURE**<br>**Must be used where the NHS NUMBER STATUS INDICATOR CODE National Code = 01 (Number present and verified)** | | | |
| R | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | **Rules** |
| | | **M** | **1..1** LOCAL PATIENT IDENTIFIER (EXTENDED) | F<br>S3 |
| | | **M** | **1..1** ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) | F |
| **M** | **1..1** | **Data Element Components** | | **Rules** |
| | | **M** | **1..1** NHS NUMBER | F<br>S3 |
| | | **M** | **1..1** NHS NUMBER STATUS INDICATOR CODE | V |
| | | **M** | **1..1** POSTCODE OF USUAL ADDRESS | F<br>S3 |
| | | R | 0..1 ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 PERSON BIRTH DATE | F<br>S3<br>S12 |

**OR**

| | | | | |
|---|---|---|---|---|
| **1..1** | **DATA GROUP: UNVERIFIED IDENTITY STRUCTURE**<br>**Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE NOT included in the above** | | | |
| R | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | **Rules** |
| | | **M** | **1..1** LOCAL PATIENT IDENTIFIER (EXTENDED) | F<br>S3 |
| | | **M** | **1..1** ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) | F |
| **M** | **1..1** | **Data Element Components** | | **Rules** |
| | | R | 0..1 NHS NUMBER | F<br>S3 |
| | | **M** | **1..1** NHS NUMBER STATUS INDICATOR CODE | V |
| R | 0..1 | Data Element Components | | **Rules** |
| | | **M**<br>**OR**<br>O<br>and<br>**M**<br>**and**<br>**M**<br>and<br>O<br>and<br>O | **1..1** PATIENT FULL NAME<br>**OR OR**<br>0..1 PATIENT TITLE<br>and and<br>**1..1** PATIENT GIVEN NAME<br>**and and**<br>**1..1** PATIENT FAMILY NAME<br>and and<br>0..1 PATIENT NAME SUFFIX<br>and and<br>0..1 PATIENT INITIALS | F<br>S3<br>I4 |
| R | 0..1 | Data Element Components | | **Rules** |
| | | **M**<br>**OR**<br>**M** | **1..1** PATIENT USUAL ADDRESS (UNSTRUCTURED)<br>**OR OR**<br>**2..5** PATIENT USUAL ADDRESS (STRUCTURED) | F<br>S3<br>I5 |
| **M** | **1..1** | **Data Element Components** | | **Rules** |
| | | R | 0..1 POSTCODE OF USUAL ADDRESS | F<br>S3 |
| | | R | 0..1 ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 PERSON BIRTH DATE | F<br>S3<br>S12 |

| **Notation** | **DATA GROUP: PATIENT CHARACTERISTICS** |
|---|---|
| | |

| Group Status | Group Repeats | FUNCTION: |
| --- | --- | --- |
| R | 0..1 | To carry the characteristics of the Patient (the Mother). |

| M | 1..1 | Data Element Components | | | Rules |
| --- | --- | --- | --- | --- | --- |
| | | R | 0..1 | PERSON STATED GENDER CODE | V |
| | | O | 0..1 | CARER SUPPORT INDICATOR | V |
| | | R | 0..1 | ETHNIC CATEGORY | V |
| | | X | 0..1 | ETHNIC CATEGORY 2021 | N2 |
| | | R | 0..1 | PERSON MARITAL STATUS | V |
| | | R | 0..1 | MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION) | F |

| Notation | | DATA GROUP: DELIVERY CHARACTERISTICS |
| --- | --- | --- |
| Group Status | Group Repeats | FUNCTION: |
| R | 0..1 | To carry the delivery characteristics of the Patient (the Mother). |

| M | 1..1 | Data Element Components | | | Rules |
| --- | --- | --- | --- | --- | --- |
| | | R | 0..1 | NUMBER OF PREVIOUS PREGNANCIES RESULTING IN REGISTRABLE BIRTH | F |

| Notation | | DATA GROUP: PATIENT CHARACTERISTICS - SOCIAL AND PERSONAL CIRCUMSTANCES (SNOMED CT) |
| --- | --- | --- |
| Group Status | Group Repeats | FUNCTION: |
| R | 0..* | To carry the Social and Personal Circumstances for the Patient (the Mother). |

One of the following DATA GROUPS may be used:

| M | 1..1 | DATA GROUP: SNOMED CT SOCIAL AND PERSONAL CIRCUMSTANCES | | | Rules |
| --- | --- | --- | --- | --- | --- |
| | | M | 1..1 | SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP | F |

OR

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
| --- | --- | --- | --- | --- | --- |
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: HOSPITAL PROVIDER SPELL - ADMISSION CHARACTERISTICS |
| --- | --- | --- |
| Group Status | Group Repeats | FUNCTION: |
| M | 1..1 | To carry the admission details of the Hospital Provider Spell containing the Unfinished Delivery Care Professional Admitted Care Episode. |

| M | 1..1 | Data Element Components | | | Rules |
| --- | --- | --- | --- | --- | --- |
| | | R | 0..1 | HOSPITAL PROVIDER SPELL IDENTIFIER | F |
| | | R | 0..1 | ADMINISTRATIVE CATEGORY CODE (ON ADMISSION) | V |
| | | R | 0..1 | PATIENT CLASSIFICATION CODE | V |
| | | R | 0..1 | METHOD OF ADMISSION (HOSPITAL PROVIDER SPELL) | V |
| | | R | 0..1 | ADMISSION SOURCE (HOSPITAL PROVIDER SPELL) | V |
| | | M | 1..1 | START DATE (HOSPITAL PROVIDER SPELL) | F<br>S13 |
| | | O | 0..1 | START TIME (HOSPITAL PROVIDER SPELL) | F<br>S14 |
| | | M | 1..1 | AGE ON ADMISSION | F |
| | | R | 0..1 | AMBULANCE CALL IDENTIFIER | F |
| | | R | 0..1 | ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST) | F |
| | | R | 0..1 | CARE CONTACT IDENTIFIER (AMBULANCE SERVICE) | F |

| Notation | DATA GROUP: HOSPITAL PROVIDER SPELL - DISCHARGE CHARACTERISTICS |
| --- | --- |

| Group Status | Group Repeats | FUNCTION: | |
|---|---|---|---|
| R | 0..1 | To carry the discharge details of the Hospital Provider Spell containing the Unfinished Delivery Care Professional Admitted Care Episode. | |

| | | | | | |
|---|---|---|---|---|---|
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | DESTINATION OF DISCHARGE (HOSPITAL PROVIDER SPELL) | V |
| | | R | 0..1 | METHOD OF DISCHARGE (HOSPITAL PROVIDER SPELL) | V |
| | | R | 0..1 | DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL) | F S13 |
| | | R | 0..1 | DISCHARGE DATE (HOSPITAL PROVIDER SPELL) | F S13 |
| | | O | 0..1 | DISCHARGE TIME (HOSPITAL PROVIDER SPELL) | F S14 |
| | | R | 0..1 | DISCHARGED TO NHS AT HOME SERVICE INDICATOR | V |

| Notation | | DATA GROUP: DELIVERY EPISODE - ACTIVITY CHARACTERISTICS |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| M | 1..1 | To carry the details of the Unfinished Delivery Care Professional Admitted Care Episode. |

| | | | | | |
|---|---|---|---|---|---|
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | EPISODE NUMBER | F |
| | | R | 0..1 | LAST EPISODE IN SPELL INDICATOR CODE | V |
| | | R | 0..1 | PSYCHIATRIC PATIENT STATUS CODE | V |
| | | **M** | **1..1** | START DATE (EPISODE) | F S1 S13 |
| | | O | 0..1 | START TIME (EPISODE) | F S14 |
| | | R | 0..1 | END DATE (EPISODE) | F S13 |
| | | O | 0..1 | END TIME (EPISODE) | F S14 |
| | | **M** | **1..1** | AGE AT CDS ACTIVITY DATE | F |
| | | O | 0..1 | REHABILITATION ASSESSMENT TEAM TYPE | V N3 |

| Notation | | DATA GROUP: DELIVERY EPISODE- OVERSEAS VISITOR CHARGING CATEGORY |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| R | 0..5 | To carry the details of the Overseas Visitor Charging Categories of the Patient (the Mother) during the Unfinished Delivery Care Professional Admitted Care Episode. |

| | | | | | |
|---|---|---|---|---|---|
| M | 1..1 | Data Element Components | | | Rules |
| | | **M** | **1..1** | OVERSEAS VISITOR CHARGING CATEGORY | V |
| | | **M** | **1..1** | OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE FROM DATE | F S13 |
| | | R | 0..1 | OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE END DATE | F S13 |

| Notation | | DATA GROUP: DELIVERY EPISODE - SERVICE AGREEMENT DETAILS |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| M | 1..1 | To carry the details of the Provider, Commissioners and Service Agreements. |

| | | | | | |
|---|---|---|---|---|---|
| M | 1..1 | Data Element Components | | | Rules |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (CODE OF PROVIDER) | F |
| M | 1..* | DATA GROUP: COMMISSIONERS | | | Rules |

| | | | | | |
|---|---|---|---|---|---|
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) | F |
| | | R | 0..1 | START DATE (COMMISSIONER ASSIGNMENT PERIOD) | F S13 |
| | | R | 0..1 | END DATE (COMMISSIONER ASSIGNMENT PERIOD) | F S13 |
| | | R | 0..1 | NHS SERVICE AGREEMENT IDENTIFIER | F |
| | | O | 0..1 | NHS SERVICE AGREEMENT LINE IDENTIFIER | F |
| | | O | 0..1 | PROVIDER REFERENCE IDENTIFIER | F |
| | | R | 0..1 | COMMISSIONER REFERENCE IDENTIFIER | F |
| | | R | 0..1 | SPECIALISED SERVICE CODE | F |

| Notation | | **DATA GROUP: CARE EPISODE - PERSON GROUP (CARE PROFESSIONAL)** | | | |
|---|---|---|---|---|---|
| **Group Status R** | **Group Repeats 0..*** | **FUNCTION:** To carry the details of the Care Professionals active during the Unfinished Delivery Admitted Patient Care Episode. | | | |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | **M** | **1..1** | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER | F |
| | | **M** | **1..1** | CARE PROFESSIONAL MAIN SPECIALTY CODE | F H4 |
| | | **M** | **1..1** | ACTIVITY TREATMENT FUNCTION CODE | F H4 |
| | | O | 0..1 | LOCAL SUB-SPECIALTY CODE | F |
| | | **M** | **1..1** | RESPONSIBLE CARE PROFESSIONAL INDICATOR | V |

| Notation | | **DATA GROUP: DELIVERY EPISODE - CLINICAL DIAGNOSIS GROUP (ICD)** | | | |
|---|---|---|---|---|---|
| **Group Status R** | **Group Repeats 0..1** | **FUNCTION:** To carry the details of the ICD coded Clinical Diagnoses for the Patient (the Mother). | | | |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | **M** | **1..1** | DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET) | V |
| **M** | **1..1** | **DATA GROUP: PRIMARY DIAGNOSIS** | | | **Rules** |
| | | **M** | **1..1** | PRIMARY DIAGNOSIS (ICD) | F |
| R | 0..* | DATA GROUP: SECONDARY DIAGNOSES | | | **Rules** |
| | | **M** | **1..1** | SECONDARY DIAGNOSIS (ICD) | F |

| Notation | | **DATA GROUP: DELIVERY EPISODE - CLINICAL DIAGNOSIS GROUP (SNOMED CT)** |
|---|---|---|
| **Group Status R** | **Group Repeats 0..*** | **FUNCTION:** To carry the details of the SNOMED CT coded Clinical Diagnoses for the Patient (the Mother). |

**One of the following DATA GROUPS may be used:**

| | | | | | |
|---|---|---|---|---|---|
| **M** | **1..1** | **DATA GROUP: SNOMED CT DIAGNOSIS** | | | **Rules** |
| | | **M** | **1..1** | DIAGNOSIS (SNOMED CT EXPRESSION) | F |
| | | **M** | **1..1** | CODED CLINICAL ENTRY SEQUENCE NUMBER | F |
| | | **M** | **1..1** | CODED DIAGNOSIS TIMESTAMP | F |

**OR**

| | | | | | |
|---|---|---|---|---|---|
| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | **Rules** |
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | **DATA GROUP: DELIVERY EPISODE - COMORBIDITY (SNOMED CT)** |
|---|---|---|
| | | **FUNCTION:** To carry the details of the SNOMED CT coded Comorbidities for the Patient (the Mother). |

| Group Status | Group Repeats | |
|---|---|---|
| R | 0..* | |

One of the following DATA GROUPS may be used:

| | | | | | |
|---|---|---|---|---|---|
| M | 1..1 | **DATA GROUP: SNOMED CT COMORBIDITY** | | | Rules |
| | | M | 1..1 | COMORBIDITY (SNOMED CT EXPRESSION) | F |

OR

| | | | | | |
|---|---|---|---|---|---|
| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | DATA GROUP: DELIVERY EPISODE - PROCEDURE GROUP (OPCS) |
|---|---|
| Group Status / Group Repeats: R / 0..1 | FUNCTION: To carry the details of the OPCS coded Procedures for the Patient (the Mother). |

| | | | | | |
|---|---|---|---|---|---|
| M | 1..1 | **Data Element Components** | | | Rules |
| | | M | 1..1 | PROCEDURE SCHEME IN USE (COMMISSIONING DATA SET) | V |
| M | 1..1 | **DATA GROUP: PRIMARY PROCEDURE** | | | Rules |
| | | M | 1..1 | PRIMARY PROCEDURE (OPCS) | F |
| | | R | 0..1 | PROCEDURE DATE | F S13 |
| O | 0..1 | DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | F |
| O | 0..1 | DATA GROUP: RESPONSIBLE ANAESTHETIST | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | F |
| R | 0..* | DATA GROUP: SECONDARY PROCEDURES | | | Rules |
| | | M | 1..1 | PROCEDURE (OPCS) | F |
| | | R | 0..1 | PROCEDURE DATE | F S13 |
| O | 0..1 | DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | F |
| O | 0..1 | DATA GROUP: RESPONSIBLE ANAESTHETIST | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | F |

| Notation | DATA GROUP: DELIVERY EPISODE - PROCEDURE GROUP (SNOMED CT) |
|---|---|
| Group Status / Group Repeats: R / 0..* | FUNCTION: To carry the details of the SNOMED CT coded Procedures for the Patient (the Mother). |

One of the following DATA GROUPS may be used:

| | | | | | |
|---|---|---|---|---|---|
| M | 1..1 | **DATA GROUP: SNOMED CT PROCEDURE** | | | Rules |
| | | M | 1..1 | PROCEDURE (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | CODED CLINICAL ENTRY SEQUENCE NUMBER | F |
| | | M | 1..1 | CODED PROCEDURE TIMESTAMP | F |
| O | 0..1 | DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |

| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) | F |
|---|---|---|---|---|---|
| O | 0..1 | DATA GROUP: RESPONSIBLE ANAESTHETIST | | | Rules |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ISSUER CODE | V |
| | | M | 1..1 | PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: DELIVERY EPISODE - OBSERVATION GROUP (SNOMED CT) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| R | 0..* | To carry the details of the SNOMED CT coded Clinical Observations for the Patient (the Mother). |

**One of the following DATA GROUPS may be used:**

| M | 1..1 | DATA GROUP: SNOMED CT OBSERVATION | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | OBSERVATION (SNOMED CT EXPRESSION) | F |
| | | R | 0..1 | OBSERVATION VALUE | F |
| | | R | 0..1 | UCUM UNIT OF MEASUREMENT | F |
| | | M | 1..1 | CODED OBSERVATION TIMESTAMP | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: DELIVERY EPISODE - FINDING GROUP (SNOMED CT) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| R | 0..* | To carry the details of the SNOMED CT coded Clinical Findings for the Patient (the Mother). |

**One of the following DATA GROUPS may be used:**

| M | 1..1 | DATA GROUP: SNOMED CT FINDING | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | FINDING (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | CODED FINDING TIMESTAMP | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: DELIVERY EPISODE - ASSESSMENT TOOL GROUP (SNOMED CT) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| R | 0..* | To carry the details of the SNOMED CT coded Assessment Tools for the Patient (the Mother). |

**One of the following DATA GROUPS may be used:**

| M | 1..1 | DATA GROUP: SNOMED CT ASSESSMENT TOOL | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | ASSESSMENT TOOL (SNOMED CT EXPRESSION) | F |
| | | M | 1..1 | PERSON SCORE | F |
| | | M | 1..1 | ASSESSMENT TOOL COMPLETION TIMESTAMP | F |

**OR**

| O | 0..1 | DATA GROUP: DATA ABSENT REASON | | | Rules |
|---|---|---|---|---|---|
| | | O | 0..1 | DATA ABSENT REASON (FHIR R4) | F |

| Notation | | DATA GROUP: LOCATION GROUP (AT START OF DELIVERY EPISODE) |
|---|---|---|
| | | |

| Group Status | Group Repeats | FUNCTION: | |
|---|---|---|---|
| R | 0..1 | To carry the details of the Location at the Start of the Unfinished Delivery Care Professional Admitted Care Episode. | |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | ORGANISATION SITE IDENTIFIER (OF TREATMENT) | F |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | O | 0..1 | WARD INTENDED CLINICAL CARE INTENSITY | V |
| | | O | 0..1 | WARD INTENDED AGE GROUP | V |
| | | O | 0..1 | WARD INTENDED SEX OF PATIENTS | V |
| | | O | 0..1 | WARD INTENDED DAY PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD INTENDED NIGHT PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD SECURITY LEVEL | V |
| | | O | 0..1 | WARD CODE | F |

| Notation | | DATA GROUP: LOCATION GROUP (AT WARD STAY) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| R | 0..97 | To carry the details of one or more Ward Stays during the Unfinished Delivery Care Professional Admitted Care Episode. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | ORGANISATION SITE IDENTIFIER (OF TREATMENT) | F |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | O | 0..1 | WARD INTENDED CLINICAL CARE INTENSITY | V |
| | | O | 0..1 | WARD INTENDED AGE GROUP | V |
| | | O | 0..1 | WARD INTENDED SEX OF PATIENTS | V |
| | | O | 0..1 | WARD INTENDED DAY PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD INTENDED NIGHT PERIOD AVAILABILITY | V |
| | | O | 0..1 | START DATE (WARD STAY) | F<br>S13 |
| | | O | 0..1 | START TIME (WARD STAY) | F<br>S14 |
| | | O | 0..1 | END DATE (WARD STAY) | F<br>S13 |
| | | O | 0..1 | END TIME (WARD STAY) | F<br>S14 |
| | | O | 0..1 | WARD SECURITY LEVEL | V |
| | | O | 0..1 | WARD CODE | F |

| Notation | | DATA GROUP: LOCATION GROUP (AT END OF DELIVERY EPISODE) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: |
| R | 0..1 | To carry the details of the Location at the End of the Unfinished Delivery Care Professional Admitted Care Episode. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | ORGANISATION SITE IDENTIFIER (OF TREATMENT) | F |
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | V |
| | | O | 0..1 | WARD INTENDED CLINICAL CARE INTENSITY | V |
| | | O | 0..1 | WARD INTENDED AGE GROUP | V |
| | | O | 0..1 | WARD INTENDED SEX OF PATIENTS | V |
| | | O | 0..1 | WARD INTENDED DAY PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD INTENDED NIGHT PERIOD AVAILABILITY | V |
| | | O | 0..1 | WARD SECURITY LEVEL | V |
| | | O | 0..1 | WARD CODE | F |

| Notation | | DATA GROUP: LOCATION GROUP - HOME LEAVE | | | |
|---|---|---|---|---|---|
| Group Status R | Group Repeats 0..* | FUNCTION: To carry the details of each separate period of Home Leave within the Unfinished Delivery Care Professional Admitted Care Episode. | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | START DATE (HOME LEAVE) | F S13 |
| | | R | 0..1 | START TIME (HOME LEAVE) | F S14 |
| | | R | 0..1 | END DATE (HOME LEAVE) | F S13 |
| | | R | 0..1 | END TIME (HOME LEAVE) | F S14 |

| Notation | | DATA GROUP: DELIVERY EPISODE - PAEDIATRIC CRITICAL CARE PERIOD | | | |
|---|---|---|---|---|---|
| Group Status R | Group Repeats 0..9 | FUNCTION: See CRITICAL CARE PERIOD To carry the details of the first 9 Critical Care Periods for care provided using Paediatric Care facilities. | | | |
| M | 1..1 | DATA GROUP: PAEDIATRIC CRITICAL CARE - ADMISSION CHARACTERISTICS | | | Rules |
| | | M | 1..1 | CRITICAL CARE LOCAL IDENTIFIER | F |
| | | M | 1..1 | CRITICAL CARE START DATE | F S13 |
| | | M | 1..1 | CRITICAL CARE START TIME | F S14 |
| | | M | 1..1 | CRITICAL CARE UNIT FUNCTION | V |
| M | 1..999 | DATA GROUP: PAEDIATRIC DAILY CARE - ACTIVITY CHARACTERISTICS | | | Rules |
| | | M | 1..1 | ACTIVITY DATE (CRITICAL CARE) | F S13 |
| | | M | 1..20 | CRITICAL CARE ACTIVITY CODE | F N4 |
| | | R | 0..20 | HIGH COST DRUGS (OPCS) | F N4 |
| R | 0..1 | DATA GROUP: PAEDIATRIC CRITICAL CARE - DISCHARGE CHARACTERISTICS | | | Rules |
| | | M | 1..1 | CRITICAL CARE DISCHARGE DATE | F S13 |
| | | M | 1..1 | CRITICAL CARE DISCHARGE TIME | F S14 |

| Notation | | DATA GROUP: DELIVERY EPISODE - ADULT CRITICAL CARE PERIOD | | | |
|---|---|---|---|---|---|
| Group Status R | Group Repeats 0..9 | FUNCTION: See CRITICAL CARE PERIOD To carry the details of the first 9 Critical Care Periods for care provided using Adult Care facilities. | | | |
| M | 1..1 | DATA GROUP: ADULT CRITICAL CARE - ADMISSION CHARACTERISTICS | | | Rules |
| | | M | 1..1 | CRITICAL CARE LOCAL IDENTIFIER | F |
| | | M | 1..1 | CRITICAL CARE START DATE | F S13 |
| | | O | 0..1 | CRITICAL CARE START TIME | F S14 |
| | | M | 1..1 | CRITICAL CARE UNIT FUNCTION | V |
| | | O | 0..1 | CRITICAL CARE UNIT BED CONFIGURATION | V |
| | | O | 0..1 | CRITICAL CARE ADMISSION SOURCE | V |
| | | O | 0..1 | CRITICAL CARE SOURCE LOCATION | V |

| | | O | 0..1 | CRITICAL CARE ADMISSION TYPE | V |
|---|---|---|---|---|---|
| **M** | **1..1** | **DATA GROUP: ADULT CRITICAL CARE - ACTIVITY CHARACTERISTICS** | | | **Rules** |
| | | R | 0..1 | ADVANCED RESPIRATORY SUPPORT DAYS | F |
| | | R | 0..1 | BASIC RESPIRATORY SUPPORT DAYS | F |
| | | R | 0..1 | ADVANCED CARDIOVASCULAR SUPPORT DAYS | F |
| | | R | 0..1 | BASIC CARDIOVASCULAR SUPPORT DAYS | F |
| | | R | 0..1 | RENAL SUPPORT DAYS | F |
| | | R | 0..1 | NEUROLOGICAL SUPPORT DAYS | F |
| | | O | 0..1 | GASTRO-INTESTINAL SUPPORT DAYS | F |
| | | R | 0..1 | DERMATOLOGICAL SUPPORT DAYS | F |
| | | R | 0..1 | LIVER SUPPORT DAYS | F |
| | | O | 0..1 | ORGAN SUPPORT MAXIMUM | V |
| | | R | 0..1 | CRITICAL CARE LEVEL 2 DAYS | F |
| | | R | 0..1 | CRITICAL CARE LEVEL 3 DAYS | F |
| R | 0..* | DATA GROUP: ADULT CRITICAL CARE - DAILY CARE ACTIVITY CHARACTERISTICS | | | **Rules** |
| | | **M** | **1..1** | ACTIVITY DATE (CRITICAL CARE) | F<br>S13 |
| | | **M** | **1..9** | ORGAN SYSTEM SUPPORTED | V |
| | | **M** | **1..1** | CRITICAL CARE LEVEL | V |
| R | 0..1 | DATA GROUP: ADULT CRITICAL CARE - DISCHARGE CHARACTERISTICS | | | **Rules** |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE DATE | F<br>S13 |
| | | **M** | **1..1** | CRITICAL CARE DISCHARGE TIME | F<br>S14 |
| | | O | 0..1 | CRITICAL CARE DISCHARGE READY DATE | F<br>S13 |
| | | O | 0..1 | CRITICAL CARE DISCHARGE READY TIME | F<br>S14 |
| | | O | 0..1 | CRITICAL CARE DISCHARGE STATUS | V |
| | | O | 0..1 | CRITICAL CARE DISCHARGE DESTINATION | V |
| | | O | 0..1 | CRITICAL CARE DISCHARGE LOCATION | V |

| **Notation** | | **DATA GROUP: GP REGISTRATION** |
|---|---|---|
| **Group Status** | **Group Repeats** | **FUNCTION:**<br>**To carry the Patient's General Medical Practitioner and the General Practice details.** |
| **R** | **0..1** | |

| **M** | **1..1** | **Data Element Components** | | | **Rules** |
|---|---|---|---|---|---|
| | | O | 0..1 | GENERAL MEDICAL PRACTITIONER (SPECIFIED) | F |
| | | R | 0..1 | GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION) | F |

| **Notation** | | **DATA GROUP: REFERRER** |
|---|---|---|
| **Group Status** | **Group Repeats** | **FUNCTION:**<br>**To carry the details of the Referrer.** |
| **R** | **0..1** | |

| **M** | **1..1** | **Data Element Components** | | | **Rules** |
|---|---|---|---|---|---|
| | | R | 0..1 | REFERRER CODE | F |
| | | R | 0..1 | ORGANISATION IDENTIFIER (REFERRING ORGANISATION) | F |

| **Notation** | | **DATA GROUP: PREGNANCY - ACTIVITY CHARACTERISTICS** |
|---|---|---|
| | | **FUNCTION:**<br>**To carry the details of the Pregnancy.** |

| Group Status | Group Repeats | |
|---|---|---|
| R | 0..1 | |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | NUMBER OF BABIES INDICATION CODE | V |

| Notation | DATA GROUP: ANTENATAL CARE - ACTIVITY CHARACTERISTICS |
|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the Antenatal Care. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | FIRST ANTENATAL ASSESSMENT DATE | F S13 |

| Notation | DATA GROUP: ANTENATAL CARE - PERSON GROUP (RESPONSIBLE CLINICIAN) |
|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the General Medical Practitioner responsible for the Antenatal Care. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE) | F |
| | | O | 0..1 | GENERAL MEDICAL PRACTITIONER PRACTICE (PATIENT ANTENATAL CARE) | F |

| Notation | DATA GROUP: ANTENATAL CARE - LOCATION GROUP - DELIVERY PLACE INTENDED |
|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the Intended Delivery Location. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | R | 0..1 | DELIVERY PLACE CHANGE REASON CODE | V |
| | | R | 0..1 | DELIVERY PLACE TYPE CODE (INTENDED) | V |

| Notation | DATA GROUP: LABOUR/DELIVERY - ACTIVITY CHARACTERISTICS |
|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the Labour/Delivery. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY CODE | V |
| | | R | 0..1 | ANAESTHETIC GIVEN POST LABOUR OR DELIVERY CODE | V |
| | | O | 0..1 | GESTATION LENGTH (LABOUR ONSET) | F |
| | | R | 0..1 | LABOUR OR DELIVERY ONSET METHOD CODE | V |
| | | R | 0..1 | DELIVERY TIMESTAMP | F |

| Notation | DATA GROUP: BIRTH OCCURRENCE |
|---|---|
| Group Status R | Group Repeats 0..9 | FUNCTION: To carry the details of up to 9 Birth Occurrences - one per Baby. |

| M | 1..1 | DATA GROUP: BIRTH OCCURRENCE - ACTIVITY CHARACTERISTICS | | | Rules |
|---|---|---|---|---|---|
| | | R | 0..1 | BIRTH ORDER | F |
| | | R | 0..1 | DELIVERY METHOD CODE | V |
| | | R | 0..1 | GESTATION LENGTH (ASSESSMENT) | F |
| | | R | 0..1 | RESUSCITATION METHOD CODE | V |
| | | R | 0..1 | STATUS OF PERSON CONDUCTING DELIVERY CODE | V |

| Notation | | DATA GROUP: PERSON IDENTITY (BABY) |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To carry the Identity of the Patient (the Baby). See Note: S3 in Commissioning Data Set Business Rules. |
| M | 1..1 | |

One of the following DATA GROUPS must be used:

| | | | | | Rules |
|---|---|---|---|---|---|
| 1..1 | DATA GROUP: WITHHELD IDENTITY STRUCTURE<br>Must be used where the Commissioning Data Set record has been anonymised | | | | |
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | NHS NUMBER STATUS INDICATOR CODE (BABY) | V |
| | | R | 0..1 | PERSON BIRTH DATE (BABY) | F<br>S3<br>S12 |
| | | R | 0..1 | WITHHELD IDENTITY REASON | V |

OR

| | | | | | |
|---|---|---|---|---|---|
| 1..1 | DATA GROUP: VERIFIED IDENTITY STRUCTURE<br>Must be used where the NHS NUMBER STATUS INDICATOR CODE (BABY) National Code = 01 (Number present and verified) | | | | |
| O | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | Rules |
| | | M | 1..1 | LOCAL PATIENT IDENTIFIER (EXTENDED (BABY)) | F<br>S3 |
| | | M | 1..1 | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (BABY)) | F |
| M | 1..1 | Data Element Components | | | Rules |
| | | M | 1..1 | NHS NUMBER (BABY) | F<br>S3 |
| | | M | 1..1 | NHS NUMBER STATUS INDICATOR CODE (BABY) | V |
| | | R | 0..1 | PERSON BIRTH DATE (BABY) | F<br>S3<br>S12 |

OR

| | | | | | |
|---|---|---|---|---|---|
| 1..1 | DATA GROUP: UNVERIFIED IDENTITY STRUCTURE<br>Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE (BABY) NOT included in the above | | | | |
| O | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | Rules |
| | | M | 1..1 | LOCAL PATIENT IDENTIFIER (EXTENDED (BABY)) | F<br>S3 |
| | | M | 1..1 | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (BABY)) | F |
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | NHS NUMBER (BABY) | F<br>S3 |
| | | M | 1..1 | NHS NUMBER STATUS INDICATOR CODE (BABY) | V |
| R | 0..1 | Data Element Components | | | Rules |
| | | R | 0..1 | PERSON BIRTH DATE (BABY) | F<br>S3<br>S12 |

| Notation | | DATA GROUP: BIRTH OCCURRENCE - PERSON CHARACTERISTICS - BABY |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To carry the characteristics of the Baby. |
| R | 0..1 | |

| | | | | | |
|---|---|---|---|---|---|
| M | 1..1 | Data Element Components | | | Rules |
| | | R | 0..1 | PERSON PHENOTYPIC SEX | V |
| | | R | 0..1 | LIVE OR STILL BIRTH CODE | V |

| | | R | 0..1 | BIRTH WEIGHT | F |
|---|---|---|---|---|---|
| | | R | 0..1 | OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE | V |

| Notation | DATA GROUP: BIRTH OCCURRENCE - LOCATION GROUP - DELIVERY PLACE ACTUAL | | | |
|---|---|---|---|---|
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the Actual Birth Location. | | |
| M | 1..1 | Data Element Components | | Rules |
| | | R 0..1 | ACTIVITY LOCATION TYPE CODE | F |
| | | R 0..1 | DELIVERY PLACE TYPE CODE (ACTUAL) | V |

| Notation | DATA GROUP: CDS V6-3 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER |
|---|---|
| Group Status | Group Repeats | FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..* | DATA GROUP: CDS V6-3 Type 004 - Commissioning Data Set Message Trailer<br>One per Commissioning Data Set Message submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

| Notation | | DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER |
|---|---|---|
| Group Status | Group Repeats | FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission. |
| M | 1..1 | DATA GROUP: CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer<br>One per Interchange submitted to the Secondary Uses Service.<br>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange. |

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**ALLIED HEALTH PROFESSIONAL REFERRAL TO TREATMENT MEASUREMENT**

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Change to Supporting Information: Changed Description

A Allied Health Professional Referral To Treatment Measurement is a REFERRAL TO TREATMENT PERIOD.

~~In 2008, the Department of Health and Social Care published 'Framing the Contribution of Allied Health Professionals', which sets out three key aspects for improving the SERVICES which CARE PROFESSIONALS in NHS Allied Health Professional Services (Referral To Treatment Measurement) provide:~~In 2008, the Department of Health and Social Care published 'Framing the Contribution of Allied Health Professionals', which sets out three key aspects for improving the SERVICES which ALLIED HEALTH PROFESSIONALS in NHS Allied Health Professional Services (Referral To Treatment Measurement) provide:

- ~~To mandate the collection of Referral To Treatment information for Allied Health Professionals and support SERVICE redesign to improve SERVICES for PATIENTS~~
- To mandate the collection of Referral To Treatment information for ALLIED HEALTH PROFESSIONALS and support SERVICE redesign to improve SERVICES for PATIENTS
- To promote the benefits of self-referral to Physiotherapy SERVICES
- To improve the quality of SERVICES delivered

~~The Department of Health and Social Care introduced voluntary collection of Allied Health Professional REFERRAL TO TREATMENT PERIOD waiting time information from April 2010, and mandatory collection from April 2011. The Community Services Data Set and the Commissioning Data Sets (version 6-2 onwards) include the facility to report the Allied Health Professional REFERRAL TO TREATMENT PERIOD waiting time data elements which are used for waiting time measurement.~~The Department of Health and Social Care introduced voluntary collection of ALLIED HEALTH PROFESSIONAL REFERRAL TO TREATMENT PERIOD waiting time information from April 2010, and mandatory collection from April 2011. The Community Services Data Set and the Commissioning Data Sets (version

6-2 onwards) include the facility to report the ALLIED HEALTH PROFESSIONAL REFERRAL TO TREATMENT PERIOD waiting time data elements which are used for waiting time measurement.

~~The Allied Health Professionals mandated to collect and flow Referral To Treatment data are:~~The ALLIED HEALTH PROFESSIONALS mandated to collect and flow Referral To Treatment data are:

- Art Therapists, Music Therapists and Dramatherapists (Arts Therapists)
- Chiropodists/Podiatrists
- Dietitians
- Occupational Therapists
- Orthoptists
- Physiotherapists
- Prosthetists and Orthotists
- Radiographers (Diagnostic and Therapeutic)
- Speech and Language Therapists

~~There is no maximum waiting time target attached to an Allied Health Professional REFERRAL TO TREATMENT PERIOD, so no adjustments can be applied to the calculated waiting time between the REFERRAL TO TREATMENT PERIOD START DATE and the REFERRAL TO TREATMENT PERIOD END DATE.~~There is no maximum waiting time target attached to an ALLIED HEALTH PROFESSIONAL REFERRAL TO TREATMENT PERIOD, so no adjustments can be applied to the calculated waiting time between the REFERRAL TO TREATMENT PERIOD START DATE and the REFERRAL TO TREATMENT PERIOD END DATE. However, locally the EARLIEST CLINICALLY APPROPRIATE DATE and the EARLIEST REASONABLE OFFER DATE can be used by Health Care Providers and their Commissioners to analyse unexpectedly long waits for First Definitive Treatment.

~~Allied Health Professionals working as part of a Consultant Led Service in secondary care are excluded.~~ALLIED HEALTH PROFESSIONALS working as part of a Consultant Led Service in secondary care are excluded.

Further guidance relating to the Allied Health Professional Referral To Treatment initiative can be found on the Department of Health and Social Care at: Allied Health Professional (AHP) Referral to Treatment (RTT) guide.

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**CARE PROFESSIONAL ADMITTED CARE EPISODE**

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Change to Supporting Information: Changed Description

A Care Professional Admitted Care Episode is an ACTIVITY GROUP.

A Care Professional Admitted Care Episode is the period of time within a Hospital Provider Spell during which the PATIENT is under the medical responsibility of a:

- CONSULTANT
- MIDWIFE
- NURSE
- ALLIED HEALTH PROFESSIONAL

A Care Professional Admitted Care Episode can be a:

- Consultant Episode (Hospital Provider)
- Midwife Episode
- Nursing Episode.

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**CARE PROFESSIONAL OUT-PATIENT ATTENDANCE**

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Change to Supporting Information: New Supporting Information

A Care Professional Out-Patient Attendance is a CARE CONTACT.

A Care Professional Out-Patient Attendance is an attendance at an Out-Patient Clinic at which a PATIENT is seen by or has contact with (face to face or via another Care Professional Out-Patient Episode) a CARE PROFESSIONAL as part of a Care Professional Out-Patient Episode.

A Care Professional Out-Patient Attendance may involve more than one PERSON (e.g. a family). The number of attendances to be recorded should be the number of PATIENTS for whom the particular CARE PROFESSIONAL has identifiable individual clinical records which will be maintained as a result of the attendance.

If the PATIENT is seen by a CARE PROFESSIONAL, is then sent elsewhere for a Clinical Investigation, and then returns to the Out-Patient Clinic to be seen again by a CARE PROFESSIONAL from the same clinical team, a single Care Professional Out-Patient Attendance is recorded.

A visit by a CARE PROFESSIONAL to the home of a PATIENT which is instigated by the Health Care Provider to review the urgency of a proposed admission to hospital, or to continue to supervise treatment initiated or prescribed at a hospital or clinic, may be recorded as a Care Professional Out-Patient Attendance.

A Care Professional Out-Patient Attendance may also be recorded if a PATIENT is seen by a CONSULTANT with a different MAIN SPECIALTY during a Consultant Episode (Hospital Provider), where there is no transfer of clinical responsibility for the care of the PATIENT. For example, a PATIENT who is admitted to hospital under Gastroenterology MAIN SPECIALTY following an overdose may be seen while still in hospital by a psychiatrist who has been asked to assess their mental condition. The assessment by the psychiatrist should be recorded as a Care Professional Out-Patient Attendance.

During the Care Professional Out-Patient Attendance, PATIENT DIAGNOSES made and Patient Procedures undertaken should be recorded in clinical records for the PATIENT.

A series of Care Professional Out-Patient Attendances form a Care Professional Out-Patient Episode which is generated from a single REFERRAL REQUEST. A PATIENT may have more than one Care Professional Out-Patient Episodes with the same CARE PROFESSIONAL for different clinical conditions, if separate REFERRAL REQUESTS are made.

A PATIENT attending a WARD for examination or care will be counted as an Care Professional Out-Patient Attendance if they are seen and/or treated by a CONSULTANT or other doctor. If they are seen by a NURSE, the activity is recorded as a Ward Attendance.

**This supporting information is also known by these names:**

| Context | Alias |
|---|---|
| plural | Care Professional Out-Patient Attendances |

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**CARE PROFESSIONAL OUT-PATIENT EPISODE**

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Change to Supporting Information: New Supporting Information

A Care Professional Out-Patient Episode is an ACTIVITY GROUP.

A Care Professional Out-Patient Episode is an episode of care for a PATIENT comprising a series of one or more Care Professional Out-Patient Attendances, relating to one REFERRAL REQUEST, managed by the same CARE PROFESSIONAL.

In the case of shared care by two or more CARE PROFESSIONALS equally participating in the care of the PATIENT, one CARE PROFESSIONAL will take overriding responsibility for the PATIENT and only one Care Professional Out-Patient Episode is recorded.

A Care Professional Out-Patient Episode can overlap with other Care Professional Out-Patient Episodes, or with Hospital Provider Spells for a PATIENT using a Hospital Bed. For example, a PATIENT in a long-stay WARD under the care of a CONSULTANT psychiatrist might also be seeing a CONSULTANT surgeon as an out-patient.

A Care Professional Out-Patient Episode starts on the date the PATIENT first sees or is in contact with the CARE PROFESSIONAL at a Care Professional Out-Patient Attendance.

A Care Professional Out-Patient Episode ends when the PATIENT is formally discharged from the care of the CARE PROFESSIONAL. Where the PATIENT is not subject to a Personalised Out-Patient Follow Up Pathway, the PATIENT may be discharged according to local clinical protocols after an agreed period of time.

A Care Professional Out-Patient Episode would not necessarily terminate because a PATIENT was admitted into hospital or placed on an ELECTIVE ADMISSION LIST; if further APPOINTMENTS in respect of the same REFERRAL REQUEST with the CONSULTANT are intended or expected, these would all be included in the same Consultant Out-Patient Episode, with Care Professional Out-Patient Attendances after the end of a Hospital Provider Spell recorded as follow-up attendances.

If after formal discharge the condition of the PATIENT deteriorates and the PATIENT is re-referred to the same CARE PROFESSIONAL, a new Care Professional Out-Patient Episode should be created.

During the Care Professional Out-Patient Episode the PATIENT may be subject to more than one ADMINISTRATIVE CATEGORY PERIODS.

For CONSULTANT-led Care Professional Out-Patient Episodes:

- if the TREATMENT FUNCTION under which the PATIENT is being treated changes, but the CONSULTANT stays the same, this is a continuation of the **same** Care Professional Out-Patient Episode
- if the CONSULTANT changes but the MAIN SPECIALTY and TREATMENT FUNCTION under which the PATIENT is being treated stay the same, this is a **new** Care Professional Out-Patient Episode.
  CARE ACTIVITIES related to the same REFERRAL REQUEST undertaken by other members of the CONSULTANTs team (such as junior doctors or NURSES) should be assigned to the same Care Professional Out-Patient Episode

For non-CONSULTANT-led Care Professional Out-Patient Episodes:

- For REFERRAL REQUESTS to team-led services, such as MIDWIFE care for Maternity PATIENTS, a single Care Professional Out-Patient Episode is recorded regardless of whether the PATIENT sees the same CARE PROFESSIONAL at each Care Professional Out-Patient Attendance

**This supporting information is also known by these names:**

| Context | Alias |
|---|---|
| plural | Care Professional Out-Patient Episodes |

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#### CDS TYPE

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Change to Supporting Information: Changed Description

A CDS Type forms part of an ELECTRONIC HEALTH RECORD EXTRACT.

~~CDS Type is a code to identify the specific type of Commissioning Data Set (CDS).~~CDS Type is a code to identify the specific type of Commissioning Data Set (CDS).

Note:

- ~~CDS Type 010 *'Accident and Emergency Attendance'* will no longer be accepted for submission to the Secondary Uses Service from 01 November 2020.~~
- CDS Type 010 *'Accident and Emergency Attendance'* was retired from 1 November 2020 and is no longer accepted for submission to the Secondary Uses Service.
- Commissioning Data Set version 6-3 does not require submission of the following CDS Types:
  - Detained and/or Long Term Psychiatric Census
  - Any Elective Admission List CDS Type

- ◦ Future Outpatient

The CDS Types are:

~~010~~ ~~Accident and Emergency Attendance~~
010 Accident and Emergency Attendance (Retired 1 November 2020)
011 Emergency Care Attendance
~~020~~ ~~Outpatient~~
~~*(Known in the Schema as Care Activity)*~~
~~May also be used to submit a Referral To Treatment Clock Stop Administrative Event~~
~~021~~ ~~Future Outpatient~~
~~*(Known in the Schema as Future Care Activity)*~~
020 Outpatient
May also be used to submit a Referral To Treatment Clock Stop Administrative Event
021 Future Outpatient
030 Elective Admission List End of Period Census (Standard)
040 Elective Admission List End of Period Census (Old)
050 Elective Admission List End of Period Census (New)
060 Elective Admission List Event During Period (Add)
070 Elective Admission List Event During Period (Remove)
080 Elective Admission List Event During Period (Offer)
090 Elective Admission List Event During Period (Available/Unavailable)
100 Elective Admission List Event During Period (Old Service Agreement)
110 Elective Admission List Event During Period (New Service Agreement)
120 Finished Birth Episode
130 Finished General Episode
140 Finished Delivery Episode
150 Other Birth
160 Other Delivery
170 Detained and/or Long-Term Psychiatric Census
180 Unfinished Birth Episode
190 Unfinished General Episode
200 Unfinished Delivery Episode

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**CDS V6-3 TYPE 001 - CDS INTERCHANGE HEADER OVERVIEW**

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Change to Supporting Information: New Supporting Information

**Introduction**

The CDS V6-3 Type 001 - Commissioning Data Set Interchange Header carries mandatory controls for a Commissioning Data Set Interchange and is only used by inclusion in other CDS Types.

Commissioning Data Set Interchanges containing Commissioning Data Set Messages submitted to the Secondary Uses Service must use the required Commissioning Data Set Interchange and Message Header and Trailer Controls to provide the correct addressing and identification for the data flows.

Multiple Commissioning Data Set messages are usually sent in a single Commissioning Data Set Interchange which consists of:

- CDS V6-2-3 Type 001 - Commissioning Data Set Interchange Header - Mandatory - One per Commissioning Data Set Interchange
CDS V6-2-3 Type 003 - Commissioning Data Set Message Header - Mandatory - One per Commissioning Data Set Message

Dependent upon the Commissioning Data Set Submission Protocol being used, one of the following must be used:

- CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol - Mandatory, one per CDS Type
- CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol - Mandatory, one per CDS Type

Followed by:

- The CDS Type - As required to carry the specific Commissioning Data Set data records

Each Commissioning Data Set message ends with:

- CDS V6-3 Type 004 - Commissioning Data Set Message Trailer - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer - Mandatory - One per Commissioning Data Set Interchange

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

**Notation**

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

**Business Rules**

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

**XML Schema**

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

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### CDS V6-3 TYPE 002 - CDS INTERCHANGE TRAILER OVERVIEW

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Change to Supporting Information: New Supporting Information

**Introduction**

The CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer carries mandatory controls for a Commissioning Data Set Interchange and is only used by inclusion in other CDS Types.

Commissioning Data Set Interchanges containing Commissioning Data Set Messages submitted to the Secondary Uses Service must use the required Commissioning Data Set Interchange and Message Header and Trailer Controls to provide the correct addressing and identification for the data flows.

Multiple Commissioning Data Set messages are usually sent in a single Commissioning Data Set Interchange which consists of:

- CDS V6-3 Type 001 - Commissioning Data Set Interchange Header - Mandatory - One per Commissioning Data Set Interchange
- CDS V6-3 Type 003 - Commissioning Data Set Message Header- Mandatory - One per Commissioning Data Set Message

Dependent upon the Commissioning Data Set Submission Protocol being used, one of the following must be used:

- CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol - Mandatory, one per CDS Type
- CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol - Mandatory, one per CDS Type

Followed by:

- The CDS Type - As required to carry the specific Commissioning Data Set data records

Each Commissioning Data Set message ends with:

- CDS V6-3 Type 004 - Commissioning Data Set Message Trailer - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer - Mandatory - One per Commissioning Data Set Interchange.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

**Notation**

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

**Business Rules**

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

**XML Schema**

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

---

**CDS V6-3 TYPE 003 - CDS MESSAGE HEADER OVERVIEW**

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Change to Supporting Information: New Supporting Information

**Introduction**

The CDS V6-3 Type 003 - Commissioning Data Set Message Header carries mandatory controls for a Commissioning Data Set Message and is only used by inclusion in other CDS Types.

Commissioning Data Set Interchanges containing Commissioning Data Set Messages submitted to the Secondary Uses Service must use the required Commissioning Data Set Interchange and Message Header and Trailer Controls to provide the correct addressing and identification for the data flows.

Multiple Commissioning Data Set messages are usually sent in a single Commissioning Data Set Interchange which consists of:

- CDS V6-3 Type 001 - Commissioning Data Set Interchange Header - Mandatory - One per Commissioning Data Set Interchange
- CDS V6-3 Type 003 - Commissioning Data Set Message Header- Mandatory - One per Commissioning Data Set Message

Dependent upon the Commissioning Data Set Submission Protocol being used, one of the following must be used:

- CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol - Mandatory, one per CDS Type
- CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol - Mandatory, one per CDS Type

Followed by:

- The CDS Type - As required to carry the specific Commissioning Data Set data records

Each Commissioning Data Set message ends with:

- CDS V6-3 Type 004 - Commissioning Data Set Message Trailer - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer - Mandatory - One per Commissioning Data Set Interchange.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

**Notation**

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

**Business Rules**

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

**XML Schema**

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

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**CDS V6-3 TYPE 004 - CDS MESSAGE TRAILER OVERVIEW**

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Change to Supporting Information: New Supporting Information

**Introduction**

The CDS V6-3 Type 004 - Commissioning Data Set Message Trailer carries mandatory controls for a Commissioning Data Set Message and is only used by inclusion in other CDS Types.

Commissioning Data Set Interchanges containing Commissioning Data Set Messages submitted to the Secondary Uses Service must use the required Commissioning Data Set Interchange and Message Header and Trailer Controls to provide the correct addressing and identification for the data flows.

Multiple Commissioning Data Set messages are usually sent in a single Commissioning Data Set Interchange which consists of:

- CDS V6-3 Type 001 - Commissioning Data Set Interchange Header - Mandatory - One per Commissioning Data Set Interchange
- CDS V6-3 Type 003 - Commissioning Data Set Message Header- Mandatory - One per Commissioning Data Set Message

Dependent upon the Commissioning Data Set Submission Protocol being used, one of the following must be used:

- CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol - Mandatory, one per CDS Type
- CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol - Mandatory, one per CDS Type

Followed by:

- The CDS Type - As required to carry the specific Commissioning Data Set data records

Each Commissioning Data Set message ends with:

- CDS V6-3 Type 004 - Commissioning Data Set Message Trailer - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer - Mandatory - One per Commissioning Data Set Interchange.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

**Notation**

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

**Business Rules**

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

**XML Schema**

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

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**CDS V6-3 TYPE 005B - CDS TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL OVERVIEW**

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Change to Supporting Information: New Supporting Information

**Introduction**

The CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol carries mandatory controls for a Commissioning Data Set Type and is only used by inclusion in other CDS Types.

Commissioning Data Set Interchanges containing Commissioning Data Set Messages submitted to the Secondary Uses Service must use the required Commissioning Data Set Interchange and Message Header and Trailer Controls to provide the correct addressing and identification for the data flows. All CDS Types using the Commissioning Data Set Bulk Replacement Update Mechanism of the Commissioning Data Set Submission Protocol must begin with this Mandatory Data Group.

Multiple Commissioning Data Set messages are usually sent in a single Commissioning Data Set Interchange which consists of:

- CDS V6-3 Type 001 - Commissioning Data Set Interchange Header - Mandatory - One per Commissioning Data Set Interchange

- CDS V6-3 Type 003 - Commissioning Data Set Message Header- Mandatory - One per Commissioning Data Set Message - Mandatory - One per Commissioning Data Set Interchange

Dependent upon the Commissioning Data Set Submission Protocol being used, one of the following must be used:

- CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol - Mandatory, one per CDS Type
- CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol - Mandatory, one per CDS Type

Followed by:

- The CDS Type - As required to carry the specific Commissioning Data Set data records

Each Commissioning Data Set message ends with:

- CDS V6-3 Type 004 - Commissioning Data Set Message Trailer - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer - Mandatory - One per Commissioning Data Set Interchange.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

**Notation**

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

**Business Rules**

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

**XML Schema**

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

---

## CDS V6-3 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL OVERVIEW

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Change to Supporting Information: New Supporting Information

**Introduction**

The CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol carries mandatory controls for a Commissioning Data Set Type and is only used by inclusion in other CDS Types.

Commissioning Data Set Interchanges containing Commissioning Data Set Messages submitted to the Secondary Uses Service must use the required Commissioning Data Set interchange and Message Header and Trailer Controls to provide the correct addressing and identification for the data flows. All CDS Types using the Commissioning Data Set Net Change Update Mechanism of the Commissioning Data Set Submission Protocol must begin with this Mandatory Data Group.

Multiple Commissioning Data Set messages are usually sent in a single Commissioning Data Set Interchange which consists of:

- CDS V6-3 Type 001 - Commissioning Data Set Interchange Header - Mandatory - One per Commissioning Data Set Interchange
- CDS V6-3 Type 003 - Commissioning Data Set Message Header- Mandatory - One per Commissioning Data Set Message

Dependent upon the Commissioning Data Set Submission Protocol being used, one of the following must be used:

- CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol - Mandatory, one per CDS Type
- CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol - Mandatory, one per CDS Type

Followed by:

- The CDS Type - As required to carry the specific Commissioning Data Set data records

Each Commissioning Data Set message ends with:

- CDS V6-3 Type 004 - Commissioning Data Set Message Trailer - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer - Mandatory - One per Commissioning Data Set Interchange.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

**Notation**

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

**Business Rules**

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

**XML Schema**

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

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## CDS V6-3 TYPE 020 - OUTPATIENT CDS OVERVIEW

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Change to Supporting Information: New Supporting Information

**Introduction**

The CDS V6-3 Type 020 - Outpatient Commissioning Data Set carries the data for a Care Professional Out-Patient Attendance or a cancelled/missed APPOINTMENT.

It covers all NHS and private Out-patient ACTIVITY taking place in any:

- acute, community, mental health NHS Trust or NHS Foundation Trust

- other NHS hospital
- non-NHS hospitals or institutions where the care delivered is NHS-funded.

under the care of a CONSULTANT, MIDWIFE, NURSE or ALLIED HEALTH PROFESSIONAL, where an appropriate MAIN SPECIALTY CODE and TREATMENT FUNCTION CODE exists.

ACTIVITY taking place under the care of ALLIED HEALTH PROFESSIONALS, other Biomedical Scientists and Clinical Scientists may also be carried (where an appropriate MAIN SPECIALTY CODE and TREATMENT FUNCTION CODE exists) if required although this is not a Commissioning Data Set Mandated Data Flow, unless the ACTIVITY falls under the Allied Health Professional Referral To Treatment Measurement standard. In this case, a Care Professional Out-Patient Attendance record for the ALLIED HEALTH PROFESSIONAL ACTIVITY must be submitted, with the CDS DATA GROUP : PATIENT PATHWAY data elements completed as necessary.

Where the Out-patient data relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, the CDS DATA GROUP : PATIENT PATHWAY data elements must be completed where appropriate.

This CDS Type may also be used to submit Referral To Treatment Clock Stop Administrative Events.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

**Notation**

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

**Business Rules**

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

**XML Schema**

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

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**CDS V6-3 TYPE 120 - ADMITTED PATIENT CARE - FINISHED BIRTH EPISODE CDS OVERVIEW**

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Change to Supporting Information: New Supporting Information

**Introduction**

CDS V6-3 Type 120 - Admitted Patient Care - Finished Birth Episode Commissioning Data Set carries the data for a Finished Birth Care Professional Admitted Care Episode.

This is required when a delivery has resulted in a REGISTRABLE BIRTH which has taken place in either an NHS Hospital or in a non-NHS ORGANISATION funded by the NHS.

The information is taken from the birth notification for each baby born.

In addition to Finished Birth Care Professional Admitted Care Episodes, Unfinished Birth Care Professional Admitted Care Episode Commissioning Data Set records are required as at midnight on 31st March each year.

CDS V6-3 Type 180 - Admitted Patient Care - Unfinished Birth Episode Commissioning Data Set should be used for the submission of this Unfinished Birth Episode Commissioning Data Set.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

**Notation**

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

**Business Rules**

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

**XML Schema**

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

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**CDS V6-3 TYPE 130 - ADMITTED PATIENT CARE - FINISHED GENERAL EPISODE CDS OVERVIEW**

---

Change to Supporting Information: New Supporting Information

**Introduction**

CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set carries the data for a Finished General Care Professional Admitted Care Episode.

It covers all NHS and private Care Professional Admitted Care Episode (day case and inpatient) ACTIVITY taking place in any:

- acute, community, mental health NHS Trust or NHS Foundation Trust
- other NHS hospital
- non-NHS hospitals or institutions where the care delivered is NHS-funded.

under the care of a CONSULTANT, MIDWIFE or NURSE, where an appropriate MAIN SPECIALTY CODE and TREATMENT FUNCTION CODE exists.

ACTIVITY taking place under the care of ALLIED HEALTH PROFESSIONALS, other Biomedical Scientists and Clinical Scientists may also be carried (where an appropriate MAIN SPECIALTY CODE and TREATMENT FUNCTION CODE exists) if required although this is not a Commissioning Data Set Mandated Data Flow.

Where the Care Professional Admitted Care Episode data relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, the CDS DATA GROUP : PATIENT PATHWAY data elements must be completed where appropriate.

An Unfinished General Care Professional Admitted Care Episode Commissioning Data Set record is required as at midnight on 31 March each year and for all unfinished short-stay informal psychiatric PATIENTS who are resident in hospital or on leave of absence (Home Leave) on 31 March and who have been in hospital for less than 12 months.

CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set should be used for the submission of this Unfinished General Episode Care Professional Admitted Care Episode data.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

**Notation**

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

**Business Rules**

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

**XML Schema**

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

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## CDS V6-3 TYPE 140 - ADMITTED PATIENT CARE - FINISHED DELIVERY EPISODE CDS OVERVIEW

---

Change to Supporting Information: New Supporting Information

**Introduction**

CDS V6-3 Type 140 - Admitted Patient Care - Finished Delivery Episode Commissioning Data Set carries the data for a Finished Delivery Care Professional Admitted Care Episode.

This is required when a delivery has resulted in a REGISTRABLE BIRTH which has taken place in either an NHS Hospital or in a non-NHS ORGANISATION funded by the NHS.

The information is taken from the birth notification for each baby born.

In addition to Finished Delivery Care Professional Admitted Care Episodes, Unfinished Delivery Care Professional Admitted Care Episode Commissioning Data Set records are required for all Unfinished Delivery Episodes as at midnight on 31 March each year.

CDS V6-3 Type 200 - Admitted Patient Care - Unfinished Delivery Episode Commissioning Data Set should be used for the submission of this Unfinished Delivery Episode Commissioning Data Set.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

**Notation**

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

**Business Rules**

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

**XML Schema**

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

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## CDS V6-3 TYPE 150 - ADMITTED PATIENT CARE - OTHER BIRTH EVENT CDS OVERVIEW

---

Change to Supporting Information: New Supporting Information

## Introduction

CDS V6-3 Type 150 - Admitted Patient Care - Other Birth Event Commissioning Data Set carries the data for an Other Birth.

This CDS Type applies to:

- NHS-funded home births and
- all other birth events which are not NHS-funded, either directly or under an NHS SERVICE AGREEMENT.

The data in these records originates from birth notification records and requires only a limited data set to be completed.

Maternity Care Professional Admitted Care Episodes taking place in either NHS hospitals or in non-NHS ORGANISATIONS funded by the NHS, will be recorded using the CDS V6-3 Type 120 - Admitted Patient Care - Finished Birth Episode Commissioning Data Set and CDS V6-3 Type 140 - Admitted Patient Care - Finished Delivery Episode Commissioning Data Set.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

## Notation

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

## Business Rules

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

## XML Schema

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

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**CDS V6-3 TYPE 160 - ADMITTED PATIENT CARE - OTHER DELIVERY EVENT CDS OVERVIEW**

---

Change to Supporting Information: New Supporting Information

## Introduction

CDS V6-3 Type 160 - Admitted Patient Care - Other Delivery Event Commissioning Data Set carries the data for an Other Delivery.

This CDS Type applies to:

- NHS-funded home deliveries and
- all other delivery events which are not NHS-funded, either directly or under an NHS SERVICE AGREEMENT.

The data in these records originates from birth notification records and requires only a limited data set to be completed.

Maternity Care Professional Admitted Care Episodes taking place in either NHS hospitals or in non-NHS ORGANISATIONS funded by the NHS, will be recorded using the CDS V6-3 Type 120 - Admitted Patient Care - Finished Birth Episode Commissioning Data Set and CDS V6-3 Type 140 - Admitted Patient Care - Finished Delivery Episode Commissioning Data Set.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

**Notation**

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

**Business Rules**

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

**XML Schema**

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

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### CDS V6-3 TYPE 180 - ADMITTED PATIENT CARE - UNFINISHED BIRTH EPISODE CDS OVERVIEW

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Change to Supporting Information: New Supporting Information

**Introduction**

CDS V6-3 Type 180 - Admitted Patient Care - Unfinished Birth Episode Commissioning Data Set carries the data for an Unfinished Birth Care Professional Admitted Care Episode.

This is required when a delivery has resulted in a REGISTRABLE BIRTH which has taken place in either an NHS Hospital or in an non-NHS ORGANISATION funded by the NHS.

The information is taken from the birth notification for each baby born.

Unfinished Birth Care Professional Admitted Care Episode Commissioning Data Set records are required for all Unfinished Birth Care Professional Admitted Care Episode as at midnight on 31st March each year.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

**Notation**

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

**Business Rules**

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

**XML Schema**

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

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### CDS V6-3 TYPE 190 - ADMITTED PATIENT CARE - UNFINISHED GENERAL EPISODE CDS OVERVIEW

---

Change to Supporting Information: New Supporting Information

**Introduction**

CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set carries the data for an Unfinished General Care Professional Admitted Care Episode.

It covers all NHS and private Care Professional Admitted Care Episode (day case and inpatient) ACTIVITY taking place in any:

- acute, community, mental health NHS Trust or NHS Foundation Trust
- other NHS hospital
- non-NHS hospitals or institutions where the care delivered is NHS-funded.

under the care of a CONSULTANT, MIDWIFE or NURSE, where an appropriate MAIN SPECIALTY CODE and TREATMENT FUNCTION CODE exists.

ACTIVITY taking place under the care of ALLIED HEALTH PROFESSIONALS, other Biomedical Scientists and Clinical Scientists may also be carried (where an appropriate MAIN SPECIALTY CODE and TREATMENT FUNCTION CODE exists) if required although this is not a Commissioning Data Set Mandated Data Flow.

Where the Care Professional Admitted Care Episode data relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, the CDS DATA GROUP : PATIENT PATHWAY data elements must be completed where appropriate.

An Unfinished General Care Professional Admitted Care Episode Commissioning Data Set record is required for all Unfinished General Care Professional Admitted Care Episodes as at midnight on 31 March each year and for all unfinished short-stay informal psychiatric PATIENTS who are resident in hospital or on leave of absence (Home Leave) on 31 March and who have been in hospital for less than 12 months.

CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set may optionally be sent more regularly, usually monthly.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

**Notation**

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

**Business Rules**

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

**XML Schema**

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

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**CDS V6-3 TYPE 200 - ADMITTED PATIENT CARE - UNFINISHED DELIVERY EPISODE CDS OVERVIEW**

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Change to Supporting Information: New Supporting Information

**Introduction**

CDS V6-3 Type 200 - Admitted Patient Care - Unfinished Delivery Episode Commissioning Data Set carries the data for an Unfinished Delivery Care Professional Admitted Care Episode.

This may take place in either NHS Hospitals or in non-NHS ORGANISATIONS funded by the NHS. The information is taken from the birth notification for each baby born.

Unfinished Birth and Delivery Care Professional Admitted Care Episode Commissioning Data Set records are required for all Unfinished Birth and Delivery Care Professional Admitted Care Episodes as at midnight on 31 March each year.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

**Notation**

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

**Business Rules**

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

**XML Schema**

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

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**CDS VERSION 6-3 MENU**

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Change to Supporting Information: New Supporting Information

Commissioning Data Set Business Rules
Commissioning Data Set Notation

**CDS Data Flow Controls - (Mandatory for every CDS Interchange):**
CDS V6-3 Type 001 - CDS Interchange Header
CDS V6-3 Type 002 - CDS Interchange Trailer
CDS V6-3 Type 003 - CDS Message Header
CDS V6-3 Type 004 - CDS Message Trailer

**CDS Transaction Header Group - (Mandatory for every CDS TYPE):**
CDS V6-3 Type 005B - CDS Transaction Header Group - Bulk Update Protocol **or**
CDS V6-3 Type 005N - CDS Transaction Header Group - Net Change Protocol

**CDS TYPES:**

**Outpatient Care:**
CDS V6-3 Type 020 - Outpatient CDS

**Admitted Patient Care:**
CDS V6-3 Type 120 - Admitted Patient Care - Finished Birth Episode CDS
CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode CDS
CDS V6-3 Type 140 - Admitted Patient Care - Finished Delivery Episode CDS
CDS V6-3 Type 150 - Admitted Patient Care - Other Birth Event CDS
CDS V6-3 Type 160 - Admitted Patient Care - Other Delivery Event CDS
CDS V6-3 Type 180 - Admitted Patient Care - Unfinished Birth Episode CDS

CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode CDS
CDS V6-3 Type 200 - Admitted Patient Care - Unfinished Delivery Episode CDS

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**COMMISSIONING DATA SET ADDRESSING GRID**

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Change to Supporting Information: Changed Description

**This page has been updated in DDCN 1645 (Specialised Commissioning: Removal of Default Code YDD82) to remove the National Commissioning Group, as NHS England became responsible for commissioning all specialised services in April 2013.**
**The page will be updated as part of an Information Standard to reflect the current arrangements for the Commissioning Data Sets.**

**Note that the Commissioning Data Set Addressing Grid is only applicable for Commissioning Data Set version 6-2, as CDS PRIME RECIPIENT IDENTITY and CDS COPY RECIPIENT IDENTITY have been replaced with ORGANISATION IDENTIFIER (CDS RECIPIENT) in Commissioning Data Set version 6-3.**

The Commissioning Data Set Addressing Grid below illustrates which ORGANISATION CODES should be used to populate the CDS PRIME RECIPIENT IDENTITY and CDS COPY RECIPIENT IDENTITY for each PATIENT / NHS SERVICE AGREEMENT. See the specific ORGANISATION CODE Data Elements for further information on their usage and Organisation Data Service Default Codes etc.

Health Care Providers need to specify the ORGANISATIONS that have a right to the commissioning data set data as a CDS PRIME RECIPIENT IDENTITY or CDS COPY RECIPIENT IDENTITY. This is so that they can access the data once it has been stored in the Secondary Uses Service.

*Please note that payment via the National Tariff Payment System is not determined by the CDS PRIME RECIPIENT IDENTITY or CDS COPY RECIPIENT IDENTITY.*

**Important Notes:**

- The CDS PRIME RECIPIENT IDENTITY must be allocated on the first creation and submission of a CDS Type for a PATIENT and **must not change even if the ADDRESS or ORGANISATION CODE (RESIDENCE RESPONSIBILITY) of the PATIENT changes during the lifetime of the Commissioning Data Set record** otherwise duplicate Commissioning Data Set data may be lodged in the Secondary Uses Service database. See the supporting information in Commissioning Data Set Submission Protocol for a detailed explanation.
- Note that if two recipients are identical for example, the ORGANISATION CODE (RESIDENCE RESPONSIBILITY) may be the same as the ORGANISATION CODE (CODE OF COMMISSIONER), only one entry for that ORGANISATION should be made for that recipient.
- Specialised service ACTIVITY commissioned by a regional Specialised Commissioning Group should include their ORGANISATION CODE as a CDS COPY RECIPIENT IDENTITY. ACTIVITY commissioned by a shared service ORGANISATION or other consortium of Primary Care Trusts, should similarly include the ORGANISATION CODE of the shared service or the lead Primary Care Trust, if this does not already appear as a CDS COPY RECIPIENT IDENTITY or CDS PRIME RECIPIENT IDENTITY.

**~~Commissioning Data Set Addressing Grid for users of Commissioning Data Set version 6-2 onwards~~Commissioning Data Set Addressing Grid for users of Commissioning Data Set version 6-2**

| **PATIENT / NHS SERVICE AGREEMENT** | **Data Elements in the Commissioning Data Sets Version 6-2 onwards** | | |
|---|---|---|---|
| | **CDS PRIME RECIPIENT IDENTITY**<br>**M*** | **CDS COPY RECIPIENT IDENTITY**<br>**O*** | |
| Private PATIENT | ORGANISATION CODE (RESIDENCE RESPONSIBILITY) | VPP00 | ORGANISATION CODE (RESPONSIBLE PCT) or ORGANISATION CODE of the |

| | | | |
|---|---|---|---|
| | | | responsible Clinical Commissioning Group |
| Overseas Visitor liable for NHS charges and not registered with a General Medical Practitioner Practice | ORGANISATION CODE (RESIDENCE RESPONSIBILITY) | VPP00 | |
| Overseas Visitor liable for NHS charges and registered with a General Medical Practitioner Practice | ORGANISATION CODE (RESIDENCE RESPONSIBILITY) | VPP00 | ORGANISATION CODE (RESPONSIBLE PCT) or ORGANISATION CODE of the responsible Clinical Commissioning Group |
| Overseas Visitor exempt from charges, current permanent residence overseas and not registered with a General Medical Practitioner Practice | TDH00 | ORGANISATION CODE (CODE OF COMMISSIONER) | |
| Overseas Visitor exempt from charges, current permanent overseas and registered with a General Medical Practitioner Practice | TDH00 | ORGANISATION CODE (CODE OF COMMISSIONER) | ORGANISATION CODE (RESPONSIBLE PCT) or ORGANISATION CODE of the responsible Clinical Commissioning Group |
| Overseas Visitor exempt from charges, current permanent residence is the UK and not registered with a General Medical Practitioner Practice | ORGANISATION CODE (RESIDENCE RESPONSIBILITY) | ORGANISATION CODE (CODE OF COMMISSIONER) | |
| Overseas Visitor exempt from charges, current permanent residence is the UK and registered with a General Medical Practitioner Practice | ORGANISATION CODE (RESIDENCE RESPONSIBILITY) | ORGANISATION CODE (CODE OF COMMISSIONER) | ORGANISATION CODE (RESPONSIBLE PCT) or ORGANISATION CODE of the responsible Clinical Commissioning Group |
| PATIENT registered with a General Medical Practitioner Practice treated as a Non-Contract Activity | ORGANISATION CODE (RESIDENCE RESPONSIBILITY) | ORGANISATION CODE (RESPONSIBLE PCT) or ORGANISATION CODE of the responsible Clinical Commissioning Group | ORGANISATION CODE (CODE OF COMMISSIONER) |
| PATIENT not registered with a General Medical Practitioner Practice treated as a Non-Contract Activity | ORGANISATION CODE (RESIDENCE RESPONSIBILITY) | ORGANISATION CODE (CODE OF COMMISSIONER) | |
| ** PATIENT registered with General Medical Practitioner Practice with a Specialised Services and Other Commissioning Consortia Service Agreement | ORGANISATION CODE (RESIDENCE RESPONSIBILITY) | ORGANISATION CODE (RESPONSIBLE PCT) or ORGANISATION CODE of the responsible Clinical Commissioning Group | ORGANISATION CODE of ORGANISATION to which costs of treatment accrue |
| ** PATIENT not registered with General Medical Practitioner Practice with a Specialised Services and Other Commissioning Consortia Service Agreement | ORGANISATION CODE (RESIDENCE RESPONSIBILITY) | ORGANISATION CODE of ORGANISATION to which costs of treatment accrue | |
| PATIENT registered with General Medical Practitioner Practice with Primary Care Trust NHS SERVICE | ORGANISATION CODE (RESIDENCE RESPONSIBILITY) | ORGANISATION CODE (RESPONSIBLE PCT) or ORGANISATION CODE of the responsible | |

| | | | |
|---|---|---|---|
| AGREEMENT (excluding Overseas Visitors) | | Clinical Commissioning Group | |
| PATIENT not registered with a General Medical Practitioner Practice but resident in an area covered by a Primary Care Trust with a Primary Care Trust NHS SERVICE AGREEMENT (excluding Overseas Visitors) | ORGANISATION CODE (RESIDENCE RESPONSIBILITY) | | |

Notes:

Key to population codes:

> **M***: This Data Element is mandatory in the CDS-XML schema. Submissions will not flow if this Data Element is absent
> **O***: This Data Element is optional
>
> ** Specialised Services and Other Commissioning Consortia Service Agreements include SERVICES that are commissioned by regional Specialised Commissioning Groups and local arrangements for commissioning ACTIVITY through shared service ORGANISATIONS.

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#### COMMISSIONING DATA SET BUSINESS RULES

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Change to Supporting Information: Changed Dataset, Description

The Commissioning Data Sets have notation to identify the business and/or processing rules which apply to individual Data Elements. This notation appears in the Rules column of the Commissioning Data Sets details page.

### Population Validation

All Data Elements are subject to **length** validation. Some Data Elements are also subject to **format** and **content** validation against a list of permitted values defined in the NHS Data Model and Dictionary. The value lists are held on the Attribute which the Data Element is based on, plus default codes which are held on the Data Element itself.

| RULE | POPULATION VALIDATION |
|---|---|
| F | The format is validated, for example the format of a date must comply with the XML standard. |
| V | The Data Element is validated against an explicit list of permitted values as defined in the NHS Data Model and Dictionary.<br>Note the permitted values differ between CDS-XML schema version 6-2 and CDS-XML version 6-2-0 for CARE PROFESSIONAL MAIN SPECIALTY CODE and ACTIVITY TREATMENT FUNCTION CODE. |

**Business Rules**

Some Data Elements are subject to additional Business Rules as indicated below:

- **Prefix H** = Healthcare Resource Group Business Rules.
- ~~**Prefix I** = CDS-XML Schema anomalies and issues.~~
- **Prefix I** = CDS-XML Schema notes, anomalies and issues.
- **Prefix N** = NHS Data Standards and Policy Rules
- **Prefix S** = Secondary Uses Service Business Rules

| PREFIX | BUSINESS RULES: H - Healthcare Resource Group Business Rules |
|---|---|
| H4 | |

| | |
|---|---|
| | This Data Element is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4.**<br>Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.<br>For further information, please refer to the NHS Digital website at: Payment by Results Guidance. |

| PREFIX | BUSINESS RULES: I - CDS-XML Schema Anomalies and Issues |
|---|---|
| **PREFIX** | **BUSINESS RULES: I - CDS-XML Schema Notes, Anomalies and Issues** |
| **I1** | This is a known schema anomaly and has been registered for future resolution. |
| **I2** | See the specifications in the NHS Data Model and Dictionary for the specific format characteristics of this Data Element. |
| **I3** | There is no national requirement to flow Healthcare Resource Group 4 (HRG4) through the Commissioning Data Sets, see DSCN 17/2008. |
| **I4** | From Commissioning Data Set version 6-3 onwards, the NHS Data Model and Dictionary data set layout has been updated to correctly represent the existing requirements of the CDS-XML Schema for PERSON NAME STRUCTURED and PERSON NAME UNSTRUCTURED |
| **I5** | From Commissioning Data Set version 6-3 onwards, the NHS Data Model and Dictionary data set layout has been updated to correctly represent the existing requirements of the CDS-XML Schema for ADDRESS STRUCTURED and ADDRESS UNSTRUCTURED |

| PREFIX | BUSINESS RULES: N - NHS Data Standards and Policy Rules |
|---|---|
| **N1** | Psychiatric PATIENTS only (Retired January 2021). |
| **N2** | Not defined or approved by the Data Alliance Partnership Board or its predecessors the Data Coordination Board, Standardisation Committee for Care Information and Information Standards Board for Health and Social Care. |
| **N3** | The definition and value list for this data is under review. |
| **N4** | Up to 20 codes per daily activity occurrence may be recorded. |
| N5 | This data should only flow in Commissioning Data Set version 6-1 for PATIENTS detained under the Mental Health Act prior to the Mental Health Act 2007 (Retired June 2015). |
| **N6** | This data should only flow in Commissioning Data Set version 6-2 for PATIENTS detained under the Mental Health Act 2007. |
| **N7** | From Commissioning Data Set version 6-0 onwards, the use of the DETAINED AND (OR) LONG TERM PSYCHIATRIC CENSUS DATE in the location group is **optional** as it **must** be carried in the Episode Characteristics. |

| PREFIX | BUSINESS RULES: S - Secondary Uses Service Business Rules |
|---|---|
| **S1** | This mandatory Commissioning Data Set date is used as the originating date to determine the mandatory CDS ACTIVITY DATE. |
| S2 | The Secondary Uses Service **DOES NOT** support the use of the CDS TEST INDICATOR. Therefore this Data Element must not be used (Retired June 2015). |
| **S3** | See Security Issues and Patient Confidentiality, for further information. |
| **S4** | Used to ensure the correct sequencing of multiple and/or subsequent Commissioning Data Set submissions. |
| S5 | These ORGANISATION CODES must be present and registered with the Secondary Uses Service. The Commissioning Data Set Schema does not validate the content value of this data |
| S5 | These ORGANISATION CODES/ORGANISATION IDENTIFIERS must be present and registered with the Secondary Uses Service. The Commissioning Data Set Schema does not validate the content value of this data |
| **S6** | All CDS REPORT PERIOD START DATES and CDS REPORT PERIOD END DATES must be consistent in all Commissioning Data Set records contained in a BULK Interchange submission.<br>The CDS REPORT PERIOD START DATE must be on or before the CDS REPORT PERIOD END DATE.<br>The CDS ACTIVITY DATE is a mandatory data element and must fall within the period defined.<br>See the Commissioning Data Set Submission Protocol. |
| **S7** | See the Commissioning Data Set Addressing Grid. |
| | |

| | |
|---|---|
| **S8** | These Data Elements are required for correct processing by the Secondary Uses Service. If omitted, the Secondary Uses Service will reject the Commissioning Data Set data. |
| **S9** | The CDS UNIQUE IDENTIFIER is a mandatory data item when using the Net Change Protocol. When using the Bulk Update Protocol this data item is optional but it is strongly advised that where it can be correctly generated and maintained it should be used. See the Commissioning Data Set Submission Protocol. |
| **S10** | For CDS V6-2 Type 170 - Admitted Patient Care - Detained and or Long Term Psychiatric Census Commissioning Data Set, the CDS ACTIVITY DATE contains the CDS CENSUS DATE which is also the DETAINED AND (OR) LONG TERM PSYCHIATRIC CENSUS DATE. |
| **S11** | For the following CDS Types, the CDS ACTIVITY DATE must contain the Date of the Elective Admission List Census which is usually the end of the Period being reported:<br>CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set<br>CDS V6-2 Type 040 - Elective Admission List - End of Period Census (Old) Commissioning Data Set<br>CDS V6-2 Type 050 - Elective Admission List - End of Period Census (New) Commissioning Data Set |
| **S12** | These PERSON BIRTH DATE Data Elements must use dates between 01/01/1880 and 31/12/2999 in order to pass validation |
| **S13** | Data Elements reporting a date (which is not a PERSON BIRTH DATE Data Element) must use dates between 01/01/1900 and 31/12/2999 in order to pass validation |
| **S14** | For Data Elements reporting a time, the hour portion must be between 00 and 23 inclusive in order to pass validation |

#### COMMISSIONING DATA SET MANDATED DATA FLOWS

Change to Supporting Information: Changed Description

The minimum Commissioning Data Sets information flow requirement to enable Hospital Episode Statistics, 18 Weeks ACTIVITY reporting, and the National Tariff Payment System to be supported by the Secondary Uses Service is shown in the table below.

The Secondary Uses Service supports every CDS Type but only a subset is mandated to flow.

Commissioning Data Sets may flow to the Secondary Uses Service using either Net Change or Bulk Replacement Commissioning Data Set Submission Protocols. Many Standard NHS Contracts between Health Care Providers and the commissioners of their SERVICES, now specify weekly submission of initially-coded data sets to the Secondary Uses Service. The use of Net Change Commissioning Data Set Submission Protocols is recommended for submissions of this frequency.

| CDS TYPE | DESCRIPTION | MIN FREQUENCY | DIRECTIVE | DATA FLOW |
|---|---|---|---|---|
| CDS010 | Accident and Emergency (Retired 01 November 2020) | | | |
| CDS 011 | Emergency Care | Weekly | Emergency Care Attendances for EMERGENCY CARE DEPARTMENT TYPE 01 and 02 were mandated to flow nationally from 1st October 2017. See SCCI0092-2062<br><br>Emergency Care Attendances for EMERGENCY CARE DEPARTMENT TYPES 03 and 04 were mandated to flow from October 2018. See SCCI0092-2062 | Data is expected to flow on a daily basis where possible, but a weekly frequency is the minimum requirement. |

| CDS 020 | Out-Patient | Weekly | Out-Patient Attendance Commissioning Data Sets (including Ward Attenders) were mandated to be submitted to the Secondary Uses Service from 1st October 2001, see DSCN 05/2001.<br><br>Out-Patient Attendance Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.<br><br>NURSE and MIDWIFE attendances and Attendances for nursing care were enabled to be carried in the Out-Patient Attendance Commissioning Data Set from 1 April 2005, DSCN 32/2004 Other Care Professional Attendances where an appropriate Treatment Function exists may also be submitted.<br><br>Out-patient records where the activity relates to the Allied Health Professional Referral To Treatment Measurement standard must be submitted to the Secondary Uses Service (in accordance with ISN ISB0092 Amd 7/2013, and must include the PATIENT PATHWAY data group data items. Note that this is only supported in Commissioning Data Set version 6-2 onwards, with the introduction of data element WAITING TIME MEASUREMENT TYPE. | NHS Acute Health Care Providers must submit data weekly.<br><br>NHS Community Health Care Providers, NHS Mental Health Care Providers and Independent Sector Healthcare Providers undertaking acute care, must submit data weekly as soon as possible and no later than 31 March 2021. |
|---|---|---|---|---|
| ~~CDS 021~~ | ~~Future Out-Patients~~ | ~~As Required for piloting~~ | ~~From 01/01/2008, submissions to support local activities and commissioning will be supported for piloting purposes only.~~ | |
| ~~CDS 030~~ | ~~Elective Admission List End of Period (Standard)~~ | ~~Monthly if used~~ | ~~All Providers should endeavour to support this data flow.~~<br><br>~~Elective Admission List End of Period Census (Standard) Commissioning Data~~ | ~~All entries where at the end of the time period being reported and defined by the Commissioning Data Set Submission Protocol, the PATIENT remains on the ELECTIVE ADMISSION LIST.~~ |

| | | | | |
|---|---|---|---|---|
| | | | Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009. | Optionally and by local agreement with commissioners, entries relating to the PATIENTS that have been removed from the ELECTIVE ADMISSION LIST may be included. |
| CDS 040 | Elective Admission List End of Period (New) | Monthly if used | Optional | May be submitted where the Commissioner has been changed during the time period reported. |
| CDS 050 | Elective Admission List End of Period (Old) | Monthly if used | Optional | May be submitted where the Commissioner has been changed during the time period reported. |
| CDS 060 | Elective Admission List Event During Period (Add) | Monthly if used | Optional<br><br>Elective Admission List Event During Period (Add) Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009. | May be submitted where an entry has been added to the ELECTIVE ADMISSION LIST during the time period reported. |
| CDS 070 | Elective Admission List Event During Period (Remove) | Monthly if used | Optional<br><br>Elective Admission List Event During Period (Remove) Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009. | May be submitted where an entry has been removed from the ELECTIVE ADMISSION LIST during the time period reported. |
| CDS 080 | Elective Admission List Event During Period (Offer) | Monthly if used | Optional<br><br>Elective Admission List Event During Period (Offer) CDS records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009. | May be submitted where an offer has been made during the time period reported. |

| ~~CDS 090~~ | ~~Elective Admission List Event During Period (Available / Unavailable)~~ | ~~Monthly if used~~ | ~~Optional~~ | ~~May be submitted where a patient becomes Available or Unavailable during the time period reported.~~ |
|---|---|---|---|---|
| ~~CDS 100~~ | ~~Elective Admission List Event During Period (Old Service Agreement)~~ | ~~Monthly if used~~ | ~~Optional~~ | ~~May be submitted where the Commissioner has been changed during the time period reported.~~ |
| ~~CDS 110~~ | ~~Elective Admission List Event During Period (New Service Agreement)~~ | ~~Monthly if used~~ | ~~Optional~~ | ~~May be submitted where the Commissioner has been changed during the time period reported.~~ |
| CDS 021 | Future Out-Patients - **Commissioning Data Set version 6-2 only** | As Required for piloting | From 01/01/2008, submissions to support local activities and commissioning will be supported for piloting purposes only. | |
| CDS 030 | Elective Admission List End of Period (Standard) - **Commissioning Data Set version 6-2 only** | Monthly if used | All Providers should endeavour to support this data flow.<br><br>Elective Admission List End of Period Census (Standard) Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009. | All entries where at the end of the time period being reported and defined by the Commissioning Data Set Submission Protocol, the PATIENT remains on the ELECTIVE ADMISSION LIST. Optionally and by local agreement with commissioners, entries relating to the PATIENTS that have been removed from the ELECTIVE ADMISSION LIST may be included. |
| CDS 040 | Elective Admission List End of Period (New) - **Commissioning Data Set version 6-2 only** | Monthly if used | Optional | May be submitted where the Commissioner has been changed during the time period reported. |
| CDS 050 | Elective Admission List End of Period (Old) - **Commissioning Data Set version 6-2 only** | Monthly if used | Optional | May be submitted where the Commissioner has been changed during the time period reported. |
| CDS 060 | Elective Admission List Event During Period (Add) **Commissioning Data Set version 6-2 only** | Monthly if used | Optional<br><br>Elective Admission List Event During Period (Add) Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009. | May be submitted where an entry has been added to the ELECTIVE ADMISSION LIST during the time period reported. |
| CDS 070 | Elective Admission List Event During Period | Monthly if used | Optional | May be submitted where an entry has been removed from the ELECTIVE ADMISSION |

| | | | | |
|---|---|---|---|---|
| | (Remove)**Commissioning Data Set version 6-2 only** | | Elective Admission List Event During Period (Remove) Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009. | LIST during the time period reported. |
| CDS 080 | Elective Admission List Event During Period (Offer) **Commissioning Data Set version 6-2 only** | Monthly if used | Optional<br><br>Elective Admission List Event During Period (Offer) CDS records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009. | May be submitted where an offer has been made during the time period reported. |
| CDS 090 | Elective Admission List Event During Period (Available / Unavailable) - **Commissioning Data Set version 6-2 only** | Monthly if used | Optional | May be submitted where a patient becomes Available or Unavailable during the time period reported. |
| CDS 100 | Elective Admission List Event During Period (Old Service Agreement) **Commissioning Data Set version 6-2 only** | Monthly if used | Optional | May be submitted where the Commissioner has been changed during the time period reported. |
| CDS 110 | Elective Admission List Event During Period (New Service Agreement) **Commissioning Data Set version 6-2 only** | Monthly if used | Optional | May be submitted where the Commissioner has been changed during the time period reported. |
| CDS 120 | Finished Birth Episode | Weekly | All finished Admitted Patient Care data must be submitted "at least monthly" (EL - Dec 1995).<br>This includes Non-Contract Activity. | NHS Acute Health Care Providers must submit data weekly.<br><br>NHS Community Health Care Providers, NHS Mental Health Care Providers and Independent Sector Healthcare Providers undertaking acute care, must submit data weekly as soon as possible and no later than 31 March 2021. |
| CDS 130 | Finished General Episode | Weekly | All finished Admitted Patient Care data must be submitted "at least monthly" (EL - Dec 1995). | NHS Acute Health Care Providers must submit data weekly. |

| | | | | |
|---|---|---|---|---|
| | | | This includes Non-Contract Activity.<br><br>Finished General Episode Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009. | NHS Community Health Care Providers, NHS Mental Health Care Providers and Independent Sector Healthcare Providers undertaking acute care, must submit data weekly as soon as possible and no later than 31 March 2021. |
| CDS 140 | Finished Delivery Episode | Weekly | All finished Admitted Patient Care data must be submitted "at least monthly" (EL - Dec 1995).<br>This includes Non-Contract Activity. | NHS Acute Health Care Providers must submit data weekly.<br><br>NHS Community Health Care Providers, NHS Mental Health Care Providers and Independent Sector Healthcare Providers undertaking acute care, must submit data weekly as soon as possible and no later than 31 March 2021. |
| CDS 150 | Other Birth | Monthly | This includes Home Birth. | All Episodes that have finished relevant to the time period defined by the Commissioning Data Set Submission Protocol being used. |
| CDS 160 | Other Delivery | Monthly | This includes Home Delivery. | All Episodes that have finished relevant to the time period defined by the Commissioning Data Set Submission Protocol being used. |
| ~~CDS 170~~ | ~~The Detained and/or Long Term Psychiatric Census~~ | ~~Annually~~ | ~~Required by the NHS Digital.~~<br><br>~~May optionally be sent more regularly, usually monthly.~~ | ~~Reflects data as at the 31st March each year.~~<br>~~All Episodes that are relevant to the time period defined by the Commissioning Data Set Submission Protocol being used.~~ |
| CDS 170 | The Detained and/or Long Term Psychiatric Census - **Commissioning Data Set version 6-2 only** | Annually | Required by the NHS Digital.<br><br>May optionally be sent more regularly, usually monthly. | Reflects data as at the 31st March each year.<br>All Episodes that are relevant to the time period defined by the Commissioning Data Set Submission Protocol being used. |
| CDS 180 | Unfinished Birth Episode | Annually | The Annual Census / Unfinished Census. Required by the NHS Digital.<br><br>May optionally be sent more regularly, usually monthly. | Data relating to episodes that were unfinished as at midnight on 31st March and have not been included in the Detained and/or Long Term Psychiatric Census, and have not been submitted to the Secondary Uses Service in either |

| | | | | |
|---|---|---|---|---|
| | | | | Finished or Unfinished Commissioning Data Set data, must be submitted to the Secondary Uses Service. |
| CDS 190 | Unfinished General Episode | Annually | The Annual Census / Unfinished Census. Required by the NHS Digital<br><br>May optionally be sent more regularly, usually monthly.<br><br>Unfinished General Episode Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009. | Data relating to episodes that were unfinished as at midnight on 31st March and have not been included in the Detained and/or Long Term Psychiatric Census, and have not been submitted to the Secondary Uses Service in either Finished or Unfinished Commissioning Data Set data, must be submitted to the Secondary Uses Service. |
| CDS 200 | Unfinished Delivery Episode | Annually | The Annual Census / Unfinished Census. Required by the NHS Digital<br><br>May optionally be sent more regularly, usually monthly. | Data relating to episodes that were unfinished as at midnight on 31st March and have not been included in the Detained and/or Long Term Psychiatric Census, and have not been submitted to the Secondary Uses Service in either Finished or Unfinished Commissioning Data Set data, must be submitted to the Secondary Uses Service. |

**COMMISSIONING DATA SET NOTATION**

Change to Supporting Information: Changed Dataset, Description

~~The Commissioning Data Set is the basic structure used for the submission of commissioning data to the Secondary Uses Service and is designed to be capable of individually conveying many different Commissioning Data Set structures, encompassing Emergency Care Attendances, Out-Patient Attendances, Admitted Patient Care and Elective Admission List.~~The Commissioning Data Set is the basic structure used for the submission of commissioning data to the Secondary Uses Service and is designed to be capable of individually conveying many different Commissioning Data Set structures, encompassing Emergency Care Attendances, Out-Patient Attendances, Admitted Patient Care. (Elective Admission List is also defined in Commissioning Data Set version 6-2 only).

The Commissioning Data Sets have been defined in specific components known as a CDS Type.

Specific notation is used to indicate the requirements of the Commissioning Data Set XML Schema Design conditions for submission of data in the Commissioning Data Sets.

The structure of the Commissioning Data Set XML Schema is shown by the use of Data Groups and Sub Groups within those Data Groups. For each Data Group, Sub Group and individual Data Element, the allowed cardinality at each level is also shown in the "Status" and "Repeats" columns.

The CDS Type specifications must therefore be read in this hierarchy, using the Status and Repeat conditions within the Data Groups and Sub Groups, to determine the requirements for the individual Data Elements.

### Status Column Notation

The Notation used for the **"STATUS"** column is as follows:

| STATUS | MEANING | DESCRIPTION |
|---|---|---|
| ~~**M**~~ | ~~**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.~~<br><br>~~If a data item is shown as **MANDATORY**, this should also be regarded as **REQUIRED** by the Department of Health and Social Care.~~<br><br>~~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.~~<br><br>~~For instance, although the Consultant 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.~~ |
| ~~**R**~~ | ~~**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.~~<br><br>~~Note that "temporal" conditions may mean that there are instances where this directive cannot be fulfilled.~~<br><br>~~For instance in a CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set, ICD and OPCS data elements 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.~~ |
| **M** | **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.<br><br>If a data item is shown as **MANDATORY**, this should also be regarded as **REQUIRED** by the Department of Health and Social Care.<br><br>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.<br><br>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. |
| **R** | **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.<br><br>Note that "temporal" conditions may mean that there are instances where this directive cannot be fulfilled.<br><br>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. |
| **O** | **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.<br><br>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. |
| ~~**X**~~ | ~~**X**~~ | ~~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. The Data Element will be in italics and not linked to the Data Element where one exists.~~ |
| **X** | **Not yet authorised** | 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. |

**Repeats Column Notation**

~~The Notation used for the **"REPEATS"** column is as follows:~~Examples of the Notation used for the **"REPEATS"** column are as follows:

| REPEATS | DESCRIPTION |
|---|---|
| **0..1** | This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 0 to a maximum of 1. |
| **0..9** | This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 0 to a maximum of 9. |
| **0..*** | This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 0 to an unlimited maximum. |
| **1..1** | This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 1 to a maximum of 1. |
| **1..97** | This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 1 to a maximum of 97. |
| **1..*** | This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 1 to an unlimited maximum. |

**Rules Column Notation**

An entry in the **"Rules"** column shows that a specific Rule applies to submission of an individual Data Element.

The meaning of these Rules can be found in Commissioning Data Set Business Rules.

**Notation Examples**

~~The following are examples of some common scenarios.~~The following are examples of some common scenarios:

| **EXAMPLE 1:**<br>**A MANDATORY Data Group with differing Sub-Groups and component data status conditions.** |
|---|
| The following example shows a **MANDATORY** Data Group - therefore the Data Group must be present for the CDS Type to be validated and accepted for processing by the Secondary Uses Service.<br><br>When a Data Group is used:<br><br>1. All **MANDATORY** Sub Groups and/or Data Elements must be present<br>2. Any **REQUIRED** Sub Groups and/or Data Elements must be present if the data is available<br>3. Any **OPTIONAL** Sub Groups and/or Data Elements may be omitted<br><br>The following data structure is one of three options when completing the Patient Identity Data Group: |

| | | | | | |
|---|---|---|---|---|---|
| ~~1..1~~ | ~~**DATA GROUP: VERIFIED IDENTITY STRUCTURE**<br>**Must be used where the** NHS NUMBER STATUS INDICATOR CODE **National Code Value = 01 = Verified**~~ | | | | ~~**Rules**~~ |
| ~~R~~ | ~~0..1~~ | ~~**DATA GROUP: LOCAL IDENTIFIER STRUCTURE**~~ | | | |
| | | ~~**M**~~ | ~~**1..1**~~ | ~~LOCAL PATIENT IDENTIFIER~~ | ~~F~~ |
| | | ~~**M**~~ | ~~**1..1**~~ | ~~ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)~~ | ~~F~~ |
| ~~**M**~~ | ~~**1..1**~~ | ~~**Data Element Components**~~ | | | ~~**Rules**~~ |
| | | ~~**M**~~ | ~~**1..1**~~ | ~~NHS NUMBER~~ | ~~F~~ |
| | | ~~**M**~~ | ~~**1..1**~~ | ~~NHS NUMBER STATUS INDICATOR CODE~~ | ~~V~~ |
| | | ~~**M**~~ | ~~**1..1**~~ | ~~POSTCODE OF USUAL ADDRESS~~ | ~~S3~~ |
| | | ~~R~~ | ~~0..1~~ | ~~ORGANISATION CODE (RESIDENCE RESPONSIBILITY)~~ | ~~F~~ |
| | | ~~R~~ | ~~0..1~~ | ~~PERSON BIRTH DATE~~ | ~~F~~<br>~~S3~~<br>~~S12~~ |
| **1..1** | **DATA GROUP: VERIFIED IDENTITY STRUCTURE**<br>**Must be used where the NHS NUMBER STATUS INDICATOR CODE National Code = 01 (Number present and verified)** | | | | |
| R | 0..1 | DATA GROUP: LOCAL IDENTIFIER STRUCTURE | | | **Rules** |
| | | **M** | **1..1** | LOCAL PATIENT IDENTIFIER (EXTENDED) | F<br>S3 |
| | | **M** | **1..1** | ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) | F |
| **M** | **1..1** | **Data Element Components** | | | **Rules** |
| | | **M** | **1..1** | NHS NUMBER | F<br>S3 |
| | | **M** | **1..1** | NHS NUMBER STATUS INDICATOR CODE | V |
| | | **M** | **1..1** | POSTCODE OF USUAL ADDRESS | F<br>S3 |
| | | R | 0..1 | ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | F |
| | | R | 0..1 | PERSON BIRTH DATE | F<br>S3<br>S12 |

~~**EXPLANATION:**~~

~~The parent Data Group has a **"Status"** of **M=MANDATORY** which indicates that this Data Group must be present in the Commissioning Data Set to ensure correct validation and acceptance when submitted to the Secondary Uses~~

~~Service. The parent Data Group **"Repeats"** = 1..1 indicates that only one occurrence of this Data Group must flow in this particular Commissioning Data Set record.~~

~~The Sub Group of "Local Identifier Structure" is marked as **R=REQUIRED** and therefore must be populated if the data is available. The **"Repeats"** notation of 0..1 indicates that population of this Sub Group is not necessary to enable the Commissioning Data Set record to be sent to the Secondary Uses Service. If it is sent, then only one occurrence of this Sub Group may flow in this particular Commissioning Data Set record.~~
~~Both Data Elements in the Sub Group are marked **M=MANDATORY** and must both be correctly populated.~~

~~The Sub Group of "Data Element Components" is a "generic" structure and is marked as **M=MANDATORY** and therefore must be populated. The "Repeats" notation of 1..1 indicates that only one occurrence of this Data Group may flow in this particular Commissioning Data Set record. All the Data Elements marked with **M=MANDATORY** must be populated. PERSON BIRTH DATE however is marked with **R=REQUIRED**, so must also be completed if the data is available.~~

**EXPLANATION:**

The parent DATA GROUP: VERIFIED IDENTITY STRUCTURE has a **"Status"** of **M=MANDATORY** which indicates that this Data Group must be present in the Commissioning Data Set to ensure correct validation and acceptance when submitted to the Secondary Uses Service. The parent Data Group **"Repeats"** = 1..1 indicates that only one occurrence of this Data Group must flow in this particular Commissioning Data Set record.

The Sub Group of "DATA GROUP: LOCAL IDENTIFIER STRUCTURE" is marked as **R=REQUIRED** and therefore must be populated if the data is available. The **"Repeats"** notation of 0..1 indicates that population of this Sub Group is not necessary to enable the Commissioning Data Set record to be sent to the Secondary Uses Service. If it is sent, then only one occurrence of this Sub Group may flow in this particular Commissioning Data Set record.
Both Data Elements in the Sub Group are marked **M=MANDATORY** and must both be correctly populated.

The Sub Group of "Data Element Components" is a "generic" structure and is marked as **M=MANDATORY** and therefore must be populated. The "**Repeats**" notation of 1..1 indicates that only one occurrence of this Data Group may flow in this particular Commissioning Data Set record. All the Data Elements marked with **M=MANDATORY** must be populated. PERSON BIRTH DATE however is marked with **R=REQUIRED**, so must also be completed if the data is available.

**EXAMPLE 2:**
**A REQUIRED Data Group with differing component data status conditions.**

The following example shows a **REQUIRED** Data Group. This data must be present in the relevant Commissioning Data Set if available. However, if submitted to the Secondary Uses Service, omission of this **REQUIRED** Data Group will not cause rejection.

When the Data Group is used:

1. All **MANDATORY** Sub Groups and/or Data Elements must be utilised
2. Any **REQUIRED** Sub Groups and/or Data Elements must be present if the data is available
3. Any **OPTIONAL** Sub Groups and/or Data Elements may be omitted

| Notation | | DATA GROUP: CONSULTANT EPISODE - CLINICAL DIAGNOSIS GROUP (ICD) |
|---|---|---|
| ~~Group Status R~~ | ~~Group Repeats 0..1~~ | ~~FUNCTION: To carry the details of the ICD coded Clinical Diagnoses.~~ |
| Group Status R | Group Repeats 0..1 | FUNCTION: To carry the details of the ICD coded Clinical Diagnoses for the Patient. |

| M | 1..1 | Data Element Components | | | Rules |
|---|---|---|---|---|---|
| | | M | 1..1 | | V |

| | | | | DIAGNOSIS SCHEME IN USE | |
|---|---|---|---|---|---|
| M | 1..1 | DATA GROUP: PRIMARY DIAGNOSIS | | | Rules |
| | | M | 1..1 | DATA GROUP: PRIMARY DIAGNOSIS | Rules |
| | | | M | 1..1 PRIMARY DIAGNOSIS (ICD) | F H4 |
| O | 0..1 | PRESENT ON ADMISSION INDICATOR | F | | |
| O | 0..* | DATA GROUP: SECONDARY DIAGNOSIS | | | Rules |
| | | R | 0..* | DATA GROUP: SECONDARY DIAGNOSIS | Rules |
| | | | M | 1..1 SECONDARY DIAGNOSIS (ICD) | F H4 |
| O | 0..1 | PRESENT ON ADMISSION INDICATOR | F | | |

**EXPLANATION:**

The Data Group **"Status"** of **R=Required** indicates that this Data Group must be populated in the relevant Commissioning Data Set if the data is available. The Data Group **"Repeats" = 0..1** indicates that population of this Data Group is not necessary to enable the Commissioning Data Set to be sent to the Secondary Uses Service. If it is sent, then only one occurrence of this Data Group may flow in this particular Commissioning Data Set record.

If the Data Group is completed then the Data Element PROCEDURE SCHEME IN USE, marked as **M=MANDATORY**, must be populated. The **"Repeats"** notation of 1..1 indicates that only one occurrence of this Data Element is valid.

If the Data Group is completed then the Data Element PRIMARY DIAGNOSIS (ICD), marked as **M=MANDATORY**, must be populated. The **"Repeats"** notation of 1..1 indicates that only one occurrence of this Data Element is valid.

If the Data Group is completed then the Sub Group "Secondary Diagnoses", marked as **O=OPTIONAL**, may be omitted, but if populated it must be in the correct format. The **"Repeats"** notation of 0..* indicates that unlimited occurrences of this Data Element are valid. Each occurrence must contain a valid SECONDARY DIAGNOSIS (ICD).

**EXPLANATION:**

The DATA GROUP: CONSULTANT EPISODE - CLINICAL DIAGNOSIS GROUP (ICD) **"Status"** of **R=Required** indicates that this Data Group must be populated in the relevant Commissioning Data Set if the data is available. The Data Group **"Repeats" = 0..1** indicates that population of this Data Group is not necessary to enable the Commissioning Data Set to be sent to the Secondary Uses Service. If it is sent, then only one occurrence of this Data Group may flow in this particular Commissioning Data Set record.

If the Data Group is completed then the Data Element PROCEDURE SCHEME IN USE, marked as **M=MANDATORY**, must be populated. The **"Repeats"** notation of 1..1 indicates that only one occurrence of this Data Element is valid.

If the Data Group is completed then the Data Element PRIMARY DIAGNOSIS (ICD), marked as **M=MANDATORY**, must be populated. The **"Repeats"** notation of 1..1 indicates that only one occurrence of this Data Element is valid.

If the Data Group is completed then the Sub Group "Secondary Diagnoses", marked as **R=REQUIRED**, must be completed if the data is available, and if populated it must be in the correct format. The **"Repeats"** notation of 0..*

indicates that unlimited occurrences of this Data Element are valid. Each occurrence must contain a valid SECONDARY DIAGNOSIS (ICD).

**EXAMPLE 3:**
**An OPTIONAL Data Group with differing component data status conditions.**

The following example shows an **OPTIONAL** Data Group. Its inclusion in the Commissioning Data Sets is therefore determined by "local agreement" between ORGANISATIONS exchanging the data.

When the Data Group is used:

1. All **MANDATORY** Sub Groups and/or Data Elements must be utilised
2. Any **REQUIRED** Sub Groups and/or Data Elements must be present if the data is available
3. Any **OPTIONAL** Sub Groups and/or Data Elements may be omitted

| ~~Notation~~ | | ~~DATA GROUP: CONSULTANT EPISODE - CLINICAL DIAGNOSIS GROUP (ICD)~~ |
|---|---|---|
| ~~Group Status~~ ~~O~~ | ~~Group Repeats~~ ~~0..1~~ | ~~FUNCTION:~~ ~~To carry the details of the ICD coded Clinical Diagnoses.~~ |
| Notation | | DATA GROUP: PATIENT PATHWAY |
| Group Status O | Group Repeats 0..1 | FUNCTION: To carry the details of the Patient Pathway. |

| | | | | | |
|---|---|---|---|---|---|
| ~~M~~ | ~~1..1~~ | ~~Data Element Components~~ | | | ~~Rules~~ |
| | | ~~M~~ | ~~1..1~~ | ~~DIAGNOSIS SCHEME IN USE~~ | ~~V~~ |
| ~~M~~ | ~~1..1~~ | ~~DATA GROUP: PRIMARY DIAGNOSIS~~ | | | ~~Rules~~ |
| | | ~~M~~ | ~~1..1~~ | ~~PRIMARY DIAGNOSIS (ICD)~~ | ~~F~~ ~~H4~~ |
| | | ~~O~~ | ~~0..1~~ | ~~PRESENT ON ADMISSION INDICATOR~~ | ~~F~~ |
| ~~O~~ | ~~0..*~~ | ~~DATA GROUP: SECONDARY DIAGNOSIS~~ | | | ~~Rules~~ |
| | | ~~M~~ | ~~1..1~~ | ~~SECONDARY DIAGNOSIS (ICD)~~ | ~~F~~ ~~H4~~ |
| | | ~~O~~ | ~~0..1~~ | ~~PRESENT ON ADMISSION INDICATOR~~ | ~~F~~ |
| **M** | **1..1** | **DATA GROUP: PATIENT PATHWAY IDENTITY** | | | **Rules** |
| | **M** *Or* **M** | **1..1** **1..1** | UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) *Or* PATIENT PATHWAY IDENTIFIER | | F F I2 |
| | **M** | **1..1** | ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER) | | F I2 |
| **M** | **1..1** | **DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS** | | | **Rules** |
| | **M** | **1..1** | REFERRAL TO TREATMENT PERIOD STATUS | | V |
| | **M** | **1..1** | WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET) | | V |
| | O | 0..1 | REFERRAL TO TREATMENT PERIOD START DATE | | F S13 |
| | O | 0..1 | REFERRAL TO TREATMENT PERIOD END DATE | | F S13 |

~~**EXPLANATION:**~~

~~The Data Group **"Status"** of **O=OPTIONAL** indicates that this Data Group may be omitted at its inclusion in the Commissioning Data Set is 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.~~<br><br>~~The Data Group **"Repeats" = 0..1** indicates that population of this Data Group is not necessary to enable the Commissioning Data Set to be sent to the Secondary Uses Service. If it is sent, then only one occurrence of this Data Group may flow in this particular Commissioning Data Set record.~~<br><br>~~If the Data Group is completed then the Data Element DIAGNOSIS SCHEME IN USE, marked as **M=MANDATORY**, must be populated. The **"Repeats"** notation of 1..1 indicates that only one occurrence of this Data Element is valid.~~<br><br>~~If the Data Group is completed then the Data Element PRIMARY DIAGNOSIS (ICD), marked as **M=MANDATORY**, must be populated. The **"Repeats"** notation of 1..1 indicates that only one occurrence of this Data Element is valid.~~<br><br>~~If the Data Group is completed then the Sub Group "Secondary Diagnoses", marked as **O=OPTIONAL**, may be omitted, but if populated it must be in the correct format. The **"Repeats"** notation of 0..* indicates that unlimited occurrences of this Data Element are valid. Each occurrence must contain a valid SECONDARY DIAGNOSIS (ICD).~~ |
| **EXPLANATION:**<br><br>The DATA GROUP: PATIENT PATHWAY **"Status"** of **O=OPTIONAL** indicates that this Data Group may be omitted and its inclusion in the Commissioning Data Set is determined by "local agreement" between the ORGANISATIONS exchanging the data.<br><br>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.<br><br>The Data Group **"Repeats" = 0..1** indicates that population of this Data Group is not necessary to enable the Commissioning Data Set to be sent to the Secondary Uses Service. If it is sent, then only one occurrence of this Data Group may flow in this particular Commissioning Data Set record.<br><br>If the DATA GROUP: PATIENT PATHWAY is submitted, then both of the sub-groups (DATA GROUP: PATIENT PATHWAY IDENTITY, and DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS) must be submitted. Data Elements marked as **M=MANDATORY**, must be populated. The **"Repeats"** notation of 1..1 indicates that only one occurrence of each of these Data Elements are valid.<br><br>In the DATA GROUP: PATIENT PATHWAY sub-group, **either** UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) **or** PATIENT PATHWAY IDENTIFIER must be submitted (but not both). |

#### COMMISSIONING DATA SETS INTRODUCTION

Change to Supporting Information: Changed Description

The Commissioning Data Sets (CDS) are maintained and developed by the NHS Digital, in accordance with the needs of the NHS and the Department of Health and Social Care.

Commissioning Data Sets form the basis of data on ACTIVITY carried out by ORGANISATIONS reported centrally for monitoring and payment purposes. They support the current Healthcare Resource Group (HRG) version for calculation of payment to trusts and monitoring of other initiatives.

Requests for changes to the Commissioning Data Sets should be submitted via email to enquiries@nhsdigital.nhs.uk, stating "Commissioning Data Sets" in the subject line.

For further information on Commissioning Data Sets, see:

- Commissioning Data Sets Overview
- Commissioning Data Set Version 6-2 Type List
- Commissioning Data Set Version 6-3 Type List
- Commissioning Data Set Versions

- Commissioning Data Set Addressing Grid
- Commissioning Data Set Business Rules
- Commissioning Data Set Data Duplication
- Commissioning Data Set Mandated Data Flows
- Commissioning Data Set Notation
- Commissioning Data Set Submission and Organisation Mergers
- Commissioning Data Set Submission Protocol
- Referral To Treatment Clock Stop Administrative Event
- Security Issues and Patient Confidentiality

- **CDS XML Schema:**
- Commissioning Data Set XML Schema Overview
- Commissioning Data Set XML Schema Design
- Commissioning Data Set XML Schema Version Numbering
- Commissioning Data Set XML Schema Documentation
- XML Schema TRUD Download

- **XML Schema Constraints:**
- Commissioning Data Set Version 6-2 XML Schema Constraints
- Commissioning Data Set Version 6-2-1 XML Schema Constraints
- Commissioning Data Set Version 6-2-2 XML Schema Constraints
- Commissioning Data Set Version 6-2-3 XML Schema Constraints
- Commissioning Data Set Version 6-3 XML Schema Constraints

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**COMMISSIONING DATA SETS MENU**

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Change to Supporting Information: Changed Description

- CDS Overview
- CDS Version 6-2 Type List
- CDS Version 6-3 Type List
- CDS Versions

- CDS Addressing Grid
- CDS Business Rules
- CDS Data Duplication
- CDS Mandated Data Flows
- CDS Notation
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- CDS Submission Protocol
- Referral To Treatment Clock Stop Administrative Event
- Security Issues and Patient Confidentiality

- **CDS XML Schema:**
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- CDS XML Schema Design
- CDS XML Schema Version Numbering
- CDS XML Schema Documentation
- XML Schema TRUD Download

**XML Schema Constraints:**
- CDS Version 6-2 XML Schema Constraints
- CDS Version 6-2-1 XML Schema Constraints
- CDS Version 6-2-2 XML Schema Constraints
- CDS Version 6-2-3 XML Schema Constraints

- CDS Version 6-3 XML Schema Constraints

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**COMMISSIONING DATA SETS OVERVIEW**

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Change to Supporting Information: Changed Description

The purpose of the Commissioning Data Sets is to enable conformant health ACTIVITY information to be generated, independent of the ORGANISATION or system that maintains it. This enables health CARE PROFESSIONALS to measure and compare the delivery and quality of care provided and to support them in sharing information with other health professionals and ORGANISATIONS.

Commissioning Data Sets currently support the following ACTIVITIES:

- monitoring and managing NHS SERVICE AGREEMENTS
- developing commissioning plans
- supporting the National Tariff Payment System
- underpinning clinical governance
- understanding the health needs of the population
- reporting waiting time measurement

Information on care provided for all PATIENTS by Health Care Providers (both NHS and Independent Sector Healthcare Providers for NHS PATIENTS only) must be submitted to the Secondary Uses Service according to the Commissioning Data Set Mandated Data Flows guidelines.

Commissioning ORGANISATIONS need access to data to monitor Non-Contract Activity as part of the management of their NHS SERVICE AGREEMENTS, and to monitor in-year REFERRAL REQUESTS to investigate the sources and reasons for Non-Contract Activity.

The Department of Health and Social Care requires accurate data for all PATIENTS admitted, treated as out-patients or treated as an Emergency Care Attendance by Health Care Providers, including PATIENTS receiving private treatment. The Commissioning Data Sets also includes NHS PATIENTS treated electively in the independent sector and overseas.

~~Referral To Treatment Clock Stop Administrative Events may also flow using the CDS V6-2 Type 020 - Outpatient Commissioning Data Set.~~Referral To Treatment Clock Stop Administrative Events may also flow using the CDS V6-2 Type 020 - Outpatient Commissioning Data Set or CDS V6-3 Type 020 - Outpatient Commissioning Data Set. This allows the Secondary Uses Service to build accurate PATIENT PATHWAYS for the reporting of waiting time measurement.

**CDS Types**

~~The Commissioning Data Sets are the basic structure used for the submission of commissioning data to the Secondary Uses Service and is designed to be capable of individually conveying many different Commissioning Data Set structures encompassing Emergency Care Attendances, Out-Patient Attendances, Future Attendances, Admitted Patient Care and Elective Admission List data.~~The Commissioning Data Sets are the basic structure used for the submission of commissioning data to the Secondary Uses Service and is designed to be capable of individually conveying many different Commissioning Data Set structures encompassing Emergency Care Attendances, Care Professional Out-Patient Attendances, and Care Professional Admitted Care Episodes for both CDS version 6-2 and CDS version 6-3. CDS version 6-2 also supports the submission of Future Out-Patient Attendances and Elective Admission List data.

**Further Information**

Further guidance material for submission of data to the Secondary Uses Service can be found at: Secondary Uses Service (SUS Guidance).

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**COMMISSIONING DATA SET SUBMISSION PROTOCOL**

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Change to Supporting Information: Changed Description

The Commissioning Data Sets submitted by providers carry information to determine the update method to be used by the Secondary Uses Service in order to update the national database.

These update rules are known as the Commissioning Data Set Submission Protocol and the set of data controls used to indicate this are carried in the Commissioning Data Set Transaction Header Group which must be present and correct in every CDS Type submitted to the Secondary Uses Service.

**Net Change:**
~~Net Change processes are managed by specific data settings as defined in the CDS V6-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol option of the CDS Transaction Header Group.~~Net Change processes are managed by specific data settings as defined in the CDS V6-2 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 option of the CDS Transaction Header Group. The Secondary Uses Service uses the following data to manage the database:

- CDS SENDER IDENTITY/ORGANISATION IDENTIFIER (CDS SENDER)
- CDS UNIQUE IDENTIFIER
- CDS APPLICABLE DATE
- CDS APPLICABLE TIME

Note that CDS SENDER IDENTITY is used for CDS V6-2, CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set and CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set. ~~ORGANISATION IDENTIFIER (CDS SENDER) is used for CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set and all other Commissioning Data Set versions after CDS V6-2.~~ ORGANISATION IDENTIFIER (CDS SENDER) is used for CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set and CDS Version 6-3 onwards.

~~Each CDS Type must have a CDS UNIQUE IDENTIFIER which must be uniquely maintained for the life of that Commissioning Data Set record.~~Each CDS Type must have a CDS UNIQUE IDENTIFIER which must be uniquely maintained throughout the life of that Commissioning Data Set record. This is a particular consideration where mergers and/or healthcare systems are changed or upgraded, see Commissioning Data Set Submission and Organisation Mergers. Any change to the CDS UNIQUE IDENTIFIER during the "lifetime" of a Commissioning Data Set record will almost certainly result in a duplicate record being lodged in the Secondary Uses Service database.

A Commissioning Data Set record delete transaction must be sent to the Secondary Uses Service database when any previously sent Commissioning Data Set record requires deletion/removal, for example to reflect Commissioner changes etc.

~~Where CDS UPDATE TYPE 1 is required (delete/cancellation), an empty XML element called 'Delete Transaction' can be used instead of submitting he original CDS Type record, after the CDS V6-2 Type 005N - CDS Transaction Header Group - Net Change Protocol. See the CDS V6-2- XML Schema Release Notes which can be downloaded via the XML Schema TRUD Download page.~~Where CDS UPDATE TYPE 1 is required (delete/cancellation), an empty XML element called 'Delete Transaction' can be used instead of submitting he original CDS Type record, after the CDS V6-2 Type 005N - CDS Transaction Header Group - Net Change Protocol/ CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol. See the CDS V6-2 or CDS V6-3 XML Schema Release Notes which can be downloaded via the XML Schema TRUD Download page.

The CDS APPLICABLE DATE and CDS APPLICABLE TIME must be used to ensure that all Commissioning data is updated in the Secondary Uses Service database in the correct chronological order.

The CDS SENDER IDENTITY/ORGANISATION IDENTIFIER (CDS SENDER) **must not change during the lifetime of the CDS data**.
~~This is particularly significant for multiple and/or merged ORGANISATIONS, and for those services who submit data on behalf of another NHS Trust, NHS Foundation Trust or Independent Sector Healthcare Provider.~~ This is particularly significant for multiple and/or merged ORGANISATIONS, and for those services who submit data on behalf of another NHS Trust, NHS Foundation Trust or Independent Sector Healthcare Provider.

**Bulk Replacement**
~~Bulk Replacement processes are managed by specific data settings as defined in the CDS V6-2 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol option of the CDS Transaction Header Group.~~Bulk Replacement processes are managed by specific data settings as defined in the CDS V6-2 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 option of the CDS Transaction Header Group. The Secondary Uses Service uses the following data to manage the database:

- CDS SENDER IDENTITY/ORGANISATION IDENTIFIER (CDS SENDER)
- CDS BULK REPLACEMENT GROUP CODE
- CDS EXTRACT DATE
- CDS EXTRACT TIME
- CDS REPORT PERIOD START DATE
- CDS REPORT PERIOD END DATE

Note that CDS SENDER IDENTITY is used for CDS V6-2, CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set and CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set. ~~ORGANISATION IDENTIFIER (CDS SENDER) is used for CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set and all other Commissioning Data Set versions after CDS V6-2.~~ ORGANISATION IDENTIFIER (CDS SENDER) is used for CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set and CDS V6-3 onwards.

Every CDS Type must be submitted using the correct CDS BULK REPLACEMENT GROUP CODE.

The CDS REPORT PERIOD START DATE and the CDS REPORT PERIOD END DATE, (i.e. the effective date period), must be valid and consistent, and reflect the dates relevant to the Commissioning data contained in the interchange.

The CDS SENDER IDENTITY/ORGANISATION IDENTIFIER (CDS SENDER) must not change during the lifetime of the Commissioning Data Set record. This is particularly significant for multiple and/or merged ORGANISATIONS, and for those services who submit data on behalf of another ORGANISATION.

~~For submissions of CDS V6-2, CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set Type 011 and CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set, the CDS PRIME RECIPIENT IDENTITY is Mandatory for submission in the CDS Type 005B - CDS Transaction Header Group - Bulk Update Protocol and CDS Type 005N - CDS Transaction Header Group - Net Change Protocol.~~For submissions of CDS V6-2, CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set Type 011 and CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set, the CDS PRIME RECIPIENT IDENTITY is Mandatory for submission in the CDS Type 005B (CDS Transaction Header Group - Bulk Update Protocol) and CDS Type 005N (CDS Transaction Header Group - Net Change Protocol). However, it no longer forms part of the key for the process of determining duplicate records within the Secondary Uses Service. ~~Note that the CDS PRIME RECIPIENT IDENTITY continues to be used to determine data access requirements within the Secondary Uses Service.~~ Note that the CDS PRIME RECIPIENT IDENTITY continues to be used to determine data access requirements within the Secondary Uses Service for Commissioning Data Set version 6-2 submissions. For Commissioning Data Set version 6-3 and CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set, data element ORGANISATION IDENTIFIER (CDS RECIPIENT) is used for this purpose.

~~Versions of the CDS Type 005B - CDS Transaction Header Group - Bulk Update Protocol and CDS Type 005N - CDS Transaction Header Group - Net Change Protocol from CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set onwards use ORGANISATION IDENTIFIER (CDS RECIPIENT) which is no longer Mandatory for submission; however the requirement for this data element to support access to data remains.~~

If it is necessary to change any of this data during the lifetime of a Commissioning Data Set record, then the Secondary Uses Service (SUS) Service Desk should be contacted for advice. See the NHS Digital website at: Secondary Uses Service (SUS).

It is strongly advised that users of the Bulk Replacement Mechanism maintain a correctly generated CDS UNIQUE IDENTIFIER within the Commissioning data. This will establish a migration path towards the use of the Net Change Mechanism and will also then minimise the risk of creating duplicate Commissioning Data Set data.

**Sub contracting**

If a Health Care Provider sub-contracts healthcare provision and its associated Commissioning Data Set submission to a second ORGANISATION (eg a different Health Care Provider or a Shared Services Organisation), arrangements to submit the Commissioning Data Set data must be made locally to ensure that only one ORGANISATION sends the Commissioning Data Set data to the Secondary Uses Service.

If the second ORGANISATION wishes to add other Commissioning data to the Secondary Uses Service database to that already submitted by the first ORGANISATION, both parties need to ensure that a different CDS SENDER IDENTITY/ORGANISATION IDENTIFIER (CDS SENDER) is used.

Note: Data sent using the same CDS SENDER IDENTITY/ORGANISATION IDENTIFIER (CDS SENDER) by two different parties will most likely overwrite each other's data in the Secondary Uses Service database. Further advice can be obtained from the Secondary Uses Service (SUS) Service Desk, see the NHS Digital website at: SUS Guidance.

Users should be aware of how the 15 character code of their CDS INTERCHANGE SENDER IDENTITY (also known as the EDI Address) is created. This may depend on how their XML interface solution has been set up. It may not be possible to rely on a change to the ORGANISATION CODE (CODE OF PROVIDER)/ORGANISATION IDENTIFIER (CODE OF PROVIDER) in order to change the CDS INTERCHANGE SENDER IDENTITY should this become necessary.

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**COMMISSIONING DATA SET VERSION 6-3 TYPE LIST**

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Change to Supporting Information: New Supporting Information

| CDS TYPE |
| --- |
| **Outpatient Care:** |
| CDS V6-3 Type 020 - Outpatient CDS |
| **Admitted Patient Care:** |
| CDS V6-3 Type 120 - Admitted Patient Care - Finished Birth Episode CDS |
| CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode CDS |
| CDS V6-3 Type 140 - Admitted Patient Care - Finished Delivery Episode CDS |
| |
| CDS V6-3 Type 150 - Admitted Patient Care - Other Birth Event CDS |
| CDS V6-3 Type 160 - Admitted Patient Care - Other Delivery Event CDS |
| |
| CDS V6-3 Type 180 - Admitted Patient Care - Unfinished Birth Episode CDS |
| CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode CDS |
| CDS V6-3 Type 200 - Admitted Patient Care - Unfinished Delivery Episode CDS |
| **Commissioning Data Set Interchange and Message Controls - Mandatory for every Interchange:** |
| CDS V6-3 Type 001 - CDS Interchange Header |
| CDS V6-3 Type 002 - CDS Interchange Trailer |
| CDS V6-3 Type 003 - CDS Message Header |
| CDS V6-3 Type 004 - CDS Message Trailer |
| **Commissioning Data Set Transaction Header Group - Mandatory for every Commissioning Data Set:** |
| CDS V6-3 Type 005B - CDS Transaction Header Group - Bulk Update Protocol |
| **or** |
| CDS V6-3 Type 005N - CDS Transaction Header Group - Net Change Protocol |

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**COMMISSIONING DATA SET VERSIONS**

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Change to Supporting Information: Changed Description

Listed below are the Commissioning Data Set versions since 2001.

**Current versions:**

- November 2012: CDS Version 6-2 Type List (updated October 2017 to support CDS Version 6-2-1, April 2019 to support CDS Version 6-2-2, April 2021 to support CDS Version 6-2-3 and April 2021 to support CDS Version 6-2-0)

- April 2022: CDS Version 6-3 Type List

**Retired versions:**

- November 2008: CDS Version 6-1 Type List
- December 2007 to November 2012: CDS Version 6-0
- April 2005 to March 2008: CDS Version NHS005 Type List
- April 2001 to March 2005: CDS Version NHS003 and 4 Type List

The XML Schemas and supporting information can be downloaded from Technology Reference Data Update Distribution (TRUD) at: NHS Data Model and Dictionary: DD XML Schemas.

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**COMMISSIONING DATA SET XML SCHEMA DESIGN**

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Change to Supporting Information: Changed Description

~~The use of XML was mandated by the e-Government Interoperability Framework (e-GIF) programme as the standard to be used for messaging by government organisations and has accordingly been adopted by the NHS.~~The use of XML was mandated by the e-Government Interoperability Framework (e-GIF) programme as the standard to be used for messaging by government organisations and was adopted by the NHS for the submission of Commissioning Data Set data to the Secondary Uses Service.

~~For the submission of Commissioning Data Set data to the Secondary Uses Service, XML based messaging has been developed to be fully adopted by the end of 2007, replacing all previously published Commissioning Data Set Message formats.~~

**XML Schema Standards**
The overall standards applied and supported by the schema are:

- W3C schema standards
- e-Government Interoperability Framework (e-GIF)
- e-GOV Best Practice guidelines for XML Schema
- The NHS Data Model and Dictionary

Note:
e-GIF and the Government Data Standards Catalogue **have been archived** and are available for reference only.

**XML Schema Naming Conventions**
These are in CamelCase reflecting recommended e-GOV guidelines for best practice. Wherever possible, schema data item names are compliant (or intuitively identifiable) with the NHS Data Model and Dictionary data naming conventions.

**XML Schema Components**
The schema consists of the following components:

- The CDS XML Message Root
- The CDS XML Standard Data Structures
- The CDS XML Standard Data Elements
- CDS Type Sub-Schemas

These are described below.

**The XML Schema Root**
The schema root is the control section of the schema and uses the "XML Include" technique to call schema sub-components:

- The Standard Data Structures
- The Standard Data Elements
- All CDS Type sub-component schemas, including the Commissioning Data Set Headers and Trailers

In addition, the schema root is the only schema entry point and on entry the schema validates the XML Attributes for:

- SchemaVersion
- SchemaDate

**XML Schema Component: Standard Data Structures**
XML Schema Version 6-0 introduced standard data structures which are invoked from the CDS Type sub-component schemas. This simplifies the management and definition of data structures and eliminates (as far as is possible) the multiple definitions of the many common structures used across the CDS Type components. It also helps to eliminate naming and spelling inconsistencies.

This implementation of the schema does not enforce the sequence of data elements within its data structures (nor its data structures within the schema), nor is it foreseen that this will be enforced in future. For ease of understanding, users are advised to implement the structure sequences as published.

In general, the restraints on the permitted occurrences of data groups have been removed and in most cases, unbounded occurrences of iterating data structures are supported. The NHS Data Model and Dictionary defines the actual requirements for the use of NHS data.

**XML Schema Component: Standard Data Elements**
XML Schema data items are defined with ***_Type*** suffixes and usually refer to a standard list of XML data types which are usually qualified with an enumeration list to reflect the NHS Data Standards as published in the NHS Data Model and Dictionary.

**Schema Component: XML Attributes**
XML Attributes are used (sparingly) to enforce certain logical data and structure relationships, an example being to determine the type of Critical Care Period data being carried.

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**COMMISSIONING DATA SET XML SCHEMA DOCUMENTATION**

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Change to Supporting Information: Changed Description

The use of XML was mandated by the e-Government Interoperability Framework (e-GIF) programme as the standard to be used for messaging by government organisations and accordingly this has been adopted by the NHS.

Note:
e-GIF and the Government Data Standards Catalogue **have been archived** and are available for reference only.

For the most part, the XML Schema applies the data specifications as authorised by the NHS and documented in the NHS Data Model and Dictionary.

**The Issued Documentation**
~~The Data Dictionary and Messaging Team maintain and issue the following XML Schema documentation:~~The NHS Digital Data Architecture Team maintain and issue the following XML Schema documentation:

- ~~**The XML Schema Files** (generated using ALTOVA XMLSPY ©)~~
  ~~The XML Schema files consist of a series of interpretable XML/HTML statements which define the data structures and content rules for the use of the message. User systems use the XML Schema to either populate or interpret a 'XML Schema instance' that is the resultant XML formatted message file which carries the data.~~
- **The XML Schema Files** (generated using ALTOVA XMLSPY ©)
  The XML Schema files consist of a series of interpretable XML/HTML statements which define the data structures and content rules for the use of the message. User systems use the XML Schema to either populate or interpret an 'XML Schema instance' that is the resultant XML formatted message file which carries the data.

The XML Schema therefore represents the 'design' of the message and it may be necessary therefore to interpret and understand the information inherent in the XML Schema file code.

- ~~**The XML Schema Documentation** (generated using ALTOVA XMLSPY ©)~~
  ~~These files are generated using XMLSPY software and may be read in any browser, e.g. MS Explorer©. The files consist of a 'root' entry HTML formatted file and a (usually) large number of supporting .png graphic files used by the root HTML.~~

- **The XML Schema Documentation** (generated using ALTOVA XMLSPY ©)
  These files are generated using XMLSPY software and may be read in any browser, e.g. Microsoft Edge©. The files consist of a 'root' entry HTML formatted file and a (usually) large number of supporting .png graphic files used by the root HTML.

This documentation enables useful "drill down" functions for investigating structures and data items, but these features are not as powerful as when using a full XML Schema editor (see below).

Most browsers will support printing and thus the XML Schema details can be printed as required but users are warned that browser based prints often generate a large number of pages.

The CDS XML Schema generates approximately 450+ pages of details, printing is therefore not advised.

- ~~**The XML Schema Release Notes**~~
  ~~This is a pdf document identifying the changes applied to the XML Schema release.~~
  ~~References to Information Standards Notices and other technical change requirements are detailed.~~
- **The XML Schema Release Notes**
  This is a pdf document identifying the changes applied to the XML Schema release, from the previous release.
  References to Information Standards Notices and other technical change requirements are detailed.

**Reading XML Schema**
Whilst XML Schemas can be read as HTML in most browsers, it may be difficult to fully interpret the XML Schema unless the reader has a detailed understanding of HTML.

It is recommended that XML Schemas are read using an XML interpreter (such as ALTOVA XMLSPY ©), many of these are freely available on the internet.

XML Schema technicians may prefer to use such software to examine XML Schemas more deeply as the interactive facilities provided are generally more powerful than browsing the XML/HTML supplied Schema code.

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**COMMISSIONING DATA SET XML SCHEMA OVERVIEW**

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Change to Supporting Information: Changed Description

~~The use of XML was mandated by the e-Government Interoperability Framework (e-GIF) programme as the standard to be used for messaging by government organisations and has accordingly been adopted by the NHS.~~The use of XML was mandated by the e-Government Interoperability Framework (e-GIF) programme as the standard to be used for messaging by government organisations and was adopted by the NHS for the submission of Commissioning Data Set data to the Secondary Uses Service.

~~For the submission of Commissioning Data Set data to the Secondary Uses Service, XML based messaging has been developed replacing all previously published Commissioning Data Set Message formats.~~

~~The CDS XML Schema is supported and applied in the Secondary Uses Service front-end software service (the XML Transfer Service - XTS) to enforce a nationally agreed data specification and thus help protect the data quality and integrity of the data submitted to and stored within the Secondary Uses Service.~~The CDS XML Schema is supported and applied in the Secondary Uses Service to enforce a nationally agreed data specification and thus help protect the data quality and integrity of the data submitted to and stored within the Secondary Uses Service.

~~It should be noted that after accepting the XML Schema instance data, the Secondary Uses Service then applies further logical data validations and may identify and report further data conditions.~~It should be noted that after accepting the XML Schema interchange data, the Secondary Uses Service then applies further logical data validations and may identify and report further data conditions.

For the most part, the XML Schema applies the data specifications as authorised by the NHS and documented in the NHS Data Model and Dictionary. However, as the NHS Data Model and Dictionary is updated on a continuous time basis and XML Schemas may be less dynamic and updated on a longer time cycle, there may be subtle differences in the data specifications applied in the XML Schema. For example, additional National Codes may be supported in one version of the Commissioning Data Set XML Schema but not in earlier versions. ~~Where this is the case, information relating to the supported National Codes can be found on the CDS Version 6-2 XML Schema~~

~~Constraints page and associated Attributes and/or Data Elements.~~ Where this is the case, information relating to the supported National Codes can be found on the CDS Version 6-2 XML Schema Constraints / CDS Version 6-3 XML Schema Constraints page and associated Attributes and/or Data Elements.

Additionally an XML Schema may deliberately retain historic National Codes as well as supporting the new National Codes in order to enable NHS users to be able to process historic data.

**XML Schema Standards**
The overall standards applied and supported by the XML Schema are:

- W3C schema standards
- e-Government Interoperability Framework (e-GIF)
- e-GOV Best Practice guidelines for XML Schema
- The NHS Data Model and Dictionary

Note:
e-GIF and the Government Data Standards Catalogue **have been archived** and are available for reference only.

**XML Schema Naming Conventions**
These are in ***CamelCase*** as accepted best practice. Wherever possible, XML Schema data item names are compliant (or intuitively identifiable) with the NHS Data Model and Dictionary naming conventions.

**XML Schema Documentation**
XML Schema documentation usually consists of several related publications:

- Information Standards Notices (ISN) issued for NHS business, process and definition changes; these will usually include the Data Sets, Data Element definitions etc.
- ~~Information Standards Notices issued to authorise the CDS XML Schema itself~~
- Information Standards Notices or Data Dictionary Change Notices issued to authorise the CDS XML Schema itself
- The CDS XML Schema Release Notes which provides a technical overview of the release (in pdf)
- The XMLSPY© generated XML Schema Documentation which is a large collection of HTML files.

**XML Schema Components: Schema Root**
The XML Schema root is the control section of the XML Schema and is the only entry point and uses the "XML Include" technique to call all XML Schema sub components:

- The Standard Data Elements
- The Standard Data Structures
- All sub-component XML Schemas for CDS Types including the Commissioning Data Set Headers and Trailers

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**COMMISSIONING DATA SET XML SCHEMA VERSION NUMBERING**

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Change to Supporting Information: Changed Description

**The CDS XML Schema Version Number Format**
~~The use of XML was mandated by the e-Government Interoperability Framework (e-GIF) programme as the standard to be used for messaging by government organisations and has accordingly been adopted by the NHS.~~The use of XML was mandated by the e-Government Interoperability Framework (e-GIF) programme as the standard to be used for messaging by government organisations and was adopted by the NHS.

Note:
e-GIF and the Government Data Standards Catalogue **have been archived** and are available for reference only.

The CDS XML Schema adopts version numbering techniques in line with published e-GOV best practice guidelines. All schema components are version numbered and date qualified; the following is an example of the adopted format:

**CDS XML Message Root**
Example: V6-0-2007-03-01 (Note that dash separators are used).
[Schema Filename] + [Major Version Number] + [Minor Version Number] + [Version Date]

| VERSION NUMBER ELEMENT | FORMAT | EXAMPLE AND NOTES |
|---|---|---|
| ~~XML Schema File Name~~ | ~~As allocated by Information Standards Delivery,~~<br>~~NHS Digital~~ | ~~CDS-XML_Message_Root-~~ |
| XML Schema File Name | As allocated by Data Architecture at NHS Digital | CDS-XML_Message_Root- |
| Major Version Number | A maximum of 3 characters incremented numerically without leading zeros | V6- |
| Minor Version Number | A maximum of 3 characters incremented numerically without leading zeros | 0- |
| Version Date | ccyy-mm-dd | 2007-03-01 |

**The Major Version Number:**
This is incremented when fundamental change has taken place such as:

- Major addition / deletion / change of XML Schema business functionality
- Major change to the technical design of the schema
- Re-alignment of the XML Schema Version Number after cumulative changes

**The Minor Version Number:**
This is incremented for all XML Schema changes ***not*** warranting a Major Version Number increment (as above).
Examples are:

- Minor changes to XML Schema business functionality
- Minor changes to the XML Schema data structures that are not upwardly compatible*
- Addition and/or deletion of data items that are not upwardly compatible*
- Changes to data item facet definitions that are not upwardly compatible*

**The Version Date:**
This may be adjusted as a defined reference point for a no risk XML Schema release to reflect minor changes and corrective releases.
Examples are:

- Minor changes to the XML Schema data structures that are upwardly compatible* for instance the addition of an optional data item.
- Changes to data item facet definitions that are upwardly compatible* for instance the addition (but not the deletion) of code values to a data item enumeration list.
- Interim development versions, released for information only

*** Upwardly Compatible:**
Minor changes and adjustments to the XML Schema which introduce little or no risk of increased data rejection are deemed upwardly compatible.

For example, corrective adjustments, which align the XML Schema to the authorised NHS Data Standards as published in the NHS Data Model and Dictionary often fall within this category.

**The XML Schema Date:**
All XML Schema releases have a designated SchemaDate XML Attribute.

**XML Schema Version Control - The Schema Root:**
The schema root is the single entry point to the XML Schema and XML Attributes for the following are validated:

- SchemaVersion
- SchemaDate

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**EMED3 FIT NOTE**

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Change to Supporting Information: New Supporting Information

The eMED3 Fit Note, formally known as a Statement of Fitness to Work, was introduced in April 2010 across England, Wales and Scotland. It enables CARE PROFESSIONALS such as CONSULTANTS and GENERAL MEDICAL PRACTITIONERS to give advice to their PATIENTS about the impact of their health condition on their fitness for work and is used to provide medical evidence for employers or to support a claim to health-related benefits through the Department for Work and Pensions.

An eMED3 Fit Note is issued after the first 7 days of sickness absence (when PATIENTS can self-certify) if the CARE PROFESSIONAL assesses that the PATIENTs health affects their fitness to work. The CARE PROFESSIONAL may decide that the PATIENT is unfit for work, or may be fit for work subject to certain conditions, with accompanying notes on suggested adjustments or adaptations to the job role or the workplace.

For further information on eMED3 Fit Notes, see the gov.uk website at: Fit Note.

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**EMED3 FIT NOTE APPLICABLE PERIOD**

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Change to Supporting Information: New Supporting Information

An eMED3 Fit Note Applicable Period is a PERSON PROPERTY ASSIGNMENT PERIOD.

An eMED3 Fit Note Applicable Period describes the period of time covered when the PATIENT is issued with an eMED3 Fit Note until the EMED3 FIT NOTE END DATE.

If the duration of the eMED3 Fit Note is indefinite, there will be no eMED3 Fit Note Applicable Period end date, and the EMED3 FIT NOTE DURATION will be Default Code '*eMED3 Fit Note is for an indefinite period*'.

**This supporting information is also known by these names:**

| Context | Alias |
|---|---|
| plural | eMED3 Fit Note Applicable Periods |

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**EMED3 FIT NOTE ASSESSMENT DATE**

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Change to Supporting Information: New Supporting Information

An eMED3 Fit Note Assessment Date is an ACTIVITY DATE TIME.

An eMED3 Fit Note Assessment Date is the date on which a PATIENT was assessed as requiring an eMED3 Fit Note during a CARE CONTACT or ACTIVITY GROUP.

**This supporting information is also known by these names:**

| Context | Alias |
|---|---|
| plural | eMED3 Fit Note Assessment Dates |

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**EMED3 FIT NOTE RECORDED DATE**

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Change to Supporting Information: New Supporting Information

An eMED3 Fit Note Recorded Date is an ACTIVITY DATE TIME.

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.

**This supporting information is also known by these names:**

| Context | Alias |
| --- | --- |
| plural | eMED3 Fit Note Assessment Dates |

#### FAST HEALTHCARE INTEROPERABILITY RESOURCES

Change to Supporting Information: New Supporting Information

Fast Healthcare Interoperability Resources (FHIR®) is a standard for exchanging healthcare information electronically, to enable ELECTRONIC HEALTH RECORD data to be structured, standardised and understandable when machine-processed.

For further information on FHIR®, see the HL7 FHIR Release 4 website.

#### FIRST CONTACT PRACTITIONER

Change to Supporting Information: New Supporting Information

A First Contact Practitioner is a CARE PROFESSIONAL.

First Contact Practitioners are regulated, advanced and autonomous health CARE PROFESSIONALS who are trained to provide expert PATIENT assessment, diagnosis and first-line treatment, self-care advice and, if required, appropriate onward referral to other SERVICES.

For further information on First Contact Practitioners in Musculoskeletal SERVICES, see the NHS Long Term Plan website at: Shorter Waits For Planned Care.

**This supporting information is also known by these names:**

| Context | Alias |
| --- | --- |
| plural | First Contact Practitioners |

#### LAST PATIENT CANCELLED DATE

Change to Supporting Information: New Supporting Information

A Last Patient Cancelled Date is an ACTIVITY DATE TIME.

A Last Patient Cancelled Date is the date of the last APPOINTMENT which the PATIENT cancelled on or before their APPOINTMENT DATE.

**This supporting information is also known by these names:**

| Context | Alias |
| --- | --- |
| plural | Last Patient Cancelled Dates |

#### LAST PATIENT DID NOT ATTEND DATE

Change to Supporting Information: New Supporting Information

A Last Patient Did Not Attend Date is an ACTIVITY DATE TIME.

A Last Patient Did Not Attend Date is the date of the last APPOINTMENT which the PATIENT did not attend without advance warning.

**This supporting information is also known by these names:**

| Context | Alias |
|---|---|
| plural | Last Patient Did Not Attend Dates |

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#### MAIN SPECIALTY AND TREATMENT FUNCTION CODES TABLE

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Change to Supporting Information: Changed Description

For further information regarding the definition and use of MAIN SPECIALTY see the attribute MAIN SPECIALTY CODE.

For further information regarding the definition and use of TREATMENT FUNCTION see the attribute TREATMENT FUNCTION CODE.

For additional queries contact the NHS Digital by email at: enquiries@nhsdigital.nhs.uk with the subject "Main Specialty and Treatment Function Codes".

Note:

- New National Codes for MAIN SPECIALTY CODE and TREATMENT FUNCTION CODE were introduced from 2 April 2020 as part of the update to the DCB0028: Treatment Function and Main Specialty Standard. Submission of these codes for the Commissioning Data Sets is only possible where the healthcare provider has updated their CDS-XML schema version to CDS-XML version 6-2-0. Users of the original CDS-XML schema version 6-2 will be unable to submit the new codes introduced in the release of DCB0028: Treatment Function and Main Specialty Standard in April 2020 or the addendum to DCB0028 released in January 2021 to add a new TREATMENT FUNCTION CODE to represent Post-COVID-19 Syndrome Services.

**Table 1 Main Specialty codes**

| | Code | Main Specialty Title | Comments |
|---|---|---|---|
| **Surgical Specialties** | | | |
| | 100 | General Surgery | For further information, see: Royal College of Surgeons - General Surgery |
| | 101 | Urology | For further information, see: Royal College of Surgeons - Urology |
| | 107 | Vascular Surgery | For further information, see: Royal College of Surgeons - Vascular Surgery |
| | 110 | Trauma and Orthopaedics | For further information, see: Royal College of Surgeons - Orthopaedic Surgery |
| | 120 | Ear Nose and Throat | Formerly known as ENT.<br>For further information, see: Royal College of Surgeons - Ear, Nose and Throat (ENT) |
| | 130 | Ophthalmology | For further information, see: The Royal College of Ophthalmologists |
| | 140 | Oral Surgery | For further information, see: Royal College of Surgeons - Oral and Maxillofacial Surgery |
| | 141 | Restorative Dentistry | For further information, see: The British Society for Restorative Dentistry (BSRD) |
| | 142 | Paediatric Dentistry | For further information, see: The British Society of Paediatric Dentistry |
| | 143 | Orthodontics | For further information, see: British Orthodontic Society |
| | 145 | Oral and Maxillofacial Surgery | |

| | | | |
|---|---|---|---|
| | | | For further information, see: Royal College of Surgeons - Oral and Maxillofacial Surgery |
| | 146 | Endodontics | For further information, see: British Endodontic Society |
| | 147 | Periodontics | For further information, see: British Society of Periodontology |
| | 148 | Prosthodontics | For further information, see: The British Society of Prosthodontics (BSSPD) |
| | 149 | Surgical Dentistry | For further information, see: Royal College of Surgeons - Faculty of Dental Surgery (FDS) |
| | 150 | Neurosurgery | For further information, see: Royal College of Surgeons - Neurosurgery |
| | 160 | Plastic Surgery | For further information, see: Royal College of Surgeons - Plastic and Reconstructive |
| | 170 | Cardiothoracic Surgery | For further information, see: Royal College of Surgeons - Cardiothoracic Surgery |
| | 171 | Paediatric Surgery | For further information, see: Royal College of Surgeons - Paediatric Surgery |
| | 191 | Pain Management (Retired 1 April 2004) | |
| **Medical Specialties** | | | |
| | 180 | Emergency Medicine | Formerly known as Accident and Emergency.<br>For further information, see: The Royal College of Emergency Medicine |
| | 190 | Anaesthetics | For further information, see: Royal College of Anaesthetists |
| | 192 | Intensive Care Medicine | Formerly known as Critical Care Medicine.<br>For further information, see: The Faculty of Intensive Care Medicine |
| | 200 | Aviation and Space Medicine | For further information, see: Joint Royal Colleges of Physicians Training Board - Aviation and Space Medicine |
| | 300 | General Internal Medicine | Formerly known as General Medicine.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - General Internal Medicine (GIM) |
| | 301 | Gastroenterology | For further information, see: Joint Royal Colleges of Physicians Training Board - Gastroenterology |
| | 302 | Endocrinology and Diabetes | Formerly known as Endocrinology.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Endocrinology and Diabetes Mellitus |
| | 303 | Clinical Haematology | For further information, see: Joint Royal Colleges of Physicians Training Board - Haematology |
| | 304 | Clinical Physiology | For further information, see: The Registration Council for Clinical Physiologists |
| | 305 | Clinical Pharmacology | For further information, see: Joint Royal Colleges of Physicians Training Board - Clinical Pharmacology and Therapeutics (CPT) |
| | 310 | Audio Vestibular Medicine | Formerly known as Audiological Medicine.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Audio vestibular Medicine |
| | 311 | Clinical Genetics | For further information, see: Joint Royal Colleges of Physicians Training Board - Clinical Genetics |
| * | 312 | Clinical Cytogenetics and Molecular Genetics (Retired 1 April 2010) | |
| | 313 | Clinical Immunology | Formerly known as Clinical Immunology and Allergy.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Immunology |
| | 314 | Rehabilitation Medicine | Formerly known as Rehabilitation.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Rehabilitation Medicine |
| | 315 | Palliative Medicine | |

| | | | |
|---|---|---|---|
| | | | For further information, see: Joint Royal Colleges of Physicians Training Board - Palliative Medicine |
| | 317 | Allergy | For further information, see: Joint Royal Colleges of Physicians Training Board - Allergy |
| | 320 | Cardiology | For further information, see: Joint Royal Colleges of Physicians Training Board - Cardiology |
| | 321 | Paediatric Cardiology | For further information, see: Joint Royal Colleges of Physicians Training Board - Paediatric Cardiology |
| | 325 | Sport and Exercise Medicine | For further information, see: Faculty of Sport and Exercise Medicine |
| | 326 | Acute Internal Medicine | For further information, see: Joint Royal Colleges of Physicians Training Board - Acute Internal Medicine |
| | 330 | Dermatology | For further information, see: Joint Royal Colleges of Physicians Training Board - Dermatology |
| | 340 | Respiratory Medicine | Also known as Thoracic Medicine.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Respiratory Medicine |
| | 350 | Infectious Diseases | For further information, see: Joint Royal Colleges of Physicians Training Board - Infectious Diseases and Tropical Medicine |
| | 352 | Tropical Medicine | For further information, see: Joint Royal Colleges of Physicians Training Board - Infectious Diseases and tropical Medicine |
| | 360 | Genitourinary Medicine | For further information, see: Joint Royal Colleges of Physicians Training Board - Genitourinary Medicine |
| | 361 | Renal Medicine | Formerly known as Nephrology.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Renal Medicine |
| | 370 | Medical Oncology | For further information, see: Joint Royal Colleges of Physicians Training Board - Medical Oncology |
| | 371 | Nuclear Medicine | For further information, see: Joint Royal Colleges of Physicians Training Board - Nuclear Medicine |
| | 400 | Neurology | For further information, see: Joint Royal Colleges of Physicians Training Board - Neurology |
| | 401 | Clinical Neurophysiology | For further information, see: Joint Royal Colleges of Physicians Training Board - Clinical Neurophysiology |
| | 410 | Rheumatology | For further information, see: British Society for Rheumatology |
| | 420 | Paediatrics | For further information, see: Royal College of Paediatrics and Child Health - General Paediatrics |
| | 421 | Paediatric Neurology | For further information, see: Royal College of Paediatrics and Child Health - Neurology |
| | 430 | Geriatric Medicine | For further information, see: Joint Royal Colleges of Physicians Training Board - Geriatric Medicine |
| | 450 | Dental Medicine | Formerly known as Dental Medicine Specialties.<br>For further information, see: Royal College of Surgeons - Faculty of Dental Surgery (FDS) |
| | 451 | Special Care Dentistry | For further information, see: Special Care Dentistry Association (SCDA) |
| | 460 | Medical Ophthalmology | For further information, see: Joint Royal Colleges of Physicians Training Board - Medical Ophthalmology |
| † | 500 | Obstetrics and Gynaecology | For further information, see: Royal College of Obstetricians and Gynaecologists |
| | 501 | Obstetrics | For further information, see: Royal College of Obstetricians and Gynaecologists |
| | 502 | Gynaecology | For further information, see: Royal College of Obstetricians and Gynaecologists |
| | 504 | | |

| | | | |
|---|---|---|---|
| | | Community Sexual and Reproductive Health | For further information, see: Faculty of Sexual & Reproductive Healthcare of the Royal College of Obstetricians & Gynaecologists |
| | 510 | Antenatal Clinic (Retired 1 April 2004) | |
| | 520 | Postnatal Clinic (Retired 1 April 2004) | |
| | 600 | General Medical Practice | For further information, see: Royal College of General Practitioners |
| | 601 | General Dental Practice | For further information, see: Royal College of Surgeons - Faculty of Dental Surgery (FDS) |
| | 610 | Maternity Function (Retired 1 April 2004) | |
| | 620 | Other Than Maternity (Retired 1 April 2004) | |
| | 831 | Medical Microbiology and Virology | For further information, see: The Royal College of Pathologists - Medical Microbiology and The Royal College of Pathologists - Virology |
| | 833 | Medical Microbiology | Also known as Microbiology and Bacteriology.<br>For further information, see: The Royal College of Pathologists - Medical Microbiology |
| | 834 | Medical Virology | For further information, See: The Royal College of Pathologists - Medical Virology |
| **Psychiatry** | | | |
| | 700 | Learning Disability | Also known as Intellectual Disability.<br>For further information, see: Royal College of Psychiatrists - Faculty of the Psychiatry of Intellectual Disability and British Institute of Learning Disabilities |
| | 710 | Adult Mental Illness | For further information, see: NHS England - Adult and older adult mental health |
| | 711 | Child and Adolescent Psychiatry | For further information, see: Royal College of Psychiatrists - Faculty of Child and Adolescent Psychiatry |
| | 712 | Forensic Psychiatry | For further information, see: Royal College of Psychiatrists - Faculty of Forensic Psychiatry |
| | 713 | Medical Psychotherapy | For further information, see: Royal College of Psychiatrists - Faculty of Medical Psychotherapy |
| | 715 | Old Age Psychiatry | For further information, see: Royal College of Psychiatrists - Faculty of Old Age Psychiatry |
| **Other** | | | |
| | 560 | Midwifery | Formerly known as Midwife Episode.<br>For further information, see: Royal College of Midwives |
| | 800 | Clinical Oncology | Formerly known as Radiotherapy.<br>For further information, see: The Royal College of Radiologists - Clinical Oncology |
| | 810 | Radiology | For further information, see: The Royal College of Radiologists (RCR) |
| | 820 | General Pathology | For further information, see: The Royal College of Pathologists |
| | 821 | Blood Transfusion | For further information, see: The Royal College of Pathologists - Blood Transfusion |
| | 822 | Chemical Pathology | For further information, see: The Royal College of Pathologists |
| | 823 | Haematology | For further information, see: The Royal College of Pathologists - Haematology |
| | 824 | Histopathology | For further information, see: The Royal College of Pathologists - Histopathology |
| | 830 | Immunopathology | For further information, see: The Royal College of Pathologists - Immunology |
| | 832 | Neuropathology (Retired 1 April 2004) | |

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| | 900 | Community Medicine | For further information, see: Faculty of Public Health |
| | 901 | Occupational Medicine | For further information, see: Royal College of Physicians - Faculty of Occupational Medicine |
| | 902 | Community Health Services Dental | For further information, see: Faculty of Public Health |
| | 903 | Public Health Medicine | For further information, see: Faculty of Public Health |
| | 904 | Public Health Dental | For further information, see: GOV.uk - Oral Health |
| | 950 | Nursing | Formerly known as Nursing Episode.<br>For further information, see: Nursing & Midwifery Council |
| | 960 | Allied Health Professional | Formerly known as Allied Health Professional Episode.<br>For further information, see: Health and Care Professions Council |
| | 990 | Joint Consultant Clinics (Retired 1 April 2004) | |

**Notes:**

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| † | Code 500 is not acceptable for data sets/collections including Hospital Episode Statistics |
| * | Code 312 is retained for CONSULTANTS qualified in this Main Specialty prior to 1 April 2010. |

**Table 2 Treatment Function codes**

| Code | Treatment Function Title | Comments |
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| **Surgical Specialties** | | |
| 100 | General Surgery Service | SERVICES delivering surgical ACTIVITY not covered by other subspecialty areas. The majority of elective procedures, about 80 per cent, fall outside subspecialty areas.<br>For further information, see: Royal College of Surgeons - Surgical Specialties |
| 101 | Urology Service | Surgical SERVICES for the treatment of disorders of the urinary system and male reproductive system. This includes surgery for gender dysphoria.<br>For further information, see: Royal College of Surgeons - Urology |
| 102 | Transplant Surgery Service | SERVICES for pre- and post-operative care for major organ transplants except heart and lung. Excludes Cardiothoracic Transplantation Service - see TREATMENT FUNCTION CODE 174, corneal grafts carried out by Ophthalmology Service - see TREATMENT FUNCTION CODE 130 and Blood and Bone Marrow Transplantation Service - see TREATMENT FUNCTION CODE 308.<br>For further information, see: Royal College of Surgeons - General Surgery |
| 103 | Breast Surgery Service | SERVICES which include surgical treatment for cancer, suspected neoplasms, indeterminate breast lesions, benign breast lumps, disorders of the nipple-areolar complex, cysts and post-cancer reconstructive, revision and symmetrising surgery. Includes breast surgery for gender dysphoria. Excludes cosmetic surgery.<br>For further information, see: Association of Breast Surgery |
| 104 | Colorectal Surgery Service | SERVICES for the surgical treatment of disorders of the lower intestine (colon, anus and rectum) |
| 105 | Hepatobiliary and Pancreatic Surgery Service | Specialist surgical SERVICES for hepatobiliary and pancreatic (HPB) disorders. To be used by recognised specialist units and associated outreach SERVICES only. Excludes Transplant Surgery Service - see TREATMENT FUNCTION CODE 102.<br>For further information, see: NHS England - A02. Hepatobiliary and Pancreas |
| 106 | Upper Gastrointestinal Surgery Service | SERVICES for surgical treatment of disorders of the upper parts of the gastrointestinal tract.<br>For further information, see: Royal College of Surgeons - General Surgery |

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| 107 | Vascular Surgery Service | SERVICES for the surgical treatment of diseases of the vascular system.<br>For further information, see: Royal College of Surgeons - Vascular Surgery |
| 108 | Spinal Surgery Service | Surgery concentrating on specialised and complex treatment of issues of the back and spine. To be used by recognised specialist units and associated outreach SERVICES only. Excludes Trauma and Orthopaedic Service - see TREATMENT FUNCTION CODE 110, Orthopaedic Service - see TREATMENT FUNCTION CODE 111, Trauma Surgery Service - see TREATMENT FUNCTION CODE 115 and Spinal Injuries Service - see TREATMENT FUNCTION CODE 323.<br>For further information, see: British Association of Spine Surgeons |
| 109 | Bariatric Surgery Service | SERVICES assessing, managing and treating obesity, and specifically consideration of bariatric (weight loss) surgery. It includes PATIENTS who are obese and have, or are at risk of, other medical conditions. It does not cover preventing a PERSON from becoming overweight or obese, or lifestyle weight management programmes for a PERSON who is overweight or obese.<br>For further information, see: National Institute for Health and Care Excellence - Obesity |
| 110 | Trauma and Orthopaedic Service | SERVICES to treat injuries, congenital and acquired disorders of the bones, joints, and their associated soft tissues, including ligaments, nerves and muscles. Excludes Orthopaedic Surgery Service - TREATMENT FUNCTION CODE 111 and Spinal Surgery Service - see TREATMENT FUNCTION CODE 108. For major trauma centres use Trauma Surgery Service - see TREATMENT FUNCTION CODE 115.<br>For further information, see: Royal College of Surgeons - Major Trauma Surgery and Royal College of Surgeons - Orthopaedic Surgery |
| 111 | Orthopaedic Service | SERVICES for the elective or planned surgical assessment or treatment of the musculoskeletal system. Excludes Trauma Surgery Service - see TREATMENT FUNCTION CODE 115. Where there is no dedicated Orthopaedic Service use Trauma and Orthopaedic Service - see TREATMENT FUNCTION CODE 110.<br>For further information, see: Royal College of Surgeons - Orthopaedic Surgery |
| 113 | Endocrine Surgery Service | SERVICES for the surgical treatment of diseases of the thyroid and/or other endocrine glands.<br>For further information, see: Royal College of Surgeons - General Surgery |
| 115 | Trauma Surgery Service | Major trauma specialist SERVICES at a designated unit, with the specific exclusion of Spinal Surgery Service - see TREATMENT FUNCTION CODE 108.<br>Excludes elective or planned Orthopaedic Surgery Service - see TREATMENT FUNCTION CODE 111. Where there is no major trauma centre use Trauma and Orthopaedics Service - see TREATMENT FUNCTION CODE 110.<br>For further information, see: Royal College of Surgeons - Major Trauma Surgery |
| 120 | Ear Nose and Throat Service | Formerly known as ENT.<br>Surgical SERVICES for the assessment, diagnosis, management and treatment of ear, nose and/or throat issues. Excludes Audiology Service - see TREATMENT FUNCTION CODE 840.<br>For further information, see: Royal College of Surgeons - Ear, Nose & Throat (ENT) |
| 130 | Ophthalmology Service | The surgical treatment of disorders and diseases of the eye. Excludes Medical Ophthalmology Service - see TREATMENT FUNCTION CODE 460 and Ophthalmic and Vision Science Service - see TREATMENT FUNCTION CODE 461.<br>For further information, see: Royal College of Ophthalmologists |

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| 140 | Oral Surgery Service | SERVICES for the diagnosis and surgical treatment of diseases, injuries and defects of hard and soft tissues of the mouth.<br>Excludes departments delivering a SERVICE where oral surgery and maxillofacial services are mixed (i.e. an out-patient clinic accepting oral surgery and maxillofacial surgery patients) – see TREATMENT FUNCTION CODE 145.<br>For further information, see: British Association of Oral Surgeons Specialty Training Curriculum – Oral Surgery |
| 141 | Restorative Dentistry Service | SERVICES providing examination and treatment of diseases of the oral cavity, the teeth and their supporting structures. Restorative Dentistry includes the dental specialties of Endodontics, Periodontics and Prosthodontics (including implantology), and its foundation is based upon how these interact in the management of cases requiring multifaceted care.<br>For further information, see: British Society for Restorative Dentistry |
| 143 | Orthodontic Service | SERVICES for the treatment of malocclusions (improper bites). Orthodontic treatment can focus on dental displacement only, or can deal with the control and modification of facial growth.<br>For further information, see: British Orthodontic Society |
| 144 | Maxillofacial Surgery Service | Professional recommendation is to use Oral and Maxillofacial Surgery Service where this SERVICE is combined with oral surgery - see TREATMENT FUNCTION CODE 145. Alternatively, for oral surgery services only see TREATMENT FUNCTION CODE 140. This code has been retained for existing SERVICES which only provide maxillofacial surgery. |
| 145 | Oral and Maxillofacial Surgery Service | Combined SERVICES providing diagnosis and surgical treatment of diseases, injuries and defects involving hard and soft tissues of the mouth, jaws, and neck.<br>These SERVICES may have formerly been categorised as TREATMENT FUNCTION CODE 140 (Oral Surgery Service) or TREATMENT FUNCTION CODE 144 (Maxillofacial Surgery Service).<br>For further information, see: British Association of Oral & Maxillofacial Surgeons |
| 149 | not a Treatment Function | |
| 150 | Neurosurgical Service | Surgical SERVICES for the treatment of disorders of the nervous system including the brain, spinal cord, peripheral nerves, and extra-cranial cerebrovascular system. Excludes Spinal Surgery Service - see TREATMENT FUNCTION CODE 108. For major trauma centres use Trauma Surgery Service – see TREATMENT FUNCTION CODE 115.<br>For further information, see: Royal College of Surgeons - Neurosurgery |
| 160 | Plastic Surgery Service | SERVICES to correct or restore form and function. In addition to cosmetic or aesthetic surgery, plastic surgery includes many types of reconstructive surgery, and the treatment of burns. For care given within specialist burn services, use Burns Care Service - see TREATMENT FUNCTION CODE 161. Excludes breast surgery for gender dysphoria, use Breast Surgery Service - see TREATMENT FUNCTION CODE 103.<br>For further information, see: Royal College of Surgeons - Plastic and Reconstructive |
| 161 | Burns Care Service | SERVICES for the surgical and non-surgical treatment of burns within recognised specialist burns units and associated outreach SERVICES only. Whilst this does not signify the CRITICAL CARE LEVEL, many PATIENTS will also come within the scope of the Critical Care Minimum Data Set.<br>For further information, see: British Burn Association |
| 170 | Cardiothoracic Surgery Service | SERVICES delivering surgical treatment of diseases affecting the heart and organs inside the thorax (the chest). Should only be used where there are no separate SERVICES for Cardiac Surgery and Thoracic |

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| | | Surgery.<br>For further information, see: Royal College of Surgeons - Cardiothoracic Surgery |
| 172 | Cardiac Surgery Service | SERVICES delivering surgical treatment of diseases affecting the heart. Procedures are often lengthy and complex, requiring support from advanced forms of technology during surgery and CRITICAL CARE LEVEL 2 and 3 for the PATIENT after surgery.<br>For further information, see: Royal College of Surgeons - Cardiothoracic Surgery |
| 173 | Thoracic Surgery Service | SERVICES providing surgical treatment of diseases affecting organs inside the thorax (the chest). Generally, treatment of conditions of the lungs, chest wall, and diaphragm. Predominantly this is surgical treatment of malignant disease or its effects.<br>For further information, see: Royal College of Surgeons - Cardiothoracic Surgery |
| 174 | Cardiothoracic Transplantation Service | SERVICES for pre- and post-operative care for heart and lung transplants. To be used by recognised specialist units and associated outreach services only.<br>For further information, see: Royal College of Surgeons - Cardiothoracic Surgery |
| **Other Children's Specialist Services -** The Paediatric TREATMENT FUNCTION CODES represent CLINICS OR FACILITIES intended to provide dedicated SERVICES to children with appropriate facilities and support staff, i.e. they are designed for children only. If a CLINIC OR FACILITY provides this but also treats adult PATIENTS as part of the SERVICE then a Paediatric TREATMENT FUNCTION CODE may not be appropriate. The age of the PATIENT attending does not initiate a change to the TREATMENT FUNCTION CODE for the ACTIVITY. | | |
| 142 | Paediatric Dentistry Service | Dedicated children's SERVICES for dentistry with appropriate facilities and support staff.<br>For further information, see: The British Society of Paediatric Dentistry |
| 171 | Paediatric Surgery Service | Dedicated children's SERVICES for general surgery.<br>For further information, see: Royal College of Surgeons - Paediatric Surgery |
| 211 | Paediatric Urology Service | Dedicated children's SERVICES for surgical treatment of disorders of the urinary system and male reproductive system.<br>For further information, see: British Association of Paediatric Surgeons - Urology |
| 212 | Paediatric Transplantation Surgery Service | Dedicated children's SERVICES for pre- and post-operative care for major organ transplants except heart and lung. Excludes Paediatric Cardiac Surgery Service - see TREATMENT FUNCTION CODE 221, Paediatric Thoracic Surgery Service - see TREATMENT FUNCTION CODE 222, corneal grafts carried out by Paediatric Ophthalmology Service - see TREATMENT FUNCTION CODE 216 and Blood and Bone Marrow Transplantation Service - see TREATMENT FUNCTION CODE 308.<br>For further information, see: Royal College of Surgeons - General Surgery |
| 213 | Paediatric Gastrointestinal Surgery Service | Dedicated children's SERVICES for surgical treatment of disorders of the gastrointestinal tract.<br>For further information, see: British Association of Paediatric Surgeons - Gastrointestinal |
| 214 | Paediatric Trauma and Orthopaedic Service | Dedicated children's SERVICES to treat injuries, congenital and acquired disorders of the bones, joints, and their associated soft tissues, including ligaments, nerves and muscles. Excludes Trauma Surgery Service - see TREATMENT FUNCTION CODE 115 and Spinal Surgery Service - see TREATMENT FUNCTION CODE 108<br>For further information, see: British Society for Children's Orthopaedic Surgery (BSCOS) |
| 215 | Paediatric Ear Nose and Throat Service | Dedicated children's surgical SERVICES for the assessment, diagnosis, management and treatment of ear, nose and/or throat issues. Excludes Audiology Service - see TREATMENT FUNCTION |

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| | | CODE 840.<br>For further information, see: British Association for Paediatric Otolaryngology |
| 216 | Paediatric Ophthalmology Service | Dedicated children's SERVICES for the surgical treatment of disorders and diseases of the eye.<br>For further information, see: British & Irish Paediatric Ophthalmology and Strabismus Association |
| 217 | Paediatric Oral and Maxillofacial Surgery Service | Dedicated children’s SERVICES providing diagnosis and surgical treatment of diseases, injuries and defects involving hard and soft tissues of the mouth, jaws, and neck.<br>Excludes Paediatric Dentistry Services - see TREATMENT FUNCTION CODE 142.<br>For further information, see: British Association of Oral & Maxillofacial Surgeons |
| 218 | Paediatric Neurosurgery Service | Dedicated children's SERVICES for the surgical treatment of disorders which affect any portion of the nervous system including the brain, spinal cord, peripheral nerves, and extra-cranial cerebrovascular system.<br>For further information, see: Royal College of Surgeons - Neurosurgery |
| 219 | Paediatric Plastic Surgery Service | Dedicated children's SERVICES for correction or to restore form and function. In addition to cosmetic or aesthetic surgery, plastic surgery includes many types of reconstructive surgery, and the treatment of burns. For care given within specialist paediatric burn services, use Paediatric Burns Care Service - see TREATMENT FUNCTION CODE 220.<br>For further information, see: NHS England: E02. Specialised Surgery in Children |
| 220 | Paediatric Burns Care Service | Dedicated children's SERVICES for the surgical and non-surgical treatment of burns within recognised specialist burns units and associated outreach SERVICES only. Whilst this does not signify the CRITICAL CARE LEVEL, many PATIENTS will also come within the scope of the Critical Care Minimum Data Set.<br>For further information, see: British Burn Association |
| 221 | Paediatric Cardiac Surgery Service | Dedicated children's SERVICES for the surgical treatment of the heart or great vessels.<br>For further information, see: NHS England: E05. Congenital Heart Services |
| 222 | Paediatric Thoracic Surgery Service | Dedicated children's SERVICES for the surgical treatment of diseases affecting organs inside the thorax (the chest). Generally, treatment of conditions of the lungs, chest wall, and diaphragm.<br>For further information, see: British Association of Paediatric Surgeons - Thoracic |
| 223 | Paediatric Epilepsy Service | Dedicated children's SERVICES by CONSULTANT paediatrician with expertise in epilepsy supported by specialist staff.<br>For further information, see: Royal College of Paediatrics and Child Health - Epilepsy |
| 230 | Paediatric Clinical Pharmacology Service | Dedicated children's SERVICES providing advice and support locally and nationally regarding the introduction of new medicines, adverse drug reactions, poisoning and toxicity, and prescribing policies.<br>For further information, see: Royal College of Paediatrics and Child Health - Drugs and medicines |
| 240 | Paediatric Palliative Medicine Service | Dedicated children's SERVICES improving the quality of life of PATIENTS and their families facing the problems associated with life-limiting illness. Prevention and relief of suffering by means of early identification, assessment and treatment of pain and other problems, physical, psychosocial and spiritual.<br>For further information, see: Royal College of Paediatrics and Child Health - Palliative care |
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| | Paediatric Pain Management Service | Dedicated children's SERVICES for complex pain disorders requiring diagnosis and treatment by a specialist Multidisciplinary Team.<br>For further information, see: Royal College of Paediatrics and Child Health - Pain management |
| 242 | Paediatric Intensive Care Service | Dedicated children's SERVICES only to be used by designated Paediatric Intensive Care Units.<br>For further information, see: Royal College of Paediatrics and Child Health - Intensive care medicine |
| 250 | Paediatric Hepatology Service | Dedicated children's SERVICES for the treatment of disease of the liver.<br>For further information, see: Royal College of Paediatrics and Child Health - Hepatology |
| 251 | Paediatric Gastroenterology Service | Dedicated children's SERVICES for the treatment of disorders of the digestive system.<br>For further information, see: Royal College of Paediatrics and Child Health - Gastroenterology |
| 252 | Paediatric Endocrinology Service | Dedicated children's SERVICES for the treatment of disorders of the endocrine system. Excludes Paediatric Diabetes Service - see TREATMENT FUNCTION CODES 263.<br>For further information, see: British Society for Paediatric Endocrinology and Diabetes |
| 253 | Paediatric Clinical Haematology Service | Dedicated children's SERVICES contributing to the diagnosis and management of diseases of the blood and bone marrow. May be consultative in other specialties including intensive care. Excludes Anticoagulant Service - see TREATMENT FUNCTION CODE 324.<br>For further information, see: NHS England: E03. Paediatric Medicine |
| 254 | Paediatric Audio Vestibular Medicine Service | Dedicated children's SERVICES for the investigation, diagnosis and management of patients with disorders of balance, hearing, tinnitus and auditory communication. Excludes Audiology Service - see TREATMENT FUNCTION CODE 840.<br>For further information, see: British Association of Paediatricians in Audiology |
| 255 | Paediatric Clinical Immunology and Allergy Service | Dedicated children's SERVICES for the treatment of disorders of the immune system and allergic disease.<br>For further information, see: Royal College of Paediatrics and Child Health - Paediatric allergy, immunology and infectious diseases - sub-specialty |
| 256 | Paediatric Infectious Diseases Service | Dedicated children's SERVICES for the diagnosis and treatment of contagious or communicable diseases.<br>For further information, see: Royal College of Paediatrics and Child Health - Paediatric allergy, immunology and infectious diseases - sub-specialty |
| 257 | Paediatric Dermatology Service | Dedicated children's SERVICES for the treatment of diseases of the skin.<br>For further information, see: The British Society for Paediatric Dermatology (BSPD) |
| 258 | Paediatric Respiratory Medicine Service | Dedicated children's SERVICES for the diagnosis and treatment of respiratory conditions.<br>Also known as Thoracic Medicine and Pulmonary Medicine.<br>For further information, see: Royal College of Paediatrics and Child Health - Paediatric respiratory medicine - sub-specialty |
| 259 | Paediatric Nephrology Service | Dedicated children's SERVICES for the diagnosis and treatment of kidney conditions and abnormalities.<br>Also known as Renal Medicine.<br>For further information, see: Royal College of Paediatrics and Child Health - Nephrology |
| 260 | Paediatric Medical Oncology Service | Dedicated children's SERVICES for the diagnosis and treatment, typically with Chemotherapy, of PATIENTS with cancer. |

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| | | For further information, see: Royal College of Paediatrics and Child Health - Oncology |
| 261 | Paediatric Inherited Metabolic Medicine Service | Formerly known as Paediatric Metabolic Disease.<br>Dedicated children's SERVICES for the diagnosis and management of inherited metabolic conditions utilising biochemistry and metabolic characteristics requiring the expertise of both the physician and chemical pathologist.<br>For further information, see: Royal College of Paediatrics and Child Health - Inherited metabolic medicine |
| 262 | Paediatric Rheumatology Service | Dedicated children's SERVICES incorporating the investigation, multidisciplinary holistic management and rehabilitation of PATIENTS with a wide spectrum of disorders of the musculoskeletal system encompassing the locomotor apparatus, bone and connective tissues and blood vessels.<br>For further information, see: Royal College of Paediatrics and Child Health - Rheumatology |
| 263 | Paediatric Diabetes Service | Formerly known as Paediatric Diabetes Medicine.<br>Dedicated children's SERVICES for the diagnosis, treatment and support of PATIENTS with diabetes.<br>For further information, see: Royal College of Paediatrics and Child Health - Diabetes |
| 264 | Paediatric Cystic Fibrosis Service | Dedicated multidisciplinary children's SERVICES concerned with the diagnosis, assessment and management of PATIENTS with cystic fibrosis. This TREATMENT FUNCTION CODE should be used by recognised specialist centres only.<br>For further information, see: NHS England: A01. Specialised Respiratory |
| 270 | Paediatric Emergency Medicine Service | Dedicated children's SERVICES to care for PATIENTS with urgent problems delivered as part of an Emergency Care Attendance.<br>Excludes Trauma Surgery Service - see TREATMENT FUNCTION CODE 115.<br>For further information, see: Royal College of Paediatrics and Child Health - Emergency Medicine |
| 280 | Paediatric Interventional Radiology Service | Dedicated children's SERVICES for the diagnosis and treatment of diseases utilising minimally invasive image-guided procedures. Not to be used for Diagnostic Imaging Service - see TREATMENT FUNCTION CODE 812.<br>For further information, see: British Society of Interventional Radiology - What is Interventional Radiology |
| 290 | Community Paediatric Service | SERVICES providing assessment and care to vulnerable children, including those with developmental disorders and disabilities, complex behavioural presentations, and those at risk of abuse or are being abused. Excludes Paediatric Neurodisability Service - see TREATMENT FUNCTION CODE 291.<br>For further information, see: Royal College of Paediatrics and Child Health - Community child health - sub-specialty |
| 291 | Paediatric Neurodisability Service | Dedicated children's SERVICES for the diagnosis and treatment of Cerebral Palsy and non-progressive handicapping neurological conditions, with or without Learning Disability/Intellectual Disability.<br>For further information, see: Royal College of Paediatrics and Child Health - Neurodisability |
| 321 | Paediatric Cardiology Service | Dedicated children's SERVICES for diseases and abnormalities of the heart. Excludes Congenital Heart Disease Service - see TREATMENT FUNCTION CODE 331.<br>For further information, see: Joint Royal Colleges of Physicians Training Board – Paediatric Cardiology |
| 421 | Paediatric Neurology Service | Dedicated children's SERVICES for diagnosis, management and medical treatment of conditions and diseases of the central nervous system, with appropriate facilities and support staff. Excludes |

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| | | Paediatric Epilepsy Service - see TREATMENT FUNCTION CODE 223.<br>For further information, see: Royal College of Paediatrics and Child Health - Neurology |
| **Medical Specialties** | | |
| 180 | Emergency Medicine Service | Formerly known as Accident & Emergency.<br>SERVICES to care for PATIENTS with urgent problems delivered as part of an Emergency Care Attendance. Excludes Trauma Surgery Service - see TREATMENT FUNCTION CODE 115.<br>For further information, see: The Royal College of Emergency Medicine |
| 190 | Anaesthetic Service | SERVICES for PATIENTS being assessed for anaesthesia, as well as the provision of sedation and anaesthesia for patients undergoing interventional radiology and radiotherapy.<br>This can be used in out-patients only. Pain Management Service should be recorded in TREATMENT FUNCTION CODE 191. Intensive Care Medicine Service should be recorded in TREATMENT FUNCTION CODE 192.<br>For further information, see: Royal college of Anaesthetists - Anaesthetists |
| 191 | Pain Management Service | SERVICES for complex pain disorders requiring diagnosis and treatment by a specialist Multidisciplinary Team |
| 192 | Intensive Care Medicine Service | Formerly known as Critical Care Medicine.<br>SERVICES using a body of specialist knowledge and practice concerned with the treatment of PATIENTS, with, at risk of, or recovering from potentially life-threatening failure of one or more of the body’s organ systems. It includes the provision of organ system support, the investigation, diagnosis, and treatment of acute illness, systems management and PATIENT safety, ethics, end-of-life care, and the support of families. Typically, this will refer to CRITICAL CARE LEVEL 2 and 3 beds within the scope of the Critical Care Minimum Data Set.<br>For further information, see: Faculty of Intensive Care Medicine |
| 200 | Aviation and Space Medicine Service | Also known as Aerospace Medicine Services.<br>Aviation and Space Medicine SERVICES study all factors affecting the PERSON in flight. This may include pre-flight preparation and checks as well as inflight care to minimise the potentially harmful effects of their abnormal environment.<br>For further information, see: Royal College of Physicians - Aviation and Space Medicine |
| 300 | General Internal Medicine Service | Formerly known as General Medicine.<br>SERVICES include adults admitted as emergencies with acute medical problems, including multiple disorders. PATIENTS with problems that are not clearly within the remit of a particular medical specialty are referred for the opinion of a general physician.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - General Internal Medicine (GIM) |
| 301 | Gastroenterology Service | Screening, diagnostic and therapeutic endoscopy SERVICES including upper and lower gastrointestinal (GI) endoscopy and hepatobiliary endoscopy. Excludes Hepatology Service - see TREATMENT FUNCTION CODE 306. |
| 302 | Endocrinology Service | The treatment of disorders of the endocrine system, excluding specific Diabetes Services - see TREATMENT FUNCTION CODE 307.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Endocrinology and Diabetes Mellitus |
| 303 | Clinical Haematology Service | SERVICES contributing to the diagnosis and management of diseases of the blood and bone marrow. May be consultative in other specialties including intensive care. Excludes Anticoagulant Service - see TREATMENT FUNCTION CODE 324. |

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| | | For further information, see: Joint Royal Colleges of Physicians Training Board - Haematology |
| 304 | Clinical Physiology Service | Physiological measurement. Excludes Clinical Neurophysiology Service - see TREATMENT FUNCTION CODE 401, Audiology Service - see TREATMENT FUNCTION CODE 840, Respiratory Physiology Service - see TREATMENT FUNCTION CODE 341, Cardiac Physiology Service - see TREATMENT FUNCTION CODE 675, Gastrointestinal Physiology Service - see TREATMENT FUNCTION CODE 677, Urological Physiology Service - see TREATMENT FUNCTION CODE 670, Vascular Physiology Service - see TREATMENT FUNCTION CODE 673 and Ophthalmic and Vision Science - see TREATMENT FUNCTION CODE 461.<br>For further information, see: The Registration Council for Clinical Physiologists |
| 305 | Clinical Pharmacology Service | SERVICES undertaking and interpreting clinical investigations including clinical trials; optimising the therapeutic use of drugs; detection and analysis of adverse drug effects; contribution to medicines evaluation and management of poisoning.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Clinical Pharmacology and Therapeutics (CPT) |
| 306 | Hepatology Service | Medical SERVICES for the diagnosis and treatment of liver disease. Also known as liver medicine. For hepatobiliary endoscopy, use Gastroenterology Service - see TREATMENT FUNCTION CODE 301 |
| 307 | Diabetes Service | Formerly known as Diabetes Medicine.<br>SERVICES to diagnose, treat and support PATIENTS with diabetes.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Endocrinology and Diabetes Mellitus |
| 308 | Blood and Marrow Transplantation Service | SERVICES recognised as specialist units and associated outreach services only. Includes pre- and post-operative specialised services for autologous, allogeneic or syngeneic Blood and Marrow Transplantation.<br>For further information, see: British Society of Blood and Marrow Transplantation |
| 309 | Haemophilia Service | Specialist SERVICES for the diagnosis, treatment and management of haemophilia.<br>For further information, see: NHS England - F02. Specialised Blood Disorders |
| 310 | Audio Vestibular Medicine Service | Formerly known as Audiological Medicine.<br>SERVICES concerned with the diagnosis and management of hearing and balance disorders, for example tinnitus, dysacusis and communication disorders. Rehabilitative/habilitative care is delivered by Multidisciplinary Teams and is aimed at improving the well-being and quality of life of the PATIENT concerned.<br>Excludes Audiology Service - see TREATMENT FUNCTION CODE 840.<br>For further information, see: Joint Royal College of Physicians Training Board - Audio vestibular Medicine |
| 311 | Clinical Genetics Service | SERVICES for the diagnosis and management of genetic disorders affecting individuals and their families.<br>For further information, see: Clinical Genetics |
| 312 | not a Treatment Function | |
| 313 | Clinical Immunology and Allergy Service | SERVICES for the diagnosis and management of PATIENTS with diseases resulting from disordered immunological mechanisms, and allergic disease (abnormal immune responses to external substances). Should only be used where there are no separate SERVICES for Clinical Immunology and Allergy.<br>For separate services - See Clinical Immunology Service - TREATMENT FUNCTION CODE 316 and Allergy Service - TREATMENT FUNCTION CODE 317. |

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| | | For further information, see: Welcome to the British Society for Allergy & Clinical Immunology (BSACI) |
| 314 | Rehabilitation Medicine Service | Formerly known as Rehabilitation Service.<br>SERVICES for the prevention, diagnosis, treatment and rehabilitation management of disabling conditions. Rehabilitation medicine is broadly divided into neurological rehabilitation, spinal cord injury, limb loss and prosthetics and/or musculoskeletal rehabilitation.<br>Excludes Mental Health Recovery and Rehabilitation Service - see TREATMENT FUNCTION CODE 725, Cardiac Rehabilitation Service - see TREATMENT FUNCTION CODE 327, Pulmonary Rehabilitation Service - see TREATMENT FUNCTION CODE 342, Orthotics Service - See TREATMENT FUNCTION CODE 658 or Prosthetics Service - see TREATMENT FUNCTION CODE 657.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Rehabilitation medicine |
| 315 | Palliative Medicine Service | SERVICES improving the quality of life of PATIENTS and their families facing the problems associated with life-limiting illness and end of life care. Prevention and relief of suffering by means of early identification, assessment and treatment of pain and other physical, psychosocial and spiritual problems.<br>For further information, see: Joint Royal College of Physicians - Specialty spotlight – palliative medicine |
| 316 | Clinical Immunology Service | SERVICES for the diagnosis and management of PATIENTS with diseases resulting from disordered immunological mechanisms, and conditions in which immunological manipulations form an important part of therapy.<br>Allergy SERVICES should be recorded against Allergy Service - see TREATMENT FUNCTION CODE 317.<br>For further information, see: Joint Royal College of Physicians Training Board - Immunology |
| 317 | Allergy Service | SERVICES for the diagnosis and management of allergic disease (abnormal immune responses to external substances) and the exclusion of allergic causes in other conditions.<br>For further information, see: Joint Royal College of Physicians Training Board - Allergy |
| 318 | Intermediate Care Service | SERVICES encompassing a range of multidisciplinary approaches, designed to safeguard independence by maximising rehabilitation and recovery after illness or injury.<br>For further information, see: National Institute for Health and Care Excellence - Understanding intermediate care, including reablement |
| 319 | Respite Care Service | SERVICES providing temporary care of a dependant PERSON, providing relief for their usual caregivers |
| 320 | Cardiology Service | SERVICES for PATIENTS with heart disease covering a wide range of clinical activities. Management can involve interventional treatment, cardiac imaging, preventative and therapeutic options. This includes both diagnostic and interventional procedures in the cardiac catheterisation laboratory.<br>For further information, see: Royal College of Physicians - Cardiology |
| 322 | Clinical Microbiology Service | SERVICES for the diagnosis, management and treatment of PATIENTS with diseases caused by bacteria, viruses, fungi and parasites. |
| 323 | Spinal Injuries Service | SERVICES for non-surgical management of issues of the back and spine. To be used by recognised specialist units and associated outreach SERVICES only.<br>Excludes Spinal Surgery Service - see TREATMENT FUNCTION CODE 108 |
| 324 | Anticoagulant Service | SERVICES providing the monitoring and control of anticoagulant therapy, including the initiation and/or supervision of oral anticoagulant |

| | | therapy and the determination of anticoagulant dosage.<br>This can be used in out-patients only |
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| 325 | Sport and Exercise Medicine Service | Specific SERVICES providing diagnosis and management of medical problems caused by physical activity, the prevention of related injury and disease and the role of exercise in disease treatment. Excludes Trauma and Orthopaedic Service - see TREATMENT FUNCTION CODE 110, Orthopaedic Surgery Service - see TREATMENT FUNCTION CODE 111, and Trauma Surgery Service - see TREATMENT FUNCTION CODE 115.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Sport and Exercise Medicine |
| 326 | Acute Internal Medicine Service | SERVICES concerned with the assessment, diagnosis and management of adults presenting to secondary care with acute medical illness.<br>For further information, see: Acute Internal Medicine |
| 327 | Cardiac Rehabilitation Service | SERVICES for PATIENTS recovering from heart-related conditions such as heart attacks or procedures such as coronary artery bypass surgery to ensure that they achieve their full potential in terms of physical and psychological health |
| 328 | Stroke Medicine Service | SERVICES for diagnosis, investigation, treatment and care of stroke PATIENTS. Excludes out-patients for Transient Ischaemic Attack Service - see TREATMENT FUNCTION CODE 329.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Stroke Medicine (sub-specialty) |
| 329 | Transient Ischaemic Attack Service | A multidisciplinary out-patient SERVICE for rapid diagnosis and treatment of PATIENTS presenting with suspected Transient Ischaemic Attack and mini-strokes to minimise the chance of a full stroke occurring and maximise the chances of independent living after a stroke.<br>For further information, see: National Institute for Health and Care Excellence - Stroke and transient ischaemic attack |
| 330 | Dermatology Service | SERVICES for the treatment of diseases of the skin.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Dermatology |
| 331 | Congenital Heart Disease Service | The management and treatment of congenital heart disease, including the ongoing care of children into adulthood.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Paediatric cardiology |
| 333 | Rare Disease Service | SERVICES for rare diseases, many of which are present at birth and are either caused by a genetic problem or deficiencies or exposures to substances around the time of conception or during pregnancy. This TREATMENT FUNCTION CODE should be used by designated specialist centres only.<br>For further information, see: National Congenital Anomaly and Rare Disease Registration Service |
| 335 | Inherited Metabolic Medicine Service | SERVICES for the diagnosis and management of inherited metabolic conditions utilising biochemistry and metabolic characteristics requiring the expertise of both the physician and chemical pathologist.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Metabolic Medicine |
| 340 | Respiratory Medicine Service | Respiratory Medicine is also known as Thoracic Medicine and Pulmonary Medicine.<br>SERVICES for the investigation, diagnosis, management and treatment of PATIENTS with respiratory complaints. Excludes acute respiratory failure and adult respiratory distress syndrome (ARDS) - see Intensive Care Medicine Service TREATMENT FUNCTION CODE 192 and Respiratory Physiology Service - see TREATMENT FUNCTION CODE 341. |

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| | | For further information, see: Joint Royal Colleges of Physicians Training Board - Respiratory Medicine |
| 341 | Respiratory Physiology Service | SERVICES for the physiological measurement of the function of the respiratory system. Excludes Sleep Medicine Service - see TREATMENT FUNCTION CODE 347.<br>For further information, see: Association for Respiratory Technology & Physiology |
| 342 | Pulmonary Rehabilitation Service | Formerly known as Programmed Pulmonary Rehabilitation.<br>A multidisciplinary SERVICE for PATIENTS with chronic respiratory impairment.<br>For further information, see: NHS England: Pulmonary rehabilitation |
| 343 | Adult Cystic Fibrosis Service | Multidisciplinary SERVICE concerned with the diagnosis, assessment and management of PATIENTS with cystic fibrosis. This TREATMENT FUNCTION CODE should be used by designated specialist centres only.<br>For further information, see: NHS England: A01. Specialised Respiratory |
| 344 | Complex Specialised Rehabilitation Service | This TREATMENT FUNCTION CODE will be removed from use from April 2022. No new services should use this code in submissions. However, the previous definition has been retained below for reference:<br><br>Complex specialised rehabilitation SERVICE which meets the NHS Specialised Services Rehabilitation Services' criteria and is registered as a Level 1 service |
| 345 | Specialist Rehabilitation Service | This TREATMENT FUNCTION CODE will be removed from use from April 2022. No new services should use this code in submissions. However, the previous definition has been retained below for reference:<br><br>Specialist rehabilitation SERVICE which meets the NHS Specialised Services Rehabilitation Services' criteria and is registered as a Level 2a service. |
| 346 | Local Specialist Rehabilitation Service | This TREATMENT FUNCTION CODE will be removed from use from April 2022. No new services should use this code in submissions. However, the previous definition has been retained below for reference:<br><br>Local specialist rehabilitation SERVICE which meets the NHS Specialised Services Rehabilitation Services' criteria and is registered as a Level 2b service. |
| 347 | Sleep Medicine Service | SERVICES providing diagnosis and management of sleep disorders including parasomnias, excessive daytime sleepiness and sleep apnoea.<br>For further information, see: Royal Society of Medicine - Sleep Medicine Section |
| 348 | Post-COVID-19 Syndrome Service | Multidisciplinary SERVICES for PATIENTS experiencing long-term health effects following COVID-19 infection, whether or not this was diagnosed at the time of acute illness or the patient was initially asymptomatic. Post-COVID-19 syndrome has also been known as 'long COVID'.<br>For further information, see: National Institute for Health and Care Excellence - COVID-19 guideline: management of the long-term effects of COVID-19 and NHS England and NHS Improvement coronavirus - National guidance for post-COVID syndrome assessment clinics |
| 350 | Infectious Diseases Service | SERVICES for the diagnosis, management and treatment of infectious diseases. Excludes Tropical Medicine Service - see TREATMENT FUNCTION CODE 352.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Infectious Diseases |
| 352 | Tropical Medicine Service | SERVICES for the diagnosis, management and treatment of diseases that are found most often in tropical or sub-tropical regions. This |

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| | | TREATMENT FUNCTION CODE should be used by designated specialist centres only. Excludes Infectious Diseases Service - see TREATMENT FUNCTION CODE 350.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Infectious Diseases and Tropical Medicine |
| 360 | Genitourinary Medicine Service | SERVICES for the investigation and management of sexually transmitted infections and HIV.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Genitourinary Medicine (GUM) |
| 361 | Renal Medicine Service | Formerly known as Nephrology.<br>SERVICES for PATIENTS with acute renal failure and chronic kidney disease requiring long term care with the help of a Multidisciplinary Team. Most general medical problems in PATIENTS with kidney disease are managed by the Renal Medicine Service.<br>Excludes acute renal replacement therapy in the critical care setting, see Intensive Care Medicine Service - TREATMENT FUNCTION CODE 192.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Renal Medicine |
| 370 | Medical Oncology Service | SERVICES for the specialised assessment and management of PATIENTS with cancer using chemotherapy. Includes treatment option discussions with PATIENTS, supervision of therapy and management of any complications of disease and/or treatment that may arise.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Medical Oncology |
| 371 | Nuclear Medicine Service | SERVICES responsible for administration of unsealed radioactive substances to PATIENTS for the purposes of diagnosis, therapy or research.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Nuclear Medicine |
| 400 | Neurology Service | SERVICES for the diagnosis, management and medical treatment of neurological conditions. Excludes Stroke Medicine Service - TREATMENT FUNCTION CODE 328, out-patients for Transient Ischaemic Attack Service – see TREATMENT FUNCTION CODE 329.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Neurology |
| 401 | Clinical Neurophysiology Service | Primarily diagnostic SERVICE concerned with recording electrical activity from the nervous system to aid diagnosis, classification and management of neurological disease. Includes Electroencephalogram (EEG) and Electromyography (EMG).<br>For further information, see: Joint Royal College of Physicians - Clinical Neurophysiology |
| 410 | Rheumatology Service | SERVICES incorporating the investigation, holistic management and rehabilitation of PATIENTS with a wide spectrum of disorders of the musculoskeletal system encompassing the locomotor apparatus, bone and connective tissues and blood vessels.<br>For further information, see: Joint Royal College of Physicians - Rheumatology |
| 420 | Paediatric Service | Dedicated children's SERVICES for the treatment of patients typically aged 0 to 18 for medical conditions, however the environments and other members of the multidisciplinary service are likely to care for surgical PATIENTS too.<br>For further information, see: Royal College of Paediatrics and Child Health - General paediatrics - level 3 training |
| 422 | Neonatal Critical Care Service | Formerly known as Neonatology.<br>SERVICES providing care for all babies that require on-going, enhanced medical care following birth. Neonatal critical care SERVICES are provided in a variety of settings dependent upon the interventions required for the baby and with dedicated transport |

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| | | services to support babies being transferred to and from neonatal care units. Use when NEONATAL LEVEL OF CARE = 1, 2 or 3. Includes Special Care Baby Units (SCBU), Local Neonatal Units (LNU) and Neonatal Intensive Care Units (NICU).<br>Any readmission would be to Paediatric Service - see TREATMENT FUNCTION CODE 420, or Paediatric Intensive Care Service - see TREATMENT FUNCTION CODE 242.<br>For further information, see: Royal College of Paediatrics and Child Health - Neonatal medicine - sub-specialty and NHS England - E08. Neonatal Critical Care |
| 424 | Well Baby Service | SERVICES for healthy infants born and referenced by the Maternity record who do not require any intervention other than health screening and prophylactic healthcare. General care given by the mother/substitute with healthcare education if needed.<br>**Use when NEONATAL LEVEL OF CARE = 0 - Normal Care**.<br>Excludes Neonatal Critical Care Service - see TREATMENT FUNCTION CODE 422 |
| 430 | Elderly Medicine Service | Formerly known as Geriatric Medicine.<br>SERVICES to treat diseases and disabilities in older adults, particularly those with multiple morbidities. There is no set age at which PATIENTS may be under the care of the Elderly Medicine Service, this decision should be determined by the individual PATIENT's needs.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Geriatric Medicine |
| 431 | Orthogeriatric Medicine Service | Multidisciplinary SERVICES addressing clinical and social needs in the management of PATIENTS with fragility fractures, including hip fractures. The care provided aims to be holistic and to include secondary prevention of fractures as well as acute care.<br>For further information, see: GM - Orthogeriatrics |
| 450 | Dental Medicine Service | SERVICES for dental treatment carried out in a hospital setting.<br>Includes Oral Medicine.<br>For further information, see: British Dental Association |
| 451 | Special Care Dentistry Service | SERVICES concerned with the improvement of the oral health of PATIENTS and groups in society who have a physical, sensory, intellectual, mental, medical, emotional or social impairment or DISABILITY or, more often, a combination of these factors. The specialty focuses on adolescents and adults only and includes the important period of transition as the adolescent moves into adulthood.<br>For further information, see: Special Care Dentistry Association (SCDA) |
| 460 | Medical Ophthalmology Service | Medically-led SERVICES including assessment, investigation, diagnosis and management of inflammatory, vascular and neurological disorders affecting vision. May include public health screening, for example diabetic retinopathy screening.<br>For further information, see: Joint Royal Colleges of Physicians Training Board - Medical Ophthalmology |
| 461 | Ophthalmic and Vision Science Service | SERVICES providing physiological measurement of the function of the eye and vision. Includes diagnostic electrophysiology of vision, imaging and biometry.<br>For further information, see: NHS Health Education England: Ophthalmic and vision science |
| 500 | not a Treatment Function | |
| 501 | Obstetrics Service | SERVICES managing high risk pregnancy and childbirth including miscarriages and stillbirths but specifically excluding planned terminations. Excludes Midwifery Service - see TREATMENT FUNCTION CODE 560.<br>For further information, see: Royal College of Obstetricians & Gynaecologists - Obstetrics and Gynaecology |
| 502 | Gynaecology Service | SERVICES for the diagnosis, management and treatment of disorders of the female reproductive system. Includes planned terminations of |

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| | | pregnancy.<br>For further information, see: Royal College of Obstetricians & Gynaecologists - Obstetrics and Gynaecology |
| 503 | Gynaecological Oncology Service | SERVICES to treat cancers of the female reproductive system, principally involving surgical members of the Multidisciplinary Team.<br>For further information, see: British Gynaecological Cancer Society |
| 504 | Community Sexual and Reproductive Health Service | SERVICES supporting people to have a positive and respectful approach to sexuality and sexual relationships and to have pleasurable and safe sexual experiences, free of infection, coercion, discrimination and violence. The SERVICE also provides access to contraception and signposts Maternity Services to support pregnancy and childbirth.<br>Excludes Genitourinary Medicine Service - see TREATMENT FUNCTION CODE 360 and Midwifery Service - see TREATMENT FUNCTION CODE 560.<br>For further information, see: Faculty of Sexual and Reproductive Healthcare (FSRH) |
| 505 | Fetal Medicine Service | SERVICES providing specialist care at a designated centre for the fetus or fetuses and mother. This includes assessment of fetal growth and wellbeing; the diagnosis and management of identified fetal disorders (including fetal abnormalities); prenatal fetal intervention and surgery; and counselling and support for parents. Excludes routine maternity screening activities - see Midwifery Service TREATMENT FUNCTION CODE 560. |
| 510 | Retired | Record as Obstetrics, antenatal clinic can be used as a local sub-specialty if required |
| 520 | Retired | Record as Obstetrics, postnatal clinic can be used as a local sub-specialty if required |
| 600 | not a Treatment Function | |
| 610 | Retired | Record as Obstetrics |
| 620 | Retired | Use the appropriate function under which the patient is treated |
| 834 | Medical Virology Service | Clinical SERVICES for the diagnosis, management and prevention of blood-borne and/or airborne viral infections. For further information, see: Royal College of Pathologists - MEDICAL VIROLOGY |
| **Mental Health Services** | | |
| 656 | Clinical Psychology Service | Mental Health Services for the assessment, management and treatment of problems including addiction, anxiety, depression, behavioural difficulties and relationship issues. Methods of assessment include psychometric tests, interviews and direct observation of behaviour. Assessment may lead to advice, counselling or therapy.<br>For further information, see: The British Psychological Society |
| 700 | Learning Disability Service | Also known as Intellectual Disability Service.<br>Mental Health Services provided to PATIENTS with a Learning Disability.<br>For further information, see: Royal College of Psychiatrists - Faculty of the Psychiatry of Intellectual Disability and British Institute of Learning Disabilities |
| 710 | Adult Mental Health Service | Mental Health Services provided to adult PATIENTS for the assessment, diagnosis and treatment of mental illness and maintenance of mental health.<br>For further information, see: Royal College of Psychiatrists - Faculty of General Adult Psychiatry |
| 711 | Child and Adolescent Psychiatry Service | Mental Health Services for children and young people with somatisation and complex presentations, behavioural challenges, eating disorders, mood disorders, anxiety, and other mental health presentations.<br>Excludes Paediatric Neurodisability Service - see TREATMENT FUNCTION CODE 291 and specialist Eating Disorders Service - see TREATMENT FUNCTION CODE 720. |

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| | | For further information, see: Royal College of Psychiatrists - Faculty of Child and Adolescent Psychiatry |
| 712 | Forensic Psychiatry Service | Mental Health Services for the assessment, management and treatment of PATIENTS who are being held in high, medium and low secure units or prisons. This includes prevention of further harm in the community or to the individual themselves.<br>For further information, see: Royal College of Psychiatrists - Faculty of Forensic Psychiatry |
| 713 | Medical Psychotherapy Service | Formerly known as Psychotherapy.<br>Multidisciplinary Mental Health Services to assess, manage and treat children and adults with mental health problems using talking therapies and other psychotherapeutic techniques.<br>For further information, see: Faculty of Medical Psychotherapy |
| 715 | Old Age Psychiatry Service | Mental Health Services providing the specialised assessment, treatment and continuing care for older adults suffering a range of mental illnesses, including dementia, depression or schizophrenia.<br>Excludes specific Dementia Assessment Service - see TREATMENT FUNCTION CODE 727.<br>For further information, see: Royal College of Psychiatrists - Faculty of Old Age Psychiatry |
| 720 | Eating Disorders Service | A specialist SERVICE for the diagnosis and treatment of eating disorders including anorexia, bulimia and compulsive overeating. This is usually a multidisciplinary service which needs to consider both physical and mental health aspects of the PATIENT's care.<br>For further information, see: Royal College of Psychiatrists - Faculty of Eating Disorders Psychiatry |
| 721 | Addiction Service | Mental Health Services for the treatment of addictive behaviour, including substance misuse, drugs, alcohol, tobacco and gambling.<br>Excludes PATIENTS with both severe mental illness and problematic substance misuse, see Mental Health Dual Diagnosis Service - TREATMENT FUNCTION CODE 726.<br>For further information, see: Royal College of Psychiatrists - Faculty of Addictions Psychiatry |
| 722 | Liaison Psychiatry Service | Mental Health Services for the provision of psychiatric treatment to PATIENTS attending acute hospitals including Out-Patient Clinics, Emergency Care Departments and admission to WARDS.<br>Deals with the interface between physical and psychological health.<br>For further information, see: Royal College of Psychiatrists - Faculty of Liaison Psychiatry |
| 723 | Psychiatric Intensive Care Service | Mental Health Services provided to vulnerable individuals with severe disturbances who are admitted to Psychiatric Intensive Care Units from mental health acute wards and forensic settings.<br>For further information, see: Royal College of Psychiatrists - Quality Network for Psychiatric Intensive Care Units |
| 724 | Perinatal Mental Health Service | Formerly known as Perinatal Psychiatry.<br>Specialist Mental Health Services for the assessment, management and treatment of pre-existing or new mental health issues during pregnancy or after delivery.<br>For further information, see: Royal College of Psychiatrists - Faculty of Perinatal Psychiatry |
| 725 | Mental Health Recovery and Rehabilitation Service | Mental Health Services provided to support recovery from mental illness that maximises the PATIENTS' quality of life and social inclusion by encouraging their skills, promoting independence and autonomy.<br>For further information, see: Faculty of Rehabilitation and Social Psychiatry |
| 726 | Mental Health Dual Diagnosis Service | Mental Health Services to provide support to PATIENTS with both severe mental illness and substance misuse problems.<br>For further information, see: Mind: Recreational drugs and alcohol |
| 727 | Dementia Assessment Service | |

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| | | Designated Mental Health Services for the assessment of PATIENTS who have or are suspected to have dementia. Dementia complicates care giving and can occur at any stage of the illness and at any age. In addition to memory impairment, dementia may include behavioural and psychological problems. For non-specific Old Age Psychiatry Service - see TREATMENT FUNCTION CODE 715.<br>For further information, see: Royal College of Psychiatrists - Dementia pathway |
| 730 | Neuropsychiatry Service | Mental Health Services for brain disorders and integration of psychiatry within clinical neurosciences.<br>For further information, see: Royal College of Psychiatrists - Faculty of Neuropsychiatry |
| **Other Services** | | |
| 560 | Midwifery Service | SERVICES for managing antenatal and perinatal care during pregnancy, and postnatal care following delivery, provided under the direct care of a MIDWIFE. Excludes Obstetrics Service - see TREATMENT FUNCTION CODE 501.<br>For further information, see: Royal College of Midwives |
| 650 | Physiotherapy Service | SERVICES helping PATIENTS affected by injury, illness or DISABILITY through movement and exercise, manual therapy, education and advice to manage pain and prevent disease. To encourage development and facilitate recovery, enabling maintenance of work and independence for as long as possible.<br>For further information, see: Chartered Society of Physiotherapy (CSP) - Physiotherapy |
| 651 | Occupational Therapy Service | SERVICES using specific activities to limit the effects of DISABILITY and promote independence in all aspects of daily life |
| 652 | Speech and Language Therapy Service | SERVICES providing assessment, management and treatment of speech, language, communication and swallowing issues in PATIENTS of all ages.<br>For further information, see: Royal College of Speech & Language Therapists - Speech and language therapy |
| 653 | Podiatry Service | Also known as Chiropody.<br>SERVICES for the diagnosis and treatment of disorders, diseases and deformities of the feet. Excludes Podiatric Surgery Service - see TREATMENT FUNCTION CODE 663.<br>For further information, see: The College of Podiatry |
| 654 | Dietetics Service | SERVICES applying the science of nutrition to improve health and treat diseases/conditions by educating and giving practical, personalised advice to PATIENTS, Patient Proxies and other members of the Multidisciplinary Team. They advise on and help to maintain nutritional status during dietary interventions such as exclusion diets and to recommend nutritional supplements.<br>For further information, see: British Dietetic Association |
| 655 | Orthoptics Service | SERVICES providing the diagnosis and treatment of visual problems involving eye movement and alignment.<br>For further information, see: British and Irish Orthoptic Society |
| 657 | Prosthetics Service | SERVICES providing gait analysis and engineering solutions to patients with limb loss. They design and provide prostheses that replicate the structural or functional characteristics of the PATIENTS absent limb. They often work autonomously or part of Multidisciplinary Teams working closely with Physiotherapists and Occupational Therapists as part of multidisciplinary amputee rehabilitation teams.<br>For further information, see: British Association of Prosthetists and Orthotists (BAPO) - Prosthetists |
| 658 | Orthotics Service | SERVICES providing gait analysis and engineering solutions to PATIENTS with needs of the neuro, muscular and skeletal systems. They design and provide orthoses that modify the structural or functional characteristics of the PATIENTS neuro-muscular and |

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| | | skeletal systems enabling patients to mobilise, eliminate gait deviations, reduce falls, reduce pain, prevent and facilitate healing of ulcers. They often work autonomously or part of Multidisciplinary Teams such as within the diabetic foot team or neuro-rehabilitation team.<br>For further information, see: The British Association of Prosthetists and Orthotists (BAPO) - Orthotists |
| 659 | Dramatherapy Service | SERVICES providing dramatherapy which is a form of psychological therapy focussing on the use of performance arts within the therapeutic relationship.<br>For further information, see: British Association of Dramatherapists |
| 660 | Art Therapy Service | SERVICES delivering a form of psychotherapy that uses art media as its primary mode of expression and communication. Within this context, art is not used as diagnostic tool but as a medium to address emotional issues which may be confusing and distressing.<br>For further information, see: British Association of Art Therapists |
| 661 | Music Therapy Service | SERVICES delivering a form of psychotherapy that uses music to support psychological, emotional, cognitive, physical, communicative and/or social needs.<br>For further information, see: British Association for Music Therapy |
| 662 | Optometry Service | SERVICES providing the diagnosis and non-surgical treatment of disorders of the eye and vision care |
| 663 | Podiatric Surgery Service | SERVICES involved in the complex management of the foot and ankle involving surgery under both local and general anaesthetic. Excludes Podiatry Service - see TREATMENT FUNCTION CODE - 653.<br>For further information, see: The College of Podiatry |
| 670 | Urological Physiology Service | Diagnostic SERVICES for the study of erectile, upper and lower urinary tract function, including urodynamics.<br>For further information, see: The British Association of Urological Surgeons |
| 673 | Vascular Physiology Service | Diagnostic SERVICES for the study of arterial and venous circulation primarily using Doppler ultrasound but including tests such as pressure measurement and plethysmography. Excludes Cardiac Physiology Service - see TREATMENT FUNCTION CODE 675.<br>For further information, see: The Society for Vascular Technology |
| 675 | Cardiac Physiology Service | SERVICES providing physiological measurements of the heart structure/function and response to therapeutic/surgical intervention through the means of a wide spectrum of non-invasive and invasive cardiac diagnostic testing. Examples include echocardiography, cardiac device management.<br>For further information, see: Society for Cardiological Science and Technology (SCST) |
| 677 | Gastrointestinal Physiology Service | SERVICES providing physiological measurement of the gastrointestinal tract. This includes standard catheter based oesophageal pH studies, oesophageal pH impedance, oesophageal manometry, ano-rectal manometry, wireless capsule studies. Excludes Gastroenterology Service - see TREATMENT FUNCTION CODE 301.<br>For further information, see: AGIP – Association of GI Physiologists |
| 800 | Clinical Oncology Service | Formerly known as Radiotherapy.<br>The diagnosis and treatment, typically with Radiotherapy, of PATIENTS with cancer.<br>For further information, see: Royal College of Radiologists - Clinical oncology |
| 810 | not a Treatment Function | |
| 811 | Interventional Radiology Service | SERVICES delivering a range of techniques using radiological image guidance including X-ray fluoroscopy, ultrasound, Computerised Tomography Scan, or Magnetic Resonance Imaging Scan (MRI) to precisely target therapy. Excludes Interventional Cardiology - see Cardiology Service TREATMENT FUNCTION CODE 320, and |

| | | Diagnostic Imaging Service - see TREATMENT FUNCTION CODE 812.<br>For further information, see: British Society of Interventional Radiology - What is Interventional Radiology |
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| 812 | Diagnostic Imaging Service | SERVICES providing medical imaging, especially X-ray based examinations, Ultrasound scan, MRI Scan, PET Scan or CT Scan. Diagnostic imaging is used to confirm, assess and document diseases, as well as to assess responses to treatment.<br>For further information, see: WHO: Diagnostic imaging |
| 820 | not a Treatment Function | |
| 821 | not a Treatment Function | |
| 822 | Chemical Pathology Service | SERVICES interpreting biochemical investigation results to assess, diagnose and treat diseases. To be used for the clinical management of PATIENTS by chemical pathology only.<br>For further information, see: Royal College of Pathologists - CHEMICAL PATHOLOGY |
| 823 | not a Treatment Function | See Clinical Haematology |
| 824 | not a Treatment Function | |
| 830 | not a Treatment Function | See Clinical Immunology |
| 831 | not a Treatment Function | See Clinical Microbiology |
| 832 | Retired | |
| 840 | Audiology Service | SERVICES providing physiological measurement and diagnosis of hearing disorders, and the rehabilitation of PATIENTS with hearing loss. Include hearing services activity, such as hearing tests and the fitting of hearing aids.<br>For further information, see: British Society of Audiology |
| 900 | not a Treatment Function | |
| 901 | not a Treatment Function | |
| 902 | not a Treatment Function | |
| 903 | not a Treatment Function | |
| 904 | not a Treatment Function | |
| 920 | Diabetic Education Service | SERVICES providing dedicated small group education courses regarding self-management for diabetic PATIENTS |
| 950 | not a Treatment Function | Use the appropriate function under which the patient is treated |
| 960 | not a Treatment Function | Use the appropriate function under which the patient is treated |
| 990 | Retired | |

**Notes:**

| † | Code 500 is not acceptable for data sets/collections including Hospital Episode Statistics |
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| | TREATMENT FUNCTION CODES should be used for all data sets/collections unless otherwise stated e.g. National Workforce Data Set uses MAIN SPECIALTY CODES |
| | ~~GENERAL MEDICAL PRACTITIONER, NURSE and Allied Health Professional/ Biomedical Scientist/ Clinical Scientist ACTIVITY should be recorded against the TREATMENT FUNCTION under which the PATIENT is treated~~ |
| | GENERAL MEDICAL PRACTITIONER, NURSE and ALLIED HEALTH PROFESSIONAL/ Biomedical Scientist/ Clinical Scientist ACTIVITY should be recorded against the TREATMENT FUNCTION under which the PATIENT is treated |
| | Joint Consultant Clinic ACTIVITY should be recorded against the TREATMENT FUNCTION which best describes the specialised service |

**NHS ALLIED HEALTH PROFESSIONAL SERVICE (REFERRAL TO TREATMENT MEASUREMENT)**

Change to Supporting Information: Changed Description

An NHS Allied Health Professional Service (Referral To Treatment Measurement) is a SERVICE.

~~An NHS Allied Health Professional Service (Referral To Treatment Measurement) is a SERVICE involving the treatment of a PATIENT by one of the following types of Allied Health Professional:~~An NHS Allied Health Professional Service (Referral To Treatment Measurement) is a SERVICE involving the treatment of a PATIENT by one of the following types of ALLIED HEALTH PROFESSIONAL:

- Art Therapists, Music Therapists and Dramatherapists (Arts Therapists)
- Chiropodists/Podiatrists
- Dietitians
- Occupational Therapists
- Orthoptists
- Physiotherapists
- Prosthetists and Orthotists
- Radiographers (Diagnostic and Therapeutic)
- Speech and Language Therapists

~~Where the Allied Health Professional works in a Community Health Service, the Department of Health and Social Care requires their Allied Health Professional Referral To Treatment Measurement activity to be reported in the Community Services Data Set.~~Where the ALLIED HEALTH PROFESSIONAL works in a Community Health Service, the Department of Health and Social Care requires their Allied Health Professional Referral To Treatment Measurement activity to be reported in the Community Services Data Set.

~~Where the Allied Health Professional activity took place at an Out-Patient Clinic, the Allied Health Professional Referral To Treatment Measurement activity must be reported in the CDS V6-2 Type 020 - Outpatient Commissioning Data Set. In addition to this, where an Allied Health Professional sees a PATIENT on a WARD but the ACTIVITY is not related to the Hospital Provider Spell the PATIENT is being treated under, this should be regarded as replacing an Out-Patient Appointment Non-Consultant, and a CDS V6-2 Type 020 - Outpatient Commissioning Data Set record should flow. ACTIVITY LOCATION TYPE CODE may be submitted to allow identification of this Allied Health Professional ACTIVITY. For example, if a Podiatrist were asked to see a patient who was currently admitted for a condition where the agreed care pathway did not include Podiatry services, then an Out-Patient Appointment Non-Consultant should be recorded, with the ACTIVITY LOCATION TYPE CODE of E02 'WARD', and the relevant Referral To Treatment data items also completed.~~Where the ALLIED HEALTH PROFESSIONAL ACTIVITY took place at an Out-Patient Clinic, the Allied Health Professional Referral To Treatment Measurement activity must be reported in the CDS V6-2 Type 020 - Outpatient Commissioning Data Set / CDS V6-3 Type 020 - Outpatient Commissioning Data Set.

In addition, where an ALLIED HEALTH PROFESSIONAL sees a PATIENT on a WARD but the ACTIVITY is not related to the Hospital Provider Spell the PATIENT is being treated under, this should be regarded as replacing a Care Professional Out-Patient Attendance under the management of the ALLIED HEALTH PROFESSIONAL , and a CDS V6-2 Type 020 - Outpatient Commissioning Data Set / CDS V6-3 Type 020 - Outpatient Commissioning Data Set record should be recorded and submitted to the Secondary Uses Service. The ACTIVITY LOCATION TYPE CODE in the CDS V6-2 Type 020 - Outpatient Commissioning Data Set / CDS V6-3 Type 020 - Outpatient Commissioning Data Set may be submitted to allow identification of this ALLIED HEALTH PROFESSIONAL ACTIVITY.

For example, if a Podiatrist were asked to see a PATIENT who was currently admitted for a condition where the agreed care pathway did not include Podiatry services, then a Care Professional Out-Patient Attendance should be recorded, with the ACTIVITY LOCATION TYPE CODE National Code '*WARD*', and the relevant Referral To Treatment data items also completed.

Further guidance relating to Allied Health Professional Referral To Treatment initiative can be found on the Department of Health and Social Care part of the gov.uk website at: the Revised guide for referral to treatment for allied health professionals.

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**NHS AT HOME SERVICE**

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Change to Supporting Information: New Supporting Information

An NHS At Home Service is a SERVICE.

An NHS At Home Service is a nationally-led programme of work providing better connected, more personalised care in PEOPLE's homes, including in Care Homes. It aims to ensure that PEOPLE have faster access to more appropriate and targeted care, maximising the use of technology to support better management of care at home.

NHS At Home Service care encompasses both the active treatment at home by health CARE PROFESSIONALS of PATIENTS who may otherwise be admitted to hospital, and early supported discharge schemes following a Hospital Provider Spell.

For further information on NHS At Home Services, see the NHS England and NHS Improvement website at: NHS @Home.

**This supporting information is also known by these names:**

| Context | Alias |
|---|---|
| plural | NHS At Home Services |

#### PATIENT INITIATED OUT-PATIENT FOLLOW UP APPOINTMENT

Change to Supporting Information: New Supporting Information

A Patient Initiated Out-Patient Follow Up Appointment is an APPOINTMENT.

A Patient Initiated Out-Patient Follow Up Appointment is a follow-up Out-Patient Appointment initiated by a PATIENT.

A Patient Initiated Out-Patient Follow Up Appointment is usually triggered by a PATIENT who is on a formal Patient Initiated Out-Patient Follow-Up Pathway, but APPOINTMENTS requested by a PATIENT who does not have this arrangement in place would also be recorded as Patient Initiated Out-Patient Follow Up Appointments.

For further information on Patient Initiated Out-Patient Follow Up Appointments, see the NHS England and NHS Improvement Outpatient Transformation Programme website at: Patient Initiated Follow Up.

**This supporting information is also known by these names:**

| Context | Alias |
|---|---|
| plural | Patient Initiated Out-Patient Follow Up Appointments |

#### PATIENT INITIATED OUT-PATIENT FOLLOW-UP PATHWAY

Change to Supporting Information: New Supporting Information

A Patient Initiated Out-Patient Follow-Up Pathway is a PATIENT PATHWAY.

A Patient Initiated Out-Patient Follow-Up Pathway allows the PATIENT to initiate their own follow-up Out-Patient Appointments and is intended to support the PATIENT to manage their own condition and book APPOINTMENTS when they are needed, rather than at routine intervals.

For further information on Patient Initiated Out-Patient Follow-Up Pathways, see the NHS England and NHS Improvement Outpatient Transformation Programme website at: Patient Initiated Follow Up.

**This supporting information is also known by these names:**

| Context | Alias |
| --- | --- |
| plural | Patient Initiated Out-Patient Follow-Up Pathways |

#### PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY

Change to Supporting Information: New Supporting Information

A Personalised Out-Patient Follow Up Pathway is a PATIENT PATHWAY.

A Personalised Out-Patient Follow Up Pathway tailors a PATIENT's follow up out-patient care to their individual clinical need, circumstances and preferences.

Personalised Out-Patient Follow Up Pathways may include the following models of care:

- Patient Initiated Out-Patient Follow-Up Pathway
- Remote Monitoring

For further information on Personalised Out-Patient Follow Up Pathways, see the NHS England and NHS Improvement Outpatient Transformation Programme website at: Patient Initiated Follow Up.

**This supporting information is also known by these names:**

| Context | Alias |
| --- | --- |
| alsoknownas | Personalised Out-Patient Follow Up |
| plural | Personalised Out-Patient Follow Up Pathways |

#### PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE

Change to Supporting Information: New Supporting Information

A Personalised Out-Patient Follow Up Pathway Expiry Date is a PLANNED ACTIVITY DATE TIME.

A Personalised Out-Patient Follow Up Pathway Expiry Date is the date that a Personalised Out-Patient Follow Up Pathway will expire.

**This supporting information is also known by these names:**

| Context | Alias |
| --- | --- |
| plural | Personalised Out-Patient Follow Up Pathway Expiry Dates |

#### PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY REVIEW DATE

Change to Supporting Information: New Supporting Information

A Personalised Out-Patient Follow Up Pathway Review Date is a PLANNED ACTIVITY DATE TIME.

A Personalised Out-Patient Follow Up Pathway Review Date is the date that review of a Personalised Out-Patient Follow Up Pathway will take place.

**This supporting information is also known by these names:**

| Context | Alias |
| --- | --- |

| plural | Personalised Out-Patient Follow Up Pathway Review Dates |
|---|---|

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**REFERRAL TO TREATMENT CLOCK STOP ADMINISTRATIVE EVENT**

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Change to Supporting Information: Changed Description

DSCN 18/2006 published in December 2006, defined essential new data items required to support the measurement of 18 week REFERRAL TO TREATMENT PERIODS (monitoring of DH PSA target 13 - "By 2008, no one will have to wait longer than 18 weeks from GP referral to hospital treatment").

In particular, DSCN 18/2006 introduced the following new data items.

- PATIENT PATHWAY IDENTIFIER
- REFERRAL TO TREATMENT PERIOD START DATE
- REFERRAL TO TREATMENT PERIOD END DATE

Strategic reporting of 18 weeks will be undertaken by the Secondary Uses Service using data obtained via the Commissioning Data Sets. The data items defined in DSCN 18/2006 are enabled to flow in Commissioning Data Set.

However, an event which results in an update to the REFERRAL TO TREATMENT PERIOD STATUS may occur outside the events that are defined in the Commissioning Data Sets (typically Outpatient or Inpatient encounters) and will therefore not flow to the Secondary Uses Service. These types of events have been termed as "administrative events". They can be defined as any communication event between the Health Care Provider and the PATIENT that occurs outside of an outpatient attendance or inpatient admission and that results in the PATIENT's REFERRAL TO TREATMENT PERIOD STATUS being changed to stop the 18 week clock. These events are not face to face consultations and do not necessarily involve clinical staff.

These Referral To Treatment Clock Stop Administrative Events may be carried using the Commissioning Data Set Type 020 Outpatient record type. They are differentiated from PATIENT contact ACTIVITY by the FIRST ATTENDANCE value carried within them. FIRST ATTENDANCE national code 5 "Referral to treatment clock stop administrative event" signifies that an ACTIVITY has taken place which has ended the REFERRAL TO TREATMENT PERIOD and changed the REFERRAL TO TREATMENT PERIOD STATUS to one of the following:

- 30 Start of First Definitive Treatment
- 31 Start of Active Monitoring initiated by the PATIENT
- 32 Start of Active Monitoring initiated by the CARE PROFESSIONAL
- 34 Decision not to treat - decision not to treat made or no further contact required
- 35 PATIENT declined offered treatment
- 36 PATIENT died before treatment

**When to Use** Referral To Treatment Clock Stop Administrative Events

These events may happen because:

- The ACTIVITY ending the event does not qualify as a "patient contact" between a clinician and PATIENT, or
- The ACTIVITY occurred in a setting where IT systems cannot produce REFERRAL TO TREATMENT PERIOD data items, or
- The ACTIVITY would be carried in a Commissioning Data Set record type not currently processed by the Secondary Uses Service

Secondary Uses Service Processing

The Secondary Uses Service currently processes the following Commissioning Data Set record types in order to build Referral To Treatment pathways.

- ~~CDS V6-2 Type 020 - Outpatient Commissioning Data Set~~
- ~~CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set~~
- ~~CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set~~
- CDS V6-2 Type 020 - Outpatient Commissioning Data Set / CDS V6-3 Type 020 - Outpatient Commissioning Data Set

- CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set / CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set
- CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set / CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set

**All other types are not currently processed** and so if they carry the REFERRAL TO TREATMENT PERIOD END DATE for a REFERRAL TO TREATMENT PERIOD, a Referral To Treatment Clock Stop Administrative Event must also be sent in order to inform the Secondary Uses Service of the clock stop.

~~Note that future versions of the Secondary Uses Service will also process:~~CDS V6-2 Type 120 - Admitted Patient Care - Finished Birth Episode Commissioning Data Set

- ~~CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set~~
- ~~CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) Commissioning Data Set~~
- ~~CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) Commissioning Data Set~~
- ~~CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) Commissioning Data Set~~

~~The dates when ORGANISATIONS submitting REFERRAL TO TREATMENT PERIOD data to the Secondary Uses Service can cease having to also send a Referral To Treatment Clock Stop Administrative Event when a clock stop is carried in one of the Elective Admission List Commissioning Data Set Types, will be notified as part of the Secondary Uses Service release documentation. A cancelled future APPOINTMENT record could carry a REFERRAL TO TREATMENT PERIOD Clock Stop. Again the timescales will be notified as part of the Secondary Uses Service release documentation.~~

~~There are no current plans for the Secondary Uses Service to process the remaining Commissioning Data Set Types:~~

- ~~CDS V6-2 Type 040 - Elective Admission List - End of Period Census (Old) Commissioning Data Set~~
- ~~CDS V6-2 Type 050 - Elective Admission List - End of Period Census (New) Commissioning Data Set~~
- ~~CDS V6-2 Type 090 - Elective Admission List - Event During Period (Available or Unavailable) Commissioning Data Set~~
- ~~CDS V6-2 Type 100 - Elective Admission List - Event During Period (Old Service Agreement) Commissioning Data Set~~
- ~~CDS V6-2 Type 110 - Elective Admission List - Event During Period (New Service Agreement) Commissioning Data Set~~
- ~~CDS V6-2 Type 120 - Admitted Patient Care - Finished Birth Episode Commissioning Data Set~~
- CDS V6-2 Type 140 - Admitted Patient Care - Finished Delivery Episode Commissioning Data Set
- CDS V6-2 Type 150 - Admitted Patient Care - Other Birth Event Commissioning Data Set
- CDS V6-2 Type 160 - Admitted Patient Care - Other Delivery Event Commissioning Data Set
- ~~CDS V6-2 Type 170 - Admitted Patient Care - Detained and or Long Term Psychiatric Census Commissioning Data Set~~
- ~~CDS V6-2 Type 180 - Admitted Patient Care - Unfinished Birth Episode Commissioning Data Set~~
- CDS V6-2 Type 180 - Admitted Patient Care - Unfinished Birth Episode Commissioning Data Set
- CDS V6-2 Type 200 - Admitted Patient Care - Unfinished Delivery Episode Commissioning Data Set

This is because a Referral To Treatment Clock Stop Administrative Event occurring in the scenarios where these record types are generated, would be rare. However this will be reviewed as part of the ongoing maintenance of the Referral To Treatment Clock Stop Administrative Event, and the requirements for the Secondary Uses Service.

**When NOT to Use a Referral To Treatment Clock Stop Administrative Event**

The Referral To Treatment Clock Stop Administrative Event should NOT be used to correct previously submitted records where a REFERRAL TO TREATMENT PERIOD END DATE was submitted incorrectly to the Secondary Uses Service.

~~For example, if an Out-Patient Appointment took place where First Definitive Treatment was started, but the REFERRAL TO TREATMENT PERIOD END DATE was not sent in the corresponding CDS V6-2 Type 020 - Outpatient Commissioning Data Set record as it was not entered on the Patient Administration System until later; then the CDS V6-2 Type 020 - Outpatient Commissioning Data Set record should be resubmitted with the correct data.~~For example, if an Out-Patient Appointment took place where First Definitive Treatment was started, but the REFERRAL TO TREATMENT PERIOD END DATE was not sent in the corresponding CDS V6-2 Type 020 - Outpatient Commissioning Data Set/CDS V6-3 Type 020 - Outpatient Commissioning Data Set record as it was not

entered on the Patient Administration System until later; then the CDS V6-2 Type 020 - Outpatient Commissioning Data Set/CDS V6-3 Type 020 - Outpatient Commissioning Data Set record should be resubmitted with the correct data. A Referral To Treatment Clock Stop Administrative Event should NOT be used.

~~Where an ORGANISATION's Patient Administration System supports the submission of cancelled and Did Not Attend appointments in the CDS V6-2 Type 020 - Outpatient Commissioning Data Set, the Referral To Treatment Clock Stop Administrative Event should NOT be used when a PATIENT has a booked Out-Patient Appointment, which is then cancelled because, for example, the PATIENT dies. In these cases the CDS V6-2 Type 020 - Outpatient Commissioning Data Set can carry the details of a cancelled CARE ACTIVITY, including the REFERRAL TO TREATMENT PERIOD END DATE and update to the REFERRAL TO TREATMENT PERIOD STATUS.~~Where an ORGANISATION's Patient Administration System supports the submission of cancelled and Did Not Attend appointments in the CDS V6-2 Type 020 - Outpatient Commissioning Data Set/CDS V6-3 Type 020 - Outpatient Commissioning Data Set, the Referral To Treatment Clock Stop Administrative Event should NOT be used when a PATIENT has a booked Out-Patient Appointment, which is then cancelled because, for example, the PATIENT dies. In these cases the CDS V6-2 Type 020 - Outpatient Commissioning Data Set/CDS V6-3 Type 020 - Outpatient Commissioning Data Set can carry the details of a cancelled CARE ACTIVITY, including the REFERRAL TO TREATMENT PERIOD END DATE and update to the REFERRAL TO TREATMENT PERIOD STATUS. (Note - not all Patient Administration Systems provide functionality to create and submit Commissioning Data Set records for cancellations/Did Not Attend's as this is not yet mandated - you should contact your Patient Administration System support team to ascertain whether your Patient Administration System supports this. If not, then it is permissible to send a Referral To Treatment Clock Stop Administrative Event in order to stop the clock in the Secondary Uses Service instead).

~~Referral To Treatment Clock Stop Administrative Events only require a sub-set of the data elements contained in the CDS V6-2 Type 020 - Outpatient Commissioning Data Set record, to be submitted to the Secondary Uses Service. All other data elements not listed should be omitted from the XML submission of the CDS V6-2 Type 020 - Outpatient Commissioning Data Set record to the Secondary Uses Service.~~Referral To Treatment Clock Stop Administrative Events only require a sub-set of the data elements contained in the CDS V6-2 Type 020 - Outpatient Commissioning Data Set/CDS V6-3 Type 020 - Outpatient Commissioning Data Set record, to be submitted to the Secondary Uses Service. All other data elements not listed should be omitted from the XML submission of the CDS V6-2 Type 020 - Outpatient Commissioning Data Set/CDS V6-3 Type 020 - Outpatient Commissioning Data Set record to the Secondary Uses Service. The submission of a Referral To Treatment Clock Stop Administrative Event is not reliant on the use of the Net Change Commissioning Data Set Submission Protocol to the Secondary Uses Service

The required data elements making up a Referral To Treatment Clock Stop Administrative Event are:

| Data Element Required | Notes |
|---|---|
| ~~UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) or PATIENT PATHWAY IDENTIFIER~~ | ~~The Commissioning Data Set Schema version 6-2 requires EITHER the PATIENT PATHWAY IDENTIFIER, or the UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) to be populated.~~ |
| ~~ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)~~ | ~~If the UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) is used, the ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) should contain X09 (which relates to the Choose and Book system)~~ |
| UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) or PATIENT PATHWAY IDENTIFIER | The Commissioning Data Set XML Schema versions 6-2 and 6-3 for Type 020 Outpatients require EITHER the PATIENT PATHWAY IDENTIFIER, or the UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) to be populated |
| ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)/ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER) | If the UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) is used, the ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)/ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER) should contain X09 (which relates to the Choose and Book system) |
| REFERRAL TO TREATMENT PERIOD STATUS | This should contain only one of the following codes to signify that the REFERRAL TO TREATMENT PERIOD has ended:<br>• 30 Start of First Definitive Treatment |

| | |
|---|---|
| | • 31 Start of Active Monitoring initiated by the PATIENT<br>• 32 Start of Active Monitoring initiated CARE PROFESSIONAL<br>• 34 Decision not to treat - decision not to treat made or no further contact required<br>• 35 PATIENT declined offered treatment<br>• 36 PATIENT died before treatment |
| WAITING TIME MEASUREMENT TYPE | This item is XML mandatory in the CDS V6-2 schema. |
| WAITING TIME MEASUREMENT TYPE/WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET) | This item is mandatory in the Commissioning Data Set XML schema versions 6-2 and 6-3 XML schema |
| REFERRAL TO TREATMENT PERIOD START DATE | |
| REFERRAL TO TREATMENT PERIOD END DATE | |
| NHS NUMBER | |
| NHS NUMBER STATUS INDICATOR CODE | |
| POSTCODE OF USUAL ADDRESS | |
| ORGANISATION CODE (RESIDENCE RESPONSIBILITY) | |
| ORGANISATION CODE (RESIDENCE RESPONSIBILITY)/ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) | |
| FIRST ATTENDANCE CODE | This should always hold the National code 5 - "Referral to Treatment Period Clock Stop Administrative Event" |
| APPOINTMENT DATE | This field is XML mandatory in Commissioning Data Set Schema version 6-2 for Type 020 Outpatients, and for the purposes of the Referral To Treatment Clock Stop Administrative Event, should hold the same date as the REFERRAL TO TREATMENT PERIOD END DATE |
| AGE AT CDS ACTIVITY DATE | This field is XML mandatory in the Commissioning Data Set Schema version 6-2 for Type 020 Outpatients, and should hold the PATIENTS age at REFERRAL TO TREATMENT PERIOD END DATE |
| ORGANISATION CODE (CODE OF PROVIDER) | This field is mandatory in the CDS V6-2 schema |
| ORGANISATION CODE (CODE OF COMMISSIONER) | This field is mandatory in the CDS V6-2 schema |
| APPOINTMENT DATE | This field is mandatory in the Commissioning Data Set XML Schema versions 6-2 and 6-3 for Type 020 Outpatients, and for the purposes of the Referral To Treatment Clock Stop Administrative Event, should hold the same date as the REFERRAL TO TREATMENT PERIOD END DATE |
| AGE AT CDS ACTIVITY DATE | This field is mandatory in the Commissioning Data Set XML Schema versions 6-2 and 6-3 for Type 020 Outpatients, and should hold the PATIENTS age at REFERRAL TO TREATMENT PERIOD END DATE |
| ORGANISATION CODE (CODE OF PROVIDER)/ORGANISATION IDENTIFIER (CODE OF PROVIDER) | This field is mandatory in the Commissioning Data Set XML schema versions 6-2 and 6-3 for Type 020 Outpatients |
| ORGANISATION CODE (CODE OF COMMISSIONER)/ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) | This field is mandatory in the Commissioning Data Set XML schema versions 6-2 and 6-3 for Type 020 Outpatients |

**REMOTE MONITORING**

Change to Supporting Information: New Supporting Information

Remote Monitoring is a CLINICAL INTERVENTION.

Remote Monitoring is the monitoring of a PATIENT (using MEDICAL DEVICES, applications, Clinical Investigation results, or ASSESSMENT TOOLS), to allow a CARE PROFESSIONAL or SERVICE to initiate an Out-Patient Appointment when required to manage the PATIENT's condition.

For further information on Remote Monitoring, see the NHS England and NHS Improvement Outpatient Transformation Programme website at: Patient Initiated Follow Up.

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**REMOTE MONITORING TRIGGERED OUT-PATIENT FOLLOW UP APPOINTMENT**

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Change to Supporting Information: New Supporting Information

A Remote Monitoring Triggered Out-Patient Follow Up Appointment is an APPOINTMENT.

A Remote Monitoring Triggered Out-Patient Follow Up Appointment is a follow-up Out-Patient Appointment which is triggered by a CARE PROFESSIONAL as a result of review of the outcome of Remote Monitoring of a PATIENT.

For further information on Remote Monitoring, see the NHS England and NHS Improvement Outpatient Transformation Programme website at: Patient Initiated Follow Up.

**This supporting information is also known by these names:**

| Context | Alias |
|---|---|
| plural | Remote Monitoring Triggered Out-Patient Follow Up Appointments |

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**SECURITY ISSUES AND PATIENT CONFIDENTIALITY**

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Change to Supporting Information: Changed Description

**A. Removal of name and address where the NHS Number is present**

- From 1 April 1999, PATIENT NAME and PATIENT USUAL ADDRESS (not POSTCODE OF USUAL ADDRESS) must be removed from all Commissioning Data Sets where a valid NHS NUMBER is present. This applies to all nationally defined Commissioning Data Set data and any additional locally agreed flows from service providers to commissioning bodies.

- A valid NHS NUMBER is one that has passed the check digit calculation on entry into the source system. If an NHS NUMBER is not valid (i.e. does not conform with the check digit algorithm) then PATIENT NAMES and PATIENT USUAL ADDRESSES should not be removed, as the reliability of the NHS NUMBER will not be known.

- The NHS NUMBER STATUS INDICATOR CODE is a mandatory part of the Commissioning Data Set. PATIENT NAME and PATIENT USUAL ADDRESS should be removed when a valid NHS NUMBER is present, even if the NHS NUMBER STATUS INDICATOR CODE does not have a status of 01, *Number present and verified*.

**B. Sensitive data**

- The Human Fertilisation and Embryology Act 1990 as amended by the Human Fertilisation and Embryology (Disclosure of Information) Act 1992 imposes statutory restrictions on the disclosure of information about identifiable individuals in connection with certain infertility treatments.

- ~~The latest approved list of codes which can be used to identify the relevant PATIENT record in which the patient-identifiable data are to be omitted from the CDS Types can be accessed via Technology Reference~~

~~Data Update Distribution (TRUD). In these cases the NHS NUMBER, LOCAL PATIENT IDENTIFIER, PATIENT NAMES, POSTCODE OF USUAL ADDRESS and PERSON BIRTH DATE should be omitted from the CDS Types.~~

- ~~From Commissioning Data Set Version 6-2, records where the patient-identifiable data has been withheld should be submitted using the PATIENT IDENTITY - WITHHELD IDENTITY STRUCTURE data group in CDS types where identification is carried. This data group allows only the NHS NUMBER STATUS INDICATOR CODE (the actual value held on source systems should be used), ORGANISATION CODE (RESIDENCE RESPONSIBILITY) and WITHHELD IDENTITY REASON to flow. The WITHHELD IDENTITY REASON allows Health Care Providers to inform their Commissioners why a record has been anonymised. Note that the same rules apply to the additional PATIENT IDENTITY structures relating to Mother and Baby in the Delivery and Birth CDS types.~~

- The latest approved list of codes which can be used to identify the relevant PATIENT record in which the patient-identifiable data are to be omitted from the CDS Types can be accessed via the Secondary Uses Service website. In these cases the NHS NUMBER, LOCAL PATIENT IDENTIFIER/LOCAL PATIENT IDENTIFIER (EXTENDED), PATIENT NAMES, POSTCODE OF USUAL ADDRESS and PERSON BIRTH DATE should be omitted from the Commissioning Data Set submission.

- From Commissioning Data Set Version 6-2 onwards, records where the patient-identifiable data has been withheld should be submitted using the PATIENT IDENTITY - WITHHELD IDENTITY STRUCTURE data group in the Commissioning Data Set XML schema. This data group allows only the NHS NUMBER STATUS INDICATOR CODE (the actual value held on source systems should be used), ORGANISATION CODE (RESIDENCE RESPONSIBILITY)/ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) and WITHHELD IDENTITY REASON to flow. The WITHHELD IDENTITY REASON allows Health Care Providers to inform their Commissioners why a record has been anonymised. Note that the same rules apply to the additional PATIENT IDENTITY structures relating to Mother and Baby in the Delivery and Birth CDS types.

- Other statutory restrictions on the disclosure of PATIENT information do not prohibit the disclosure to individuals involved with the treatment and prevention of certain specific diseases (HIV/AIDS and venereal diseases) in the population.

- ~~**All records containing patient identifiable information, other than those covered by the Sensitive Data section, should be treated as sensitive.** ORGANISATIONS may continue to exchange records containing NHS NUMBER, POSTCODE OF USUAL ADDRESS and PERSON BIRTH DATE in these cases, but receiving ORGANISATIONS must ensure that only those staff with legitimate need have access to this information, e.g. public health departments, and strictly on a need to know basis. No-one should have unrestricted access unless fully justified in accordance with the principles of the Caldicott Committee Report.~~

- ~~Where PATIENT level data is required for other purposes within an ORGANISATION, it should be anonymised/aggregated prior to disclosure by someone with legitimate access. If this is not practicable, local protocols defining which CDS Types are particularly sensitive (including, but not necessarily restricted to HIV/AIDS and venereal disease) agreed by the ORGANISATION Caldicott Guardian, should be put in place and identifiers stripped from these records.~~

- **All records containing patient identifiable information, other than those covered by the Sensitive Data section, should be treated as sensitive.** ORGANISATIONS may continue to exchange records containing NHS NUMBER, POSTCODE OF USUAL ADDRESS and PERSON BIRTH DATE in these cases, but receiving ORGANISATIONS must ensure that only those staff with legitimate need have access to this information, e.g. public health departments, and strictly on a need to know basis. No-one should have unrestricted access unless fully justified in accordance with the Caldicott Principles.

- Where PATIENT level data is required for other purposes within an ORGANISATION, it should be anonymised/aggregated prior to disclosure by someone with legitimate access. If this is not practicable, local protocols defining which CDS Types are particularly sensitive (including, but not necessarily restricted to HIV/AIDS and venereal disease) agreed by the ORGANISATION Caldicott Guardian, should be put in place and identifiers stripped from these records.

- Your Caldicott Guardian will be able to advise you further on all issues relating to patient confidentiality.

- Where appropriate, further information about confidentiality is contained within the notes for individual data items.

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**SUPPORTING DEFINITIONS MENU**

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Change to Supporting Information: Changed Description


- **Main Menu**

- NHS Business Definitions
- Supporting Information

**Supporting Definitions:**
- 18 Weeks
- Accessible Information
- Assistive Technology
- Automatic Identification and Data Capture
- Care Programme Approach
- Children's Nursing
- Children Act 2004
- Choose and Book
- Community Treatment Order
- Community Treatment Order Recall
- Contract Monitoring
- Data Dictionary Change Notice
- Data Dictionary for Care
- Data Landing Portal
- Data Processing Services
- Data Services for Commissioners
- Delen
- Department
- Department for Work and Pensions Overseas Healthcare Team
- Discharge After Patient Did Not Attend
- e-Government Interoperability Framework
- Elective Admission
- Electronic Staff Record
- Electronic Staff Record Data Warehouse
- eMED3 Fit Note
- European Economic Area
- Fast Healthcare Interoperability Resources
- Fever Nursing
- Government Data Standards Catalogue
- GS1 Application Identifier (Global)
- GS1 Application Identifier (Internal)
- GS1 Global Service Relation Number
- Healthcare Resource Group
- HES Data Dictionary
- Hospital Episode Statistics
- Information Standards and Collections (Including Extraction)
- Information Standards Board for Health and Social Care
- Information Standards Notice
- Integrated Care System
- International Esophageal Database
- Internet Enabled Therapy Activity Log
- Laboratory
- Learning Disabilities Nursing
- Market Forces Factor
- Mental Health Care Cluster Super Class
- Mental Health Nursing

- National Casemix Office
- National Health Service (Overseas Visitors Hospital Charging Regulations)
- National Health Service Act 2006
- National Tariff Payment System
- Neonatal Critical Care Unit
- Neonatal Unit
- NHS Continuing Healthcare Local Appeal
- NHS Continuing Healthcare Local Resolution
- NHS Data Model and Dictionary Service
- NHS England (Region)
- NHS Standard Contract
- Non-Contract Activity
- Organisation Data Service
- Overseas Visitor Treatment Portal
- Patient Level Information Costing
- Personal Demographics Service
- Point of Delivery
- Primary Care Network
- Reciprocal Healthcare Agreement
- Rupture of Membranes
- S2
- Secondary Uses Service
- Special Education Needs
- Standardisation Committee for Care Information
- Strategic Data Collection Service
- Strategic Data Collection Service in the Cloud
- Sustainability and Transformation Partnership
- Technology Reference Data Update Distribution (TRUD)
- Terminology and Classifications Delivery Service

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#### TIMED OUT-PATIENT FOLLOW UP APPOINTMENT

Change to Supporting Information: New Supporting Information

A Timed Out-Patient Follow Up Appointment is an APPOINTMENT.

A Timed Out-Patient Follow Up Appointment is a follow-up Out-Patient Appointment which is planned with the PATIENT during an Out-Patient Appointment, with the length of time between APPOINTMENTS based on the individual PATIENT's needs.

For further information on Timed Out-Patient Follow Up Appointments, see the NHS England and NHS Improvement Outpatient Transformation Programme website at: Patient Initiated Follow Up.

**This supporting information is also known by these names:**

| Context | Alias |
|---|---|
| plural | Timed Out-Patient Follow Up Appointments |

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#### ACTIVITY GROUP

Change to Class: Changed Attributes

*Attributes of this Class are:*

ACTIVITY GROUP TYPE
ADJUSTED LENGTH OF STAY FOR PATIENT LEVEL INFORMATION COSTING
ADMISSION METHOD
ADMISSION SOURCE

CANCER OR SYMPTOMATIC BREAST REFERRAL PATIENT STATUS
CANCER TRANSFER REASON FOR INTER PROVIDER TRANSFER
CANCER TREATMENT INTENT
CARE PACKAGE IDENTIFIER FOR NHS CONTINUING HEALTHCARE
CARE PACKAGE REVIEW ELIGIBILITY OUTCOME FOR NHS CONTINUING HEALTHCARE
CARE PACKAGE REVIEW OUTCOME CODE FOR NHS CONTINUING HEALTHCARE
CARE PACKAGE REVIEW TYPE FOR NHS CONTINUING HEALTHCARE
CARER RESIDENT INDICATION CODE FOR NATIONAL NEONATAL DATA SET
CHILDREN TEENAGERS AND YOUNG ADULTS AGE CATEGORY
CLINICAL COMMISSIONING GROUP ELIGIBILITY DECISION OUTCOME FOR NHS CONTINUING HEALTHCARE STANDARD
CLINICAL COMMISSIONING GROUP REVIEW ELIGIBILITY DECISION OUTCOME FOR NHS CONTINUING HEALTHCARE
COMMUNITY TREATMENT ORDER END REASON
CONSULTANT EPISODE COMPLETION STATUS FOR PATIENT LEVEL INFORMATION COSTING
CONTINUITY OF CARER PATHWAY INDICATOR
DAUGHTER BORN AT THIS ENCOUNTER INDICATOR
DELIVERY PLACE CHANGE REASON
DESTINATION OF DISCHARGE
DISCHARGE DESTINATION
DISCHARGED TO HOSPITAL AT HOME SERVICE INDICATOR
DISCHARGED TO NHS AT HOME SERVICE INDICATOR
DISCHARGE FROM IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES SERVICE REASON
DISCHARGE METHOD
DISCHARGE REASON FOR MOTHER MATERNITY SERVICES
ESTIMATED DATE OF DELIVERY
FIRST REGULAR DAY OR NIGHT ADMISSION
FITNESS ASSESSMENT FOR OLDER PATIENTS WITH BREAST CANCER INDICATOR
HOLISTIC NEEDS ASSESSMENT POINT OF PATHWAY FOR CANCER
HOSPITAL PROVIDER SPELL COMPLETION STATUS FOR PATIENT LEVEL INFORMATION COSTING
LAST EPISODE IN SPELL INDICATOR CODE
LENGTH OF STAY ADJUSTMENT
LENGTH OF STAY ADJUSTMENT REASON
MATERNAL CRITICAL INCIDENT INDICATOR
MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY
MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION
MENTAL HEALTH CONDITIONAL DISCHARGE END REASON
MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE
MENTAL HEALTH DELAYED DISCHARGE REASON
METHOD OF ADMISSION
METHOD OF DISCHARGE
MULTIDISCIPLINARY TEAM RECOMMENDATION FOR NHS CONTINUING HEALTHCARE STANDARD
NEONATAL CRITICAL INCIDENT INDICATOR
NEONATAL LEVEL OF CARE
NHS CONTINUING HEALTHCARE ACTIVITY TYPE
NHS CONTINUING HEALTHCARE COMMISSIONED SERVICES INDICATOR
NHS CONTINUING HEALTHCARE PREVIOUSLY UNASSESSED PERIOD OF CARE DECISION OUTCOME
NHS CONTINUING HEALTHCARE REFERRAL EXCEEDING 28 DAYS TIME BAND CATEGORY
NHS CONTINUING HEALTHCARE TYPE
NON SMOKING CONFIRMATION STATUS AT 4 WEEKS

OPERATION FUNDING FOR NATIONAL JOINT REGISTRY
OUTCOME AT 4 WEEK FOLLOW UP FOR STOP SMOKING
OUTPATIENT ATTENDANCE OUTCOME
PALLIATIVE CARE SPECIALIST SEEN INDICATOR
PALLIATIVE TREATMENT REASON FOR UPPER GASTROINTESTINAL
PATIENT ATTENDANCE SYMPTOMATIC INDICATOR FOR SEXUAL HEALTH SERVICE
PATIENT CLASSIFICATION
PATIENT ON PATIENT INITIATED OUTPATIENT FOLLOW UP PATHWAY INDICATOR
PATIENT RECEIVING ONE TO ONE NURSING CARE INDICATOR
PERSONALISED CARE AND SUPPORT PLANNING POINT OF CANCER PATHWAY
PHARMACOTHERAPY STOP SMOKING AID RECEIVED
PLANNED DELIVERY SETTING CHANGE REASON
PREGNANCY OUTCOME
PSYCHIATRIC PATIENT STATUS
SOURCE OF ADMISSION

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**ALLIED HEALTH PROFESSIONAL**

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Change to Class: New Class

A subtype of CARE PROFESSIONAL.

A PERSON who is registered with and regulated by the Health and Care Professions Council.

**This class is also known by these names:**

| Context | Alias |
|---|---|
| plural | ALLIED HEALTH PROFESSIONALS |

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**ALLIED HEALTH PROFESSIONAL**

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Change to Class: New Class

*This class has no attributes.*

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**ALLIED HEALTH PROFESSIONAL**

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Change to Class: New Class

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**APPOINTMENT**

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Change to Class: Changed Attributes

*Attributes of this Class are:*

K APPOINTMENT DATE
K APPOINTMENT IDENTIFIER
K APPOINTMENT TIME
APPOINTMENT BOOKED REASON
APPOINTMENT CANCELLED DATE
APPOINTMENT FIRST ATTENDANCE
APPOINTMENT TYPE FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES
ATTENDED OR DID NOT ATTEND

UNIQUE BOOKING REFERENCE NUMBER CONVERTED

**CARE PROFESSIONAL TEAM**

Change to Class: Changed Attributes

*Attributes of this Class are:*

K CARE PROFESSIONAL TEAM IDENTIFIER
CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE
MEMBER OF SPECIALIST MULTIDISCIPLINARY TEAM INDICATOR
REHABILITATION ASSESSMENT TEAM TYPE
RESPONSIBLE CARE PROFESSIONAL INDICATOR

**CLINICAL INTERVENTION**

Change to Class: Changed Attributes

*Attributes of this Class are:*

ABDOMINAL XRAY PERFORMED REASON
ABDOMINAL XRAY PERFORMED TO INVESTIGATE ABDOMINAL SIGNS INDICATOR
ABLATIVE THERAPY TYPE
ACUTE ONCOLOGY ASSESSMENT PATIENT PRESENTATION TYPE
ACUTE ONCOLOGY EPISODE OUTCOME
ADDITIONAL UNPLANNED PROCEDURE REQUIRED INDICATOR
ADJUNCTIVE THERAPY TYPE
ANAESTHETIC TYPE FOR JOINT REPLACEMENT
ANTIRETROVIRAL THERAPY DRUG REGIMEN GROUP CODE
ANTIRETROVIRAL THERAPY HOME DELIVERY INDICATOR
ARTHROPLASTY REVISION TYPE FOR HIP KNEE AND ANKLE REPLACEMENT
ARTHROPLASTY REVISION TYPE FOR SHOULDER AND ELBOW REPLACEMENT
ASA PHYSICAL STATUS CLASSIFICATION SYSTEM CODE
ASA PHYSICAL STATUS CLASSIFICATION SYSTEM CODE FOR NATIONAL JOINT REGISTRY
ASSOCIATED PROCEDURE TYPE FOR ANKLE REPLACEMENT
BIOLOGICAL GLENOID RESURFACING TYPE FOR SHOULDER REPLACEMENT
BIOPSY ANAESTHETIC TYPE
BIOPSY TYPE FOR CENTRAL NERVOUS SYSTEM TUMOURS
BLOOD PRODUCTS REQUIRED FOLLOWING OESOPHAGECTOMY INDICATION CODE
BLOOD TRANSFUSION PRODUCT TYPE
BLOOD TRANSFUSION TYPE
BONE GRAFT INDICATOR FOR JOINT REPLACEMENT
BONE GRAFT SOURCE FOR JOINT REPLACEMENT
BONE GRAFT STRUCTURE FOR JOINT REPLACEMENT
BREAST ASSESSMENT OUTCOME
BREAST TRIPLE DIAGNOSTIC ASSESSMENT INDICATOR
BRONCHOSCOPY PERFORMED TYPE
CANCER CARE SETTING FOR TREATMENT
CANCER IMAGING MODALITY
CANCER IMAGING OUTCOME
CANCER SURGICAL ADMISSION TYPE
CANCER TREATMENT MODALITY
CANCER TREATMENT MODALITY FOR REGISTRATION
CARDIOPULMONARY EXERCISE TEST TYPE

CD4 CELL COUNT PERFORMED INDICATOR
CEMENT REMOVAL INDICATOR FOR JOINT REPLACEMENT
CHEMICAL THROMBOPROPHYLAXIS REGIME TYPE FOR JOINT REPLACEMENT
CHEST DRAIN IN SITU INDICATOR
CHRONIC VIRAL LIVER DISEASE TREATMENT INDICATOR FOR HIV
CLINICAL INTERVENTION TEXT STRING
CLINICAL INTERVENTION TYPE
CO MORBIDITY ADJUSTMENT INDICATOR
COMPONENT REMOVAL INDICATOR FOR JOINT REPLACEMENT
COMPUTER GUIDED SURGERY INDICATOR FOR JOINT REPLACEMENT
CONTINUOUS INFUSION OF PULMONARY VASODILATOR RECEIVED INDICATOR
CONTRACEPTION METHOD STATUS
DEINFIBULATION UNDERTAKEN REASON
DELIVERED IN WATER INDICATOR
DELIVERY INSTRUMENT TYPE
DIEPOXYBUTANE TEST RESULT
DRUG REGIMEN ACRONYM
EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR
ENDOSCOPIC OR RADIOLOGICAL COMPLICATION TYPE
ENDOSCOPIC PROCEDURE TYPE
ENTERAL FEEDING METHOD
ENTERAL FEED TYPE GIVEN
ESCALATION IN LEVEL OF PATIENT CARE FOLLOWING OESOPHAGECTOMY INDICATOR
EXCISION TYPE FOR CENTRAL NERVOUS SYSTEM TUMOURS
FETAL ORDER
FIRST ANTIRETROVIRAL THERAPY IN THE UNITED KINGDOM INDICATOR
FIXATION TYPE FOR ELBOW REPLACEMENT
FIXATION TYPE FOR SHOULDER REPLACEMENT
FORMULA MILK OR MILK FORTIFIER TYPE
FRACTION NUMBER
GERMLINE GENETIC TEST TYPE OFFERED
HIP JOINT SURGERY PATIENT POSITION
HUMAN PAPILLOMAVIRUS VACCINATION DOSE GIVEN
IMAGE GUIDED SURGERY INDICATOR
IMAGING ANATOMICAL SITE
INFECTION CULTURE TEST INDICATOR
INTERNATIONAL ESOPHAGEAL DATABASE SURGICAL COMPLICATIONS
INTERVENTION SESSION TYPE FOR STOP SMOKING
INTERVENTION SETTING TYPE FOR STOP SMOKING
INTRAPARTUM ANTIBIOTICS GIVEN INDICATOR
INTRAVESICAL CHEMOTHERAPY RECEIVED INDICATOR
INTRAVESICAL IMMUNOTHERAPY RECEIVED INDICATOR
JOINT REPLACEMENT PATIENT PROCEDURE PERFORMED INDICATOR
JOINT REPLACEMENT REVISION REASON CODE FOR ANKLE
JOINT REPLACEMENT REVISION REASON CODE FOR ELBOW
JOINT REPLACEMENT REVISION REASON CODE FOR HIP
JOINT REPLACEMENT REVISION REASON CODE FOR KNEE
JOINT REPLACEMENT REVISION REASON CODE FOR SHOULDER
KI 67 STAINING PERFORMED INDICATION CODE
LABOUR OR DELIVERY ONSET METHOD
LABOUR OR DELIVERY ONSET METHOD CODE FOR NATIONAL NEONATAL DATA SET
LAPAROTOMY FOR NECROTISING ENTEROCOLITIS INDICATION CODE

LATENT TUBERCULOSIS TEST PERFORMED INDICATOR
LINER REMOVAL INDICATOR FOR JOINT REPLACEMENT
LIVER CANCER SURVEILLANCE SCAN INDICATOR
LIVER SURGERY PERFORMED TYPE
LIVER TRANSARTERIAL EMBOLISATION MATERIAL INJECTION TYPE
MALIGNANCY TREATMENT INDICATOR FOR HIV
MARGIN INVOLVED INDICATION CODE
MARGIN INVOLVED INDICATION CODE FOR COLORECTAL
MATERNITY CARE SETTING
MECHANICAL THROMBOPROPHYLAXIS REGIME TYPE FOR JOINT REPLACEMENT
MECONIUM PRESENT IN LIQUOR INDICATOR
MEDIASTINAL SAMPLING INDICATOR
MINIMALLY INVASIVE OESOPHAGECTOMY SURGICAL APPROACH TYPE
MINIMALLY INVASIVE SURGERY INDICATOR FOR JOINT REPLACEMENT
MORE THAN THREE RECTAL WASHOUTS RECEIVED INDICATOR
MRI ULTRASOUND FUSION GUIDED BIOPSY INDICATOR
MULTIPARAMETRIC MRI SCAN INDICATOR
NEOADJUVANT THERAPY INDICATOR
NEONATAL RESUSCITATION METHOD FOR NATIONAL NEONATAL DATA SET
NEURODEVELOPMENTAL ASSESSMENT ALREADY TAKEN INDICATOR
NEWBORN HEARING SCREENING TEST TYPE
NITRIC OXIDE GIVEN INDICATOR
NUMBER OF TELETHERAPY FIELDS
OBSERVATION SCHEME IN USE
OESOPHAGECTOMY ANASTOMOSIS TYPE
OESOPHAGECTOMY NECK DISSECTION INDICATOR
OESOPHAGECTOMY OESOPHAGEAL CONDUIT TYPE
OESOPHAGECTOMY SURGICAL APPROACH TYPE
OPEN OESOPHAGECTOMY SURGICAL APPROACH TYPE
OPERATION STATUS CODE
PARENTAL CONSENT TO ADMINISTER VITAMIN K INDICATOR
PARENTAL CONSENT TO POST MORTEM INDICATOR
PARENTERAL NUTRITION RECEIVED INDICATOR
PATHOLOGY INVESTIGATION TYPE
PATHOLOGY INVESTIGATION TYPE FOR BREAST SCREENING
PATIENT CONSENT FOR TISSUE BANKED AT DIAGNOSIS INDICATION CODE
PATIENT DIAGNOSIS TREATMENT PROVIDED INDICATION CODE FOR SEXUAL HEALTH SERVICE
PATIENT PROCEDURE PERFORMED INDICATOR
PATIENT PROCEDURE TYPE FOR PRIMARY ANKLE REPLACEMENT
PATIENT PROCEDURE TYPE FOR PRIMARY ELBOW REPLACEMENT
PATIENT PROCEDURE TYPE FOR PRIMARY HIP REPLACEMENT
PATIENT PROCEDURE TYPE FOR PRIMARY KNEE REPLACEMENT
PATIENT PROCEDURE TYPE FOR PRIMARY SHOULDER REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION ANKLE REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION ELBOW REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION HIP REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION KNEE REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION SHOULDER REPLACEMENT
PATIENT SPECIFIC INSTRUMENTS INDICATOR FOR SHOULDER OR KNEE REPLACEMENT
PATIENT SUBJECT TO REMOTE MONITORING INDICATOR
PATIENT TREATED TO CHILDRENS CANCER AND LEUKAEMIA GROUP GUIDELINES INDICATOR

PLANE OF SURGICAL EXCISION INDICATOR
POST MORTEM CARRIED OUT INDICATOR
POST MORTEM CONFIRMED NECROTISING ENTEROCOLITIS DIAGNOSIS INDICATOR
PRETREATMENT PROSTATE BIOPSY TECHNIQUE TYPE
PREVIOUS BONY INFECTION INDICATOR OF TIBIA OR HINDFOOT FOR ANKLE REPLACEMENT
PREVIOUS FRACTURE OF INDEX JOINT INDICATOR FOR ANKLE REPLACEMENT
PREVIOUS INDEX JOINT SURGERY TYPE FOR ANKLE REPLACEMENT
PREVIOUS SURGERY TYPE FOR SHOULDER REPLACEMENT
PRIMARY INDUCTION CHEMOTHERAPY FAILURE INDICATOR
PRINCIPAL DIAGNOSTIC IMAGING TYPE
PROCEDURE SCHEME IN USE
PROSTATE NERVE SPARING SURGERY TYPE
RADICAL PROSTATECTOMY MARGIN STATUS
RADIOISOTOPE
RADIOTHERAPY ACTUAL DOSE
RADIOTHERAPY BEAM TYPE
RADIOTHERAPY INTENT
RADIOTHERAPY PRESCRIBED DOSE
RADIOTHERAPY TREATMENT MODALITY
REGIONAL ANAESTHETIC TECHNIQUE FOR CANCER
RELAPSE METHOD DETECTION TYPE
RENAL VEIN TUMOUR INDICATOR FOR PAEDIATRIC KIDNEY
RENAL VEIN TUMOUR THROMBUS INDICATION CODE FOR UROLOGICAL
REPLOGLE TUBE IN SITU INDICATOR
RESPIRATORY SUPPORT DEVICE TYPE FOR NATIONAL NEONATAL DATA SET
RESPIRATORY SUPPORT MODE FOR NATIONAL NEONATAL DATA SET
RESUSCITATION METHOD CODE
RETINOPATHY OF PREMATURITY SCREENING OUTCOME STATUS CODE
REVISION PROCEDURE TYPE FOR ANKLE REPLACEMENT
REVISION PROCEDURE TYPE FOR ELBOW REPLACEMENT
REVISION PROCEDURE TYPE FOR HIP REPLACEMENT
REVISION PROCEDURE TYPE FOR KNEE REPLACEMENT
REVISION PROCEDURE TYPE FOR SHOULDER REPLACEMENT
ROTATOR CUFF CONDITION FOR SHOULDER REPLACEMENT
ROTATOR CUFF REPAIRED INDICATOR FOR SHOULDER REPLACEMENT
ROTATOR CUFF REPAIR TYPE FOR SHOULDER REPLACEMENT
SENTINEL LYMPH NODE BIOPSY TYPE
SIGNIFICANT MATERNAL PYREXIA IN LABOUR INDICATOR
STAFF ROLE CARRYING OUT HOLISTIC NEEDS ASSESSMENT OR PERSONALISED CARE AND SUPPORT PLANNING
STEM CELL INFUSION DONOR TYPE
STEM CELL INFUSION SOURCE CODE
STEM CELL TRANSPLANT CONDITIONING REGIMEN
STEROIDS GIVEN DURING PREGNANCY TO MATURE FETAL LUNGS INDICATOR
STOMA PRESENT INDICATOR
SURFACTANT GIVEN INDICATOR
SURGICAL ACCESS TYPE
SURGICAL ACCESS TYPE FOR HEAD AND NECK CANCER
SURGICAL APPROACH FOR PRIMARY HIP REPLACEMENT
SURGICAL APPROACH FOR PRIMARY KNEE REPLACEMENT
SURGICAL APPROACH FOR PRIMARY OR REVISION ANKLE REPLACEMENT
SURGICAL APPROACH FOR PRIMARY OR REVISION ELBOW REPLACEMENT

SURGICAL APPROACH FOR PRIMARY OR REVISION SHOULDER REPLACEMENT
SURGICAL APPROACH FOR REVISION HIP REPLACEMENT
SURGICAL APPROACH FOR REVISION KNEE REPLACEMENT
SURGICAL PALLIATION TYPE
SYSTEMIC ANTI CANCER THERAPY CURATIVE TREATMENT COMPLETED AS PLANNED INDICATOR
SYSTEMIC ANTI CANCER THERAPY CURATIVE TREATMENT NOT COMPLETED OUTCOME REASON
SYSTEMIC ANTI CANCER THERAPY DRUG REGIMEN MODIFICATION INDICATOR FOR DOSE REDUCTION
SYSTEMIC ANTI CANCER THERAPY DRUG REGIMEN TREATMENT INTENT
SYSTEMIC ANTI CANCER THERAPY DRUG ROUTE OF ADMINISTRATION
SYSTEMIC ANTI CANCER THERAPY NON CURATIVE TREATMENT PATIENT BENEFIT INDICATOR
TRACHEOSTOMY TUBE IN SITU INDICATOR
TREATMENT TYPE FOR NECROTISING ENTEROCOLITIS
TREATMENT TYPE FOR PATENT DUCTUS ARTERIOSUS
TUBERCULOSIS TREATMENT INDICATOR FOR HIV
UNITS OF BLOOD TRANSFUSED FOLLOWING OESOPHAGECTOMY
UNTOWARD INTRAOPERATIVE EVENT CODE FOR ANKLE REPLACEMENT
UNTOWARD INTRAOPERATIVE EVENT CODE FOR ELBOW REPLACEMENT
UNTOWARD INTRAOPERATIVE EVENT CODE FOR HIP REPLACEMENT
UNTOWARD INTRAOPERATIVE EVENT CODE FOR KNEE REPLACEMENT
UNTOWARD INTRAOPERATIVE EVENT CODE FOR SHOULDER REPLACEMENT
VASCULAR LINE TYPE IN SITU
VIRAL LOAD COUNT PERFORMED INDICATOR
VISUAL INSPECTION CONFIRMED NECROTISING ENTEROCOLITIS DURING LAPAROTOMY INDICATOR
VITAMIN K ADMINISTERED INDICATOR
VITAMIN K ROUTE OF ADMINISTRATION

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**CODED CLINICAL ENTRY**

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Change to Class: Changed Relationships, Attributes, Description

~~A CLINICAL TERMINOLOGY CODE or CLINICAL CLASSIFICATION CODE.~~An entry in an ELECTRONIC HEALTH RECORD, recorded by a CARE PROFESSIONAL, PATIENT or Patient Proxy, or other authorised PERSON, relating to ACTIVITIES for the care and treatment of a PATIENT.

~~This may describe:~~CODED CLINICAL ENTRIES may describe:

- CLINICAL INTERVENTIONS
- CLINICAL INVESTIGATION RESULT ITEMS
- PATIENT DIAGNOSES
- PERSON PROPERTIES
- PLANNED ACTIVITIES
- ~~ACTIVITY DRUGS.~~
- ACTIVITY DRUGS
- CARE PLANS
- ACTIVITY GROUPS
- CARE ACTIVITIES
- any other aspect of PATIENT care and management.

A CODED CLINICAL ENTRY in an ELECTRONIC HEALTH RECORD should include the recording of relevant CLINICAL TERMINOLOGY CODES and/or CLINICAL CLASSIFICATION CODES. Where information to complete the CODED CLINICAL ENTRY is missing, a DATA ABSENT REASON should be recorded.

**CODED CLINICAL ENTRY**

Change to Class: Changed Relationships, Attributes, Description

*Attributes of this Class are:*

CLINICAL CLASSIFICATION CODE
CLINICAL TERMINOLOGY CODE
CODED CLINICAL ENTRY SEQUENCE NUMBER
DATA ABSENT REASON
DM AND D TAXONOMY CODE
SNOMED VERSION

**CODED CLINICAL ENTRY**

Change to Class: Changed Relationships, Attributes, Description

*Each CODED CLINICAL ENTRY*

must be an entry in one and only one ELECTRONIC HEALTH RECORD
may be a classification for one or more ACTIVITY DRUG
may be a classification for one or more CLINICAL INTERVENTION
may be a classification for one or more CLINICAL INVESTIGATION RESULT ITEM
may be a classification for one or more PATIENT DIAGNOSIS
may be a classification for one or more PERSON PROPERTY
may be a classification for one or more PLANNED ACTIVITY

**NHS SERVICE AGREEMENT**

Change to Class: Changed Attributes

*Attributes of this Class are:*

~~K NHS SERVICE AGREEMENT NUMBER~~
K NHS SERVICE AGREEMENT IDENTIFIER
NHS SERVICE AGREEMENT NUMBER

**NHS SERVICE AGREEMENT LINE**

Change to Class: Changed Attributes

*Attributes of this Class are:*

~~K NHS SERVICE AGREEMENT LINE NUMBER~~
K NHS SERVICE AGREEMENT LINE IDENTIFIER
NHS SERVICE AGREEMENT LINE NUMBER

**PATIENT PATHWAY**

Change to Class: Changed Attributes

*Attributes of this Class are:*

K PATIENT PATHWAY IDENTIFIER
CANCER FASTER DIAGNOSIS PATHWAY END REASON
CANCER FASTER DIAGNOSIS PATHWAY EXCLUSION REASON

CANCER TREATMENT EVENT TYPE
PERSONALISED OUTPATIENT FOLLOW UP PATHWAY EXPIRY DATE
RAPID DIAGNOSTIC CENTRE PATHWAY COMPLIANCE INDICATOR
WAITING TIME MEASUREMENT TYPE

---

**PERSON PROPERTY ASSIGNMENT PERIOD**

---

Change to Class: Changed Attributes

*Attributes of this Class are:*

PERSON PROPERTY ASSIGNMENT PERIOD DURATION
PERSON PROPERTY ASSIGNMENT PERIOD TYPE

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**SERVICE PROVIDED UNDER AGREEMENT**

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Change to Class: Changed Attributes

*Attributes of this Class are:*

BEST PRACTICE TARIFF CODE
CARE PRODUCT TYPE FOR NHS CONTINUING HEALTHCARE
COMMISSIONED SERVICE CATEGORY CODE
CONTRACT UNIT FREQUENCY CODE FOR NHS CONTINUING HEALTHCARE
COST CENTRE CODE FOR NHS CONTINUING HEALTHCARE
HEALTHCARE RESOURCE GROUP CODE
LOCAL POINT OF DELIVERY DESCRIPTION
NUMBER OF COMMISSIONED WEEKLY HOURS OF CARE FOR NHS CONTINUING HEALTHCARE
PERSONAL HEALTH BUDGET TYPE
POINT OF DELIVERY CODE
POINT OF DELIVERY CODE FOR PATIENT LEVEL INFORMATION COSTING
POINT OF DELIVERY FURTHER DETAIL CODE
POINT OF DELIVERY FURTHER DETAIL DESCRIPTION
PROVIDER REFERENCE IDENTIFIER
PROVIDER REFERENCE NUMBER
SERVICE PROVIDED UNDER AGREEMENT TEXT STRING
SPECIALISED MENTAL HEALTH SERVICE CATEGORY CODE
SPECIALISED SERVICE CODE
SPECIALIST SERVICES FLAG
SUBJECTIVE CODE FOR NHS CONTINUING HEALTHCARE
UNBUNDLED ACTIVITY CURRENCY SCHEME IN USE
UNBUNDLED CARE ACTIVITY TYPE FOR PATIENT LEVEL INFORMATION COSTING
UNBUNDLED CURRENCY CODE
UNBUNDLED EPISODE INDICATOR

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**SERVICE REQUEST**

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Change to Class: Changed Attributes

*Attributes of this Class are:*

K SERVICE REQUEST IDENTIFIER
ACTIVITY SERVICE REQUEST DATE
ACTIVITY SERVICE REQUEST TIME
CLINICAL RESPONSE PRIORITY TYPE
COMMISSIONER REFERENCE IDENTIFIER

DIRECT ACCESS REFERRAL INDICATOR
ONWARD REFERRAL REASON
ORIGINAL REFERRAL REQUEST RECEIVED DATE
REASON FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH
REFERRAL OR NOTIFICATION OUTCOME FOR NHS CONTINUING HEALTHCARE STANDARD
REFERRAL OR NOTIFICATION TYPE FOR NHS CONTINUING HEALTHCARE STANDARD
REFERRAL REQUEST OR NOTIFICATION RECEIVED DATE FOR NHS CONTINUING HEALTHCARE STANDARD
REFERRAL REQUEST RECEIVED DATE
REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR
REFERRED OUT OF AREA REASON FOR ADULT ACUTE MENTAL HEALTH
SERVICE REQUEST DATE
SERVICE REQUEST RAISED REASON
SOURCE OF REFERRAL FOR NHS CONTINUING HEALTHCARE STANDARD

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**WARD OPERATIONAL PLAN**

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Change to Class: Changed Attributes, Description

~~A statement of the operational planning intent for a particular WARD, including intended time and Hospital Bed availability, TREATMENT FUNCTION and CLINICAL CARE INTENSITY.~~A statement of the operational planning intent for a WARD, including intended Hospital Bed numbers and times available, the TREATMENT FUNCTION the Hospital Beds are planned to be assigned to, and the WARD INTENDED CLINICAL CARE INTENSITY.

~~Hospital Bed availability, in the above, is expressed as the WARD Total Beds Intended (CONSULTANT Care, NURSE Care and MIDWIFE Care) available for the use of PATIENTS.~~Hospital Bed availability, in the above, is expressed as the total number of Hospital Beds intended to be available for the use of PATIENTS receiving CONSULTANT Care, NURSE Care or MIDWIFE Care. This should reflect the number of places available for PATIENT care rather than just a count of physical devices that may be used as a Hospital Bed.

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**WARD OPERATIONAL PLAN**

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Change to Class: Changed Attributes, Description

*Attributes of this Class are:*

K WARD OPERATIONAL PLAN START DATE
AGE GROUP INTENDED
AGE GROUP INTENDED FOR MENTAL HEALTH
CLINICAL CARE INTENSITY
SEX OF PATIENTS
WARD DAY PERIOD AVAILABILITY
WARD INTENDED AGE GROUP
WARD INTENDED CLINICAL CARE INTENSITY
WARD INTENDED DAY PERIOD AVAILABILITY
WARD INTENDED NIGHT PERIOD AVAILABILITY
WARD INTENDED SEX OF PATIENTS
WARD NIGHT PERIOD AVAILABILITY
WARD OPERATIONAL PLAN END DATE

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**ACTIVITY COUNT**

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Change to Attribute: Changed Dataset

The number or count of individual ACTIVITIES.

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**ACTIVITY DATE**

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Change to Attribute: Changed Dataset

The date, month, year and century, or any combination of these elements, that is of relevance to an ACTIVITY.

The specific nature of the ACTIVITY DATE will be identified by the ACTIVITY DATE TYPE.

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**ACTIVITY DATE TYPE**

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Change to Attribute: Changed Description

The type of date that defines the usage with regard to the ACTIVITY.

An ACTIVITY may have many dates associated with it but may only have one date of a particular type.

*National Codes:*

| | |
|---|---|
| 001 | Angiogram Date (Retired July 2012) |
| 002 | Arrival Date At Accident and Emergency Department (Retired 01 November 2020) |
| 003 | Breast Assessment Date (Retired 1 January 2013) |
| 004 | Cancer Dental Assessment Date (Retired September 2018) |
| 005 | Colorectal or Stoma Nurse Seen Date (Retired 1 January 2013) |
| 006 | Coronary Angiography Date (Retired July 2012) |
| 007 | Care Programme Approach Review Date (Retired September 2018) |
| 008 | Date Biopsy Taken (Retired 01 April 2014) |
| 009 | Discharge Date |
| 010 | Discharge Ready Date |
| 011 | End Date |
| 012 | Event Date (Retired July 2012) |
| 013 | Expected Delivery Date (Retired September 2012) |
| 014 | First Antenatal Assessment Date |
| 015 | Full Postnatal Examination Date (Retired September 2012) |
| 016 | Initial Patient Contact Date (Retired July 2012) |
| 017 | Investigation Transfer Date (Retired July 2012) |
| 018 | Intrauterine Device Application Date (Retired September 2012) |
| 019 | Intrauterine Device Fitted Date (Retired September 2012) |
| 020 | Last Dosage Date (Retired April 2019) |
| 021 | Mental Health Care Assessment Date (Retired September 2012) |
| 022 | Miscarriage Date (Retired September 2012) |
| 023 | Pathology Result Due Date (Retired April 2019) |
| 024 | Patient Informed Biopsy Result Date (Retired April 2019) |
| 025 | Patient Informed Of Outcome Date (Retired September 2012) |
| 026 | Smoking Quit Date (Retired October 2017) |
| 027 | Review Planned Date (Retired 01 April 2014) |
| 028 | Screening Result Date (Retired 01 April 2014) |
| 029 | Screening Result Sent Date (Retired April 2019) |
| 030 | Specialist Palliative Care Date (Retired 01 April 2014) |
| 031 | Start Date |
| 032 | Cancer Symptoms First Noted Date (Retired September 2018) |
| 033 | Attendance Date (Retired September 2018) |

034 Clinical Intervention Date
035 Immunisation Completion Date (Retired 01 September 2015)
036 Clinical Status Assessment Date (Retired September 2018)
037 Dose Given Date (Retired September 2012)
038 Test Date (Retired September 2012)
039 Contact Date (Retired September 2018)
040 Appointment Date (Retired September 2018)
041 Primary Procedure Date (Retired September 2018)
042 Second Operation Date (Retired 01 April 2014)
043 Speech and Language Assessment Date (Retired September 2018)
044 Third Operation Date (Retired 01 April 2014)
045 Date First Seen (Retired September 2018)
046 Statutory Assessment Date (Retired 01 January 2016)
047 Screening Test Date (Retired September 2018)
048 Genitourinary Care Contact Date (Retired January 2014)
049 Consultant Upgrade Date
101 Referral Closure Date (Community Care) (Retired 01 September 2015)
102 Discharge Letter Issued Date (Community Care) (Retired 01 September 2015)
103 Systemic Anti-Cancer Therapy Administration Date (Retired September 2018)
104 Procedure Date
105 Immunisation Date (Retired September 2018)
106 Antenatal Appointment Date (Retired 1 April 2019)
107 Antenatal Booking Appointment Date (Retired September 2018)
108 Pregnancy First Contact Date
109 Screening Test Information Given Date (Retired 1 April 2019)
110 Assessment Date For Transplant Suitability
111 Accident and Emergency Initial Assessment Date (Retired 01 November 2020)
112 Accident and Emergency Date Seen For Treatment (Retired 01 November 2020)
113 Accident and Emergency Attendance Conclusion Date (Retired 01 November 2020)
114 Accident and Emergency Departure Date (Retired 01 November 2020)
115 Clinical Assessment Date (Retired September 2018)
116 Imaging or Radiodiagnostic Event Date (Retired September 2018)
117 Neonatal Critical Care Daily Care Date
118 Two Year Neonatal Outcomes Assessment Date (Retired September 2018)
119 Date of Pregnancy Outcome (Current Fetus) (Retired 1 April 2019)
120 Neonatal Critical Incident Date (Retired 1 April 2019)
121 American Joint Committee on Cancer Stage Date (Retired September 2018)
122 Ann Arbor Stage Date (Retired September 2018)
123 Barcelona Clinic Liver Cancer Stage Date (Retired September 2018)
124 Binet Stage Date (Retired September 2018)
125 Chang Staging System Stage Date (Retired September 2018)
126 Clinical Stage Date (Pancreatic Cancer) (Retired September 2018)
127 Final Figo Stage Date (Retired September 2018)
128 Holistic Needs Assessment Completed Date (Retired September 2018)
129 Intergroup Rhabdomyosarcoma Study Post Surgical Group Date (Retired September 2018)
130 International Neuroblastoma Staging System Date (Retired 01 April 2017)
131 Myeloma International Staging System Stage Date (Retired September 2018)
132 Modified Dukes Stage Date (Retired September 2018)
133 Multidisciplinary Team Discussion Date (Cancer)
134 Multidisciplinary Team Meeting Date (Cancer)
135 Murphy St Jude Stage Date (Retired September 2018)
136 Rai Stage Date (Retired 01 April 2017)
137 Retinoblastoma Assessment Date (Retired September 2018)
138 TNM Stage Grouping Date (Final Pretreatment) (Retired September 2018)

139 TNM Stage Grouping Date (Integrated) (Retired September 2018)
140 Wilms Tumour Stage Date (Retired September 2018)
141 Care Contact Cancellation Date
142 Care Contact Date
143 Child Protection Plan End Date (Retired September 2018)
144 Child Protection Plan Start Date (Retired September 2018)
145 Discharge Letter Issued Date (Mental Health and Community Care)
146 Health Visitor First Antenatal Visit Date (Retired September 2018)
147 Infant Physical Examination Date (Retired September 2018)
148 Onward Referral Date (Retired September 2018)
149 Referral Closure Date
150 Referral Rejection Date
151 Replacement Appointment Booked Date
152 Replacement Appointment Date Offered
153 Service Discharge Date (Retired September 2018)
154 Date of Restrictive Intervention (Retired 01 April 2019)
155 Indirect Activity Date
156 Mental Health Crisis Plan Creation Date (Retired 01 April 2017)
157 Mental Health Crisis Plan Last Updated Date (Retired 01 April 2017)
158 Care Plan Agreed Date
159 Care Plan Creation Date
160 Care Plan Implementation Date
161 Care Plan Last Updated Date
162 Five Forensic Pathways Assessment Date (Retired September 2018)
163 International Neuroblastoma Risk Group Staging System Stage Date (Retired September 2018)
164 Stage Grouping Date (Testicular Cancer) (Retired September 2018)
165 Emergency Care Arrival Date
166 Emergency Care Initial Assessment Date
167 Emergency Care Date Seen For Treatment
168 Emergency Care Attendance Conclusion Date
169 Emergency Care Departure Date
170 Injury Date (Retired September 2018)
171 Referred To Service Assessment Date (Retired September 2018)
172 Intended Smoking Quit Date (Moved to PLANNED ACTIVITY DATE TYPE September 2018)
173 Cancer Transformation Agreed Date (Primary Cancer Pathway)
174 Cancer Progression Agreed Date (Primary Cancer Pathway)
175 Clinical Trial Decision Date
176 Treatment Start Date (Cancer) (Retired September 2018)
177 Cancer Faster Diagnosis Pathway End Date (Retired September 2018)
178 Cancer Referral To Treatment Period Start Date (Retired September 2018)
179 Cancer Treatment Period Start Date (Retired September 2018)
180 Observable Entity Date
181 Package of Care or Year of Care Start Date (Contract Monitoring)
182 NHS Continuing Healthcare Standard Checklist Completed Date
183 Clinical Commissioning Group Eligibility Decision Date (NHS Continuing Healthcare Standard)
184 Clinical Commissioning Group Eligibility Decision Outcome Communicated To Patient Date (NHS Continuing Healthcare Standard)
185 NHS Continuing Healthcare Fast Track Pathway Tool Completed Date
186 NHS Continuing Healthcare Request Received Date
187 NHS Continuing Healthcare Local Resolution Formal Meeting Date
188 NHS Continuing Healthcare Local Resolution Informal Meeting Date
189 Local Resolution Eligibility Decision Outcome Communicated To Patient Date (NHS Continuing Healthcare)
190 NHS Continuing Healthcare Care Package Eligibility Status Change Date

191 NHS Continuing Healthcare Eligibility Start Date Following Independent Review
192 NHS Continuing Healthcare Previously Unassessed Period Of Care Decision Made Date
193 NHS Continuing Healthcare Previously Unassessed Period Of Care Eligibility Decision Communicated To Requester Date
194 Unbundled Care Activity Date
195 Activity Date for Age (Contract Monitoring)
196 Activity End Date (Contract Monitoring)
197 Activity Start Date (Contract Monitoring)
198 Care Plan Content Agreed Date
??? eMED3 Fit Note Assessment Date
??? eMED3 Fit Note Recorded Date
??? Last Patient Did Not Attend Date
??? Last Patient Cancelled Date

---

**ACTIVITY DURATION**

---

Change to Attribute: Changed Dataset

The duration of an ACTIVITY.

---

**ACTIVITY GROUP TYPE**

---

Change to Attribute: Changed Description

The type of ACTIVITY GROUP.

*National Codes:*

01 Accident and Emergency Episode (Retired 01 November 2020)
02 Acute Myocardial Infarction Care Spell (Retired July 2012)
03 Augmented Care Period (Retired 1 April 2006)
04 Breast Cancer Care Spell
05 Cancer Care Spell
06 Care Home Stay (Consultant Care)
07 Care Home Stay (Midwife Care)
08 Care Home Stay (Nursing Care)
09 Care Home Stay (Residential)
10 Care Programme Approach Care Episode
11 Colorectal Cancer Care Spell
12 Community Episode (Retired 01 January 2016)
13 Mental Health Care Professional Episode (Acute Home-Based) (Retired 01 January 2016)
14 Consultant Episode (Hospital Provider)
15 Consultant Out-Patient Episode
16 Dental Episode (Retired 01 April 2014)
17 Drug Misuse Episode (Retired 1 April 2019)
18 Sexual Health and HIV Episode
19 Head and Neck Cancer Care Spell
20 Home Dialysis Episode (Retired October 2019)
21 Hospital Provider Spell
22 Lung Cancer Care Spell
23 Adult Mental Health, Learning Disability or Autism Spectrum Disorder Care Spell (Retired 01 January 2016)
24 Midwife Episode

25 Neonatal Level Of Care Period
26 Nursing Episode
27 Palliative Care Episode
28 Person Stop Smoking Episode
29 Pregnancy Episode (Retired 1 April 2019)
30 Professional Staff Group Episode (Retired 01 January 2016)
31 Regular Attender Episode (Retired 01 January 2016)
32 Road Traffic Accident Treatment (Retired 01 April 2014)
33 Sarcoma Cancer Care Spell
34 Skin Cancer Care Spell
35 Supervised Discharge Episode (Retired 01 April 2014)
36 Supervision Register Episode (Retired 01 April 2014)
37 Upper Gastrointestinal Cancer Care Spell
38 Urological Cancer Care Spell
39 Ward Stay
40 Hospital Stay
41 Care Spell
42 CRITICAL CARE PERIOD
43 PATIENT PATHWAY
44 REFERRAL TO TREATMENT PERIOD
45 Active Monitoring
46 Supervised Community Treatment Recall (Retired 01 January 2016)
47 Supervised Community Treatment (Retired 01 January 2016)
48 Mental Health Care Without Patient Consent (Retired 01 January 2016)
49 Cancer Treatment Period
50 Gynaecological Cancer Care Spell
51 Mental Health Care Spell (Retired 01 January 2016)
52 Improving Access to Psychological Therapies Care Spell (Retired 1 April 2020)
53 Adult Mental Health Care Team Episode (Retired 01 January 2016)
54 Mental Health NHS Day Care Episode (Retired 01 January 2016)
55 Mental Health Delayed Discharge Period
56 Mental Health Care Cluster Assignment Period (Retired 01 January 2016)
57 Mental Health Care Coordinator Assignment Period
58 Child and Adolescent Mental Health Clinical Intervention Episode (Retired 01 January 2016)
59 Child and Adolescent Mental Health Care Spell (Retired 01 January 2016)
60 Maternity Episode
61 HIV Episode
62 Central Nervous System Cancer Care Spell
63 Children Teenagers and Young Adults Cancer Care Spell
64 Haematological Cancer Care Spell
65 Lung Cancer Care Spell (Retired 1 April 2018)
66 Commissioner Assignment Period
67 Breast Screening Episode
68 High Risk Breast Screening Episode
69 Open Breast Screening Episode
70 Neonatal Critical Care Spell
71 Radiotherapy Episode
72 Healthy Person Stay
73 Mental Health Responsible Clinician Assignment Period
74 Mental Health Conditional Discharge Period
75 Mental Health Act Legal Status Classification Period (Moved to PERSON PROPERTY ASSIGNMENT PERIOD TYPE 01 January 2016)
76 Care Professional Admitted Care Episode
77 Liver Cancer Care Spell

78 NHS Continuing Healthcare
79 NHS-funded Nursing Care
80 Package of Care
81 Acute Oncology Episode
82 Personalised Care and Support Planning
83 Community Bed-based Intermediate Care
84 Crisis Response Intermediate Care
85 Home-based Intermediate Care
86 Reablement Intermediate Care
87 Emergency Care Episode
?? Care Professional Out-Patient Episode

---

**ACTIVITY IDENTIFIER**

---

Change to Attribute: Changed Dataset

A unique number or set of characters that is applicable to only one ACTIVITY for a PATIENT within an ORGANISATION.

---

**ACTIVITY LOCATION TYPE CODE**

---

Change to Attribute: Changed Dataset, Description

The type of LOCATION for an ACTIVITY:

- where PATIENTS are seen
- where SERVICES are provided or
- from which requests for SERVICES are sent.

Notes:

- ~~The following National Code is **only** valid for the Community Services Data Set, Improving Access to Psychological Therapies Data Set, Maternity Services Data Set and Mental Health Services Data Set. Users of other data sets must map National Code G04 locally to other appropriate ACTIVITY LOCATION TYPE CODES for the purposes of flowing data:~~
  - ~~G04 '*Integrated Care Home Without Nursing and Care Home With Nursing*'~~
- ~~The following National Codes have been introduced for the Improving Access to Psychological Therapies Data Set and Mental Health Services Data Set **only** to add further granularity to National Code M04 '*Young Offender Institution*'. However, National Code M04 is still valid for the Improving Access to Psychological Therapies Data Set and Mental Health Services Data Set where extra detail cannot be collected:~~
  - ~~M06 '*Young Offender Institution (15-17)*'~~
  - ~~M07 '*Young Offender Institution (18-21)*'~~
- National Code G04 '*Integrated Care Home Without Nursing and Care Home With Nursing*' is **not** valid for the Commissioning Data Set Version 6-2.
- The following National Codes have been introduced for the Improving Access to Psychological Therapies Data Set and Mental Health Services Data Set **only** to add further granularity to National Code M04 '*Young Offender Institution*'. However, National Code M04 is still valid for the Improving Access to Psychological Therapies Data Set and Mental Health Services Data Set where extra detail cannot be collected:
  - M06 '*Young Offender Institution (15-17)*'
  - M07 '*Young Offender Institution (18-21)*'
- The following National Code has been updated in DCB0092-2062: Commissioning Data Sets: Emergency Care Data Set. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct:
  - E04 '*Emergency Care Department or Minor Injuries Department*'.

**Further information on the groupings and scope of each ACTIVITY LOCATION TYPE CODE is provided at: Activity Location Type Codes.**

*National Codes:*

| | |
|---|---|
| A01 | PATIENT's Home |
| A02 | Carer's Home |
| A03 | PATIENT's Workplace |
| A04 | Other PATIENT Related Location |
| B01 | Primary Care Health Centre |
| B02 | Polyclinic |
| C01 | General Medical Practitioner Practice |
| C02 | Dental Practice |
| C03 | OPHTHALMIC MEDICAL PRACTITIONER Premises |
| D01 | Walk In Centre |
| D02 | Out of Hours Centre |
| D03 | Emergency Community Dental Service |
| E01 | Out-Patient Clinic |
| E02 | WARD |
| E03 | Day Hospital |
| E04 | Emergency Care Department or Minor Injuries Department |
| E99 | Other Departments |
| F01 | Hospice |
| G01 | Care Home Without Nursing |
| G02 | Care Home With Nursing |
| G03 | Children's Home |
| G04 | Integrated Care Home Without Nursing and Care Home With Nursing |
| H01 | Day Centre |
| J01 | Resource Centre |
| K01 | Sure Start Children's Centre |
| K02 | Child Development Centre |
| L01 | School |
| L02 | Further Education College |
| L03 | University |
| L04 | Nursery Premises |
| L05 | Other Childcare Premises |
| L06 | Training Establishments |
| L99 | Other Educational Premises |
| M01 | Prison |
| M02 | Probation Service Premises |
| M03 | Police Station / Police Custody Suite |
| M04 | Young Offender Institution |
| M05 | Immigration Removal Centre |
| M06 | Young Offender Institution (15-17) |
| M07 | Young Offender Institution (18-21) |
| N01 | Street or other public open space |
| N02 | Other publicly accessible area or building |
| N03 | Voluntary or charitable agency premises |
| N04 | Dispensing Optician Premises |
| N05 | Dispensing Pharmacy Premises |
| X01 | Other locations not elsewhere classified |

---

**ACTIVITY TIME**

---

Change to Attribute: Changed Dataset

The time (using a 24 hour clock) that is of relevance to an ACTIVITY.

This may include representation of a time zone.

The specific nature of the time will be identified by the ACTIVITY TIME TYPE.

---

**ACTUAL DELIVERY PLACE**

---

Change to Attribute: Changed Dataset

The actual place type of Delivery.

Recording both the planned and the actual place of Delivery allows all changes of intent to be logged. Note that if a baby is delivered in a different hospital to the one originally specified, there would be no change in the Delivery place type, since the Birth would still have taken place in an NHS hospital.

*National Codes:*

| | |
|---|---|
| 1 | At a domestic ADDRESS |
| 2 | In NHS hospital - Delivery facilities associated with CONSULTANT WARD |
| 3 | In NHS hospital - Delivery facilities associated with GENERAL MEDICAL PRACTITIONER WARD |
| 0 | In NHS hospital - Delivery facilities associated with MIDWIFE WARD |
| 4 | In NHS hospital - Delivery facilities associated with CONSULTANT/ GENERAL MEDICAL PRACTITIONER/ MIDWIFE WARD inclusive of any combination of two of the professionals mentioned |
| 7 | In NHS hospital - WARD or unit without Delivery facilities |
| 5 | In private hospital |
| 6 | In other hospital or institution |
| 8 | None of the above |
| 9 | Not known |

---

**ADDRESS**

---

Change to Attribute: Changed Dataset

The identification of a place of relevance to a PERSON, ORGANISATION, ORGANISATION SITE or LOCATION.

---

**ADMINISTRATIVE CATEGORY CODE**

---

Change to Attribute: Changed Dataset

This is recorded for PATIENT ACTIVITY.

A PATIENT who is an Overseas Visitor does not qualify for free NHS healthcare and can choose to pay for NHS treatment or for private treatment. If they pay for NHS treatment then they should be recorded as NHS PATIENTS.

The PATIENT's ADMINISTRATIVE CATEGORY CODE may change during an episode or spell. For example, the PATIENT may opt to change from NHS to private health care. In this case, the start and end dates for each new ADMINISTRATIVE CATEGORY PERIOD (episode or spell) should be recorded.

If the ADMINISTRATIVE CATEGORY CODE changes during a Hospital Provider Spell the ADMINISTRATIVE CATEGORY CODE (ON ADMISSION) is used to derive the 'Category of PATIENT' for Hospital Episode Statistics (HES).

The category 'amenity PATIENT' is only applicable to PATIENTS using a Hospital Bed.

*National Codes:*

| | |
|---|---|
| 01 | NHS PATIENT, including Overseas Visitors charged under the National Health Service (Overseas Visitors Hospital Charging Regulations) |
| 02 | Private PATIENT, one who uses accommodation or SERVICES authorised under the National Health Service Act 2006 |
| 03 | Amenity PATIENT, one who pays for the use of a single room or small ward in accordance with the National Health Service Act 2006 |
| 04 | Category II PATIENT, one for whom work is undertaken by hospital medical or dental staff within category II as defined in paragraph 37 of the Terms and Conditions of Service of Hospital Medical and Dental Staff. |

---

**ADMISSION SOURCE**

---

Change to Attribute: Changed Dataset

~~**This item is being used for development purposes and has not yet been approved.**~~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.

National Code 51 *'NHS other hospital provider - WARD for general PATIENTS or the younger physically disabled or Emergency Care Department'* should not be used if the PATIENT arrives at an Emergency Care Department and is admitted to the same Hospital Provider.

*National Codes:*

| | |
|---|---|
| 19 | Usual place of residence unless listed below, for example, a private dwelling whether owner occupied or owned by Local Authority, housing association or other landlord. This includes wardened accommodation but not residential accommodation where health care is provided. It also includes PATIENTS with no fixed abode. |
| 29 | Temporary place of residence when usually resident elsewhere (e.g. hotels, residential Educational Establishments) |
| 37 | Court |
| 40 | Penal establishment |
| 42 | Police Station / Police Custody Suite |
| 49 | NHS other Hospital Provider - high security psychiatric accommodation in an NHS Hospital Provider (NHS Trust or NHS Foundation Trust) |
| 51 | NHS other Hospital Provider - WARD for general PATIENTS or the younger physically disabled or Emergency Care Department |
| 52 | NHS other Hospital Provider - WARD for maternity PATIENTS or Neonates |
| 53 | NHS other Hospital Provider - WARD for PATIENTS who are mentally ill or have Learning Disabilities |
| 55 | Care Home With Nursing |
| 56 | Care Home Without Nursing |
| 66 | Local Authority foster care |
| 79 | Babies born in or on the way to hospital |
| 87 | Independent Sector Healthcare Provider run hospital |
| 88 | Hospice |

**SOURCE OF ADMISSION will be replaced with ADMISSION SOURCE, which is the most recent approved national information standard to describe the required definition.**

---

**AGE GROUP INTENDED**

---

Change to Attribute: Changed Description

The age group of PATIENTS intended to use a WARD indicated in the operational plan.

*National Codes:*

1 Neonates
2 Children and/or adolescents
3 Elderly
8 Any age

**AGE GROUP INTENDED will be replaced with WARD INTENDED AGE GROUP, which is the most recent approved national information standard to describe the required definition.**

---

**AMBULANCE CALL IDENTIFIER**

Change to Attribute: Changed Dataset
A unique identifier for each Ambulance Call.

---

**ANAESTHETIC OR ANALGESIC CATEGORY**

Change to Attribute: Changed Dataset

The type of anaesthetic and/or analgesic administered to the mother during or after Labour and Delivery.

Where an analgesic is administered in addition to an anaesthetic, only the anaesthetic or combination of anaesthetics should be recorded.

*National Codes:*

1 General anaesthetic, the administration by a doctor of an agent intended to produce unconsciousness
2 Epidural or caudal anaesthetic, the injection of a local anaesthetic agent into the epidural space
3 Spinal anaesthetic, the injection of a local anaesthetic agent into the subarachnoid space
4 General anaesthetic and epidural or caudal anaesthetic
5 General anaesthetic and spinal anaesthetic
6 Epidural or caudal and spinal anaesthetic
7 Anaesthetic other than in 1 to 6, or analgesic only
8 No analgesic or anaesthetic administered

---

**APPOINTMENT BOOKED REASON**

Change to Attribute: New Attribute

The reason that an APPOINTMENT was booked.

*National Codes:*

1 Timed Out-Patient Follow Up Appointment
2 Patient Initiated Out-Patient Follow Up Appointment
3 Remote Monitoring Triggered Out-Patient Follow Up Appointment

**This attribute is also known by these names:**

| Context | Alias |
|---|---|
| plural | APPOINTMENT BOOKED REASONS |

---

**APPOINTMENT BOOKED REASON**

Change to Attribute: New Attribute

## APPOINTMENT BOOKED REASON

**Data Elements:**

| APPOINTMENT BOOKED REASON |
|---|

---

**APPOINTMENT DATE**

---

Change to Attribute: Changed Dataset

The date of an APPOINTMENT.

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.

---

**APPOINTMENT DATE OFFERED**

---

Change to Attribute: Changed Dataset

The actual date offered for an APPOINTMENT in response to a SERVICE REQUEST or an invitation as part of a HEALTH PROGRAMME.

---

**APPOINTMENT TIME**

---

Change to Attribute: Changed Dataset

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.

Note: The PATIENT may be advised to attend earlier for preliminary investigations.

---

**ATTENDED OR DID NOT ATTEND**

---

Change to Attribute: Changed Dataset

An indication of whether an APPOINTMENT for a CARE CONTACT took place.

If the APPOINTMENT did not take place it also indicates if advance warning was given.

When an APPOINTMENT is cancelled the APPOINTMENT CANCELLED DATE should also be recorded.

Notes:

- National Code 0 - '*Not applicable - APPOINTMENT occurs in the future'* is **not** valid for use in the following data sets:
  - Community Services Data Set
  - Improving Access to Psychological Therapies Data Set
  - Maternity Services Data Set
  - Mental Health Services Data Set.

**Use in the Future Outpatient Commissioning Data Set:**

- For referral records with **no** APPOINTMENT yet made, or for **future** APPOINTMENTS, National Code 0 *'Not applicable - APPOINTMENT occurs in the future'* should be used.
- Where the future attendance has been ***cancelled***, use the appropriate value from the National Codes.

*National Codes:*

| | |
|---|---|
| 5 | Attended on time or, if late, before the relevant CARE PROFESSIONAL was ready to see the PATIENT |
| 6 | Arrived late, after the relevant CARE PROFESSIONAL was ready to see the PATIENT, but was seen |
| 7 | PATIENT arrived late and could not be seen |
| 2 | APPOINTMENT cancelled by, or on behalf of, the PATIENT |
| 3 | Did not attend - no advance warning given |
| 4 | APPOINTMENT cancelled or postponed by the Health Care Provider |
| 0 | Not applicable - APPOINTMENT occurs in the future |

---

**BIRTH ORDER**

---

Change to Attribute: Changed Dataset

The sequence in which the baby was born, if part of a Delivery having multiple births.

---

**CARE CONTACT TYPE**

---

Change to Attribute: Changed Description

The type of CARE CONTACT.

*National Codes:*

| | |
|---|---|
| 01 | Accident and Emergency Attendance (Retired 01 November 2020) |
| 02 | Acute Home-Based Contact (Retired 01 January 2016) |
| 03 | Audiology Attendance (Retired 01 April 2014) |
| 04 | Cancer Clinical Status Assessment |
| 05 | Care Programme Approach Review |
| 06 | Clinic Attendance Consultant |
| 07 | Clinic Attendance Sexual and Reproductive Health Service (Retired November 2014) |
| 08 | Clinic Attendance Midwife |
| 09 | Clinic Attendance Non-Consultant |
| 10 | Clinic Attendance Nurse |
| 11 | Contact Tracing Activity (Retired 01 April 2014) |
| 12 | Dental Treatment Contact (Retired 01 April 2014) |
| 13 | Day Care Attendance (Retired 01 January 2016) |
| 14 | Domiciliary Consultation |
| 15 | Emergency Dental Attendance (Retired 01 April 2014) |
| 16 | Face To Face Contact Community Care (Retired 01 January 2016) |
| 17 | Face To Face Contact CPA Care Coordinator (Retired 01 January 2016) |
| 18 | Face To Face Contact Dental (Retired 01 April 2014) |
| 19 | Face To Face Contact Optical (Retired 01 April 2014) |
| 20 | Face To Face Contact Social Worker (Retired 01 April 2011) |
| 21 | Face To Face Contact Surveillance (Retired 01 April 2014) |
| 22 | Sexual and Reproductive Health Domiciliary Visit |
| 23 | Genitourinary Consultant Clinic Attendance |
| 24 | GMP Consultation (Retired 01 April 2014) |
| 25 | GMP Practice Consultation (Retired 01 April 2014) |
| 26 | Home Assessment Visit (Retired 01 January 2016) |
| 27 | Maternity Domiciliary Visit |
| 28 | Night Consultation Visit (Retired 01 April 2014) |
| 29 | Nurse or Midwife Contact |
| 30 | Out-Patient Attendance Consultant |
| 31 | Registration Health Check (Retired 01 April 2014) |
| 32 | Sheltered Work Attendance (Retired 01 April 2011) |

33	Sight Test (Retired 01 April 2014)
34	Social Services Statutory Assessment (Retired 01 January 2016)
35	Professional Advice And Support Contact (Retired 01 April 2014)
36	Professional Staff Group Contact (Retired 01 January 2016)
37	Telephone Contact NHS Direct (Mental Health) (Retired 01 April 2011)
38	Theatre Case
39	Ward Attendance
40	Genitourinary Care Contact (Retired January 2014)
41	Improving Access to Psychological Therapies Contact
42	NHS Health Check Assessment (Retired April 2019)
43	Antenatal Booking Appointment (Retired 1 April 2019)
44	Pregnancy First Contact
45	Nutritional Assessment
46	HIV Clinic Attendance
47	Multi-Disciplinary Consultation (National Tariff Payment System)
48	Multi-Professional Consultation (National Tariff Payment System)
49	Two Year Neonatal Outcomes Assessment
50	Radiotherapy Attendance
51	Holistic Needs Assessment
52	Emergency Care Attendance
??	Care Professional Out-Patient Attendance

---

**CARE PROFESSIONAL IDENTIFIER**

---

Change to Attribute: Changed Dataset

A number or set of characters which uniquely identifies a CARE PROFESSIONAL.

---

**CARE PROFESSIONAL TYPE**

---

Change to Attribute: Changed Description

The type of CARE PROFESSIONAL.

*National Codes:*

010	Arts Therapist (Art Therapists, Music Therapists and Dramatherapists)
020	Biomedical Scientist
030	Chiropodist / Podiatrist
040	Chiropractor
050	Clinical Scientist
060	CONSULTANT
070	Clinical Dental Technician
080	Dental Hygienist
090	Dental Nurse
100	Dental Technician
110	Dental Therapist
120	Orthodontic Therapist
130	Dietitian
140	Dispensing Optician
150	GENERAL DENTAL PRACTITIONER
160	GENERAL MEDICAL PRACTITIONER
170	MIDWIFE

| | |
|---|---|
| 180 | NURSE |
| 190 | Occupational Therapist |
| 200 | Operating Department Practitioner |
| 210 | OPHTHALMIC MEDICAL PRACTITIONER |
| 220 | OPTOMETRIST |
| 230 | Orthoptist |
| 240 | Orthotist |
| 250 | Osteopath |
| 260 | Paramedic |
| 270 | Pharmacist |
| 280 | Physiotherapist |
| 290 | Practitioner Psychologist |
| 300 | Prosthetist |
| 310 | Radiographer |
| 320 | Specialist Community Public Health Nurse: Family Health Nurse |
| 330 | Specialist Community Public Health Nurse: Health Visitor |
| 340 | Specialist Community Public Health Nurse: Occupational Health Nurse |
| 350 | Specialist Community Public Health Nurse: School Nurse |
| 360 | Speech and Language Therapist |
| 370 | Hearing Aid Dispenser |
| 380 | Pharmacy Technician |
| 390 | Social Worker in England |
| 400 | Improving Access to Psychological Therapies Care Professional |
| 410 | ALLIED HEALTH PROFESSIONAL |
| XXX | Other (not listed) |

**CARER SUPPORT INDICATOR**

Change to Attribute: Changed Dataset

An indication of whether 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 and care is provided by a Care Worker.

*National Codes:*

| | |
|---|---|
| 01 | Yes - Carer support is available |
| 02 | No - Carer support is not available |

**CDS BULK REPLACEMENT GROUP CODE**

Change to Attribute: Changed Dataset, Description

The Commissioning Data Set Group into which CDS Types must be grouped when using the Commissioning Data Set Bulk Replacement Update Mechanism.

Note:

- National Code 160 '*Emergency Care Attendance*' is **only** valid for:
  - CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol
  - CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol
  - CDS V6-2-2 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol
  - CDS V6-2-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol
  - CDS V6-2-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol

- ◦ CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol
- ~~National Code 140 *'Accident and Emergency Attendance'* will no longer be accepted from 01 November 2020.~~

~~*National Codes:*~~

- CDS Type 010 *'Accident and Emergency Attendance'* was retired from 1 November 2020 and is no longer accepted for submission to the Secondary Uses Service.

- Commissioning Data Set version 6-3 does not require submission of the following CDS Types:
  - Detained and/or Long Term Psychiatric Census
  - Any Elective Admission List CDS Type
  - Future Outpatient

*National Codes:*

| | |
|---|---|
| 010 | Finished General, Delivery and Birth Episodes |
| 020 | Unfinished General, Delivery and Birth Episodes |
| 030 | Other Delivery |
| 040 | Other Birth |
| 050 | Detained and/or Long Term Psychiatric Census |
| 060 | Outpatient |
| 070 | Standard variation of Elective Admission List End Of Period Census |
| 080 | New and Old variations of Elective Admission List End Of Period Census |
| 090 | Add variation of Elective Admission List Event During Period |
| 100 | Remove variation of Elective Admission List Event During Period |
| 110 | Offer variation of Elective Admission List Event During Period |
| 120 | Available/Unavailable variation of Elective Admission List Event During Period |
| 130 | New and Old variations of Elective Admission List Event During Period |
| ~~140~~ | ~~Accident and Emergency Attendance~~ |
| 140 | Accident and Emergency Attendance (Retired 1 November 2020) |
| 150 | Future Outpatient |
| 160 | Emergency Care Attendance |

---

#### CDS INTERCHANGE APPLICATION REFERENCE

---

Change to Attribute: Changed Dataset

The application content of the Interchange where the Interchange contains only one type of Commissioning Data Set Message.

*National Codes:*

| | |
|---|---|
| NHSCDS | CDS Interchange |

---

#### CDS INTERCHANGE CONTROL COUNT

---

Change to Attribute: Changed Dataset
The count of Commissioning Data Set Messages contained in the Commissioning Data Set Interchange.

---

#### CDS INTERCHANGE CONTROL REFERENCE

---

Change to Attribute: Changed Dataset
A unique number (per sender identity) to identify every Commissioning Data Set Interchange submission.

---

#### CDS INTERCHANGE RECEIVER IDENTITY

---

Change to Attribute: Changed Dataset

The address of the physical site receiving a Commissioning Data Set interchange.

#### CDS INTERCHANGE SENDER IDENTITY

Change to Attribute: Changed Dataset
The assigned Electronic Data Interchange (EDI) address of the physical ORGANISATION or ORGANISATION SITE responsible for sending Commissioning data.

#### CDS INTERCHANGE TEST INDICATOR

Change to Attribute: Changed Dataset

An indication of whether the Commissioning Data Set Interchange is a production or test Interchange.

Note: Any CDS INTERCHANGE TEST INDICATOR not populated, or populated with any code other than the specified National Codes will be treated as Production data.

*National Codes:*

| | |
|---|---|
| 1 | The whole Interchange contains Test data |
| 0 | The whole Interchange contains Production data |

#### CDS MESSAGE REFERENCE

Change to Attribute: Changed Dataset
A sequentially incremented number for each Commissioning Data Set message within an interchange.

#### CDS MESSAGE TYPE

Change to Attribute: Changed Dataset

The type of message within a Commissioning Data Set Interchange.

*National Codes:*

| | |
|---|---|
| NHSCDS | CDS Message |

#### CDS MESSAGE VERSION NUMBER

Change to Attribute: Changed Dataset, Description

The version number of the Commissioning Data Set XML Schema in use.

The Commissioning Data Set message version numbers are updated as required during the on-going message development processes.

*National Codes:*

| | |
|---|---|
| NHS003 | The 2000 / 2001 Specification |
| NHS004 | The 2004 / 2005 CDS XML Specification |
| NHS005 | The 2005 / 2006 CDS XML Specification: For implementation of XML messaging in the Secondary Uses Service |
| CDS006 | The 2007 CDS-XML Specification (CDS V6-0/6-1/6-1-1): Note the change to the prefix **CDS** |
| CDS062 | The 2012 CDS XML Specification (V6-2/6-2-1/6-2-2/6-2-3/6-2-0): Note the change to the format which represents the sub-version identifier (version 6-2) |
| CDS063 | The 2022 CDS XML Specification (V6-3) |

#### CDS PROTOCOL IDENTIFIER CODE

Change to Attribute: Changed Dataset
A code to identify the Commissioning Data Set Submission Protocol associated with the transaction.

*National Codes:*

| | |
|---|---|
| 010 | Net Change Update Mechanism<br>*(This is the recommended Protocol for Commissioning Data Set submissions)* |
| 020 | Bulk Replacement Update Mechanism |

#### CDS TYPE CODE

Change to Attribute: Changed Dataset, Description

A code to identify the specific type of Commissioning Data Set data.

Note:

- ~~National Code 011 '*Emergency Care Attendance*' is **only** valid for:~~
  - ~~CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol~~
  - ~~CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol~~
  - ~~CDS V6-2-2 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol~~
  - ~~CDS V6-2-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol~~
  - ~~CDS V6-2-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol~~
  - ~~CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol.~~
- National Code 011 '*Emergency Care Attendance*' is **only** valid for:
  - CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol
  - CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol
  - CDS V6-2-2 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol
  - CDS V6-2-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol
  - CDS V6-2-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol
  - CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol

- CDS Type 010 *'Accident and Emergency Attendance'* was retired on 1 November 2020 and is no longer accepted for submission to the Secondary Uses Service.

- Commissioning Data Set version 6-3 does not require submission of the following CDS Types:
  - Detained and/or Long Term Psychiatric Census
  - Any Elective Admission List CDS Type
  - Future Outpatient

~~Note:~~

- ~~CDS Type 010 *'Accident and Emergency Attendance'* will no longer be accepted from 01 November 2020.~~

*National Codes:*

| | |
|---|---|
| ~~010~~ | ~~Accident and Emergency Attendance~~ |
| 010 | Accident and Emergency Attendance (Retired 1 November 2020) |
| 011 | Emergency Care Attendance |
| 020 | Outpatient<br>May also be used to submit a Referral To Treatment Clock Stop Administrative Event |
| 021 | Future Outpatient |
| 030 | Elective Admission List End of Period Census (Standard) |
| 040 | Elective Admission List End of Period Census (Old) |
| 050 | Elective Admission List End of Period Census (New) |
| 060 | Elective Admission List Event During Period (Add) |
| 070 | Elective Admission List Event During Period (Remove) |

| | |
|---|---|
| 080 | Elective Admission List Event During Period (Offer) |
| 090 | Elective Admission List Event During Period (Available/Unavailable) |
| 100 | Elective Admission List Event During Period (Old Service Agreement) |
| 110 | Elective Admission List Event During Period (New Service Agreement) |
| 120 | Finished Birth Episode |
| 130 | Finished General Episode |
| 140 | Finished Delivery Episode |
| 150 | Other Birth |
| 160 | Other Delivery |
| 170 | Detained and/or Long-Term Psychiatric Census |
| 180 | Unfinished Birth Episode |
| 190 | Unfinished General Episode |
| 200 | Unfinished Delivery Episode |

---

**CDS UPDATE TYPE**

---

Change to Attribute: Changed Dataset, Description

A code to indicate the required database update process for the submitted Commissioning Data Set Message.

*National Codes:*

| | |
|---|---|
| 1 | To indicate a CDS Deletion or Cancellation |
| ~~9~~ | ~~To indicate a CDS Original or Replacement~~ |
| 9 | To indicate a CDS Original or Replacement |

---

**CLINICAL CARE INTENSITY**

---

Change to Attribute: Changed Description

The level of resources and intensity of care which it is intended to provide or is provided in a particular WARD.

Notes:

- National Code descriptions have been updated to remove National Code headings and add prefixes. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

*National Codes:*

| | |
|---|---|
| 51 | Mental Illness intensive care: specially designated ward for PATIENTS needing containment and more intensive management (e.g. Psychiatric Intensive Care Unit (PICU)). This is not to be confused with intensive nursing where PATIENTS may require one to one nursing while on a standard WARD |
| 52 | Mental Illness short stay: PATIENTS intended to stay less than a year |
| 53 | Mental Illness long stay: PATIENTS intended to stay a year or more |
| 61 | Learning Disability PATIENTS in a designated or interim secure unit |
| 62 | Learning Disability PATIENTS intending to stay less than a year |
| 63 | Learning Disability PATIENTS intending to stay a year or more |
| 41 | Only for maternity PATIENTS looked after by CONSULTANTS |
| 43 | Only for maternity PATIENTS looked after by GENERAL MEDICAL PRACTITIONERS |
| 42 | Joint use for maternity PATIENTS looked after by CONSULTANTS and GENERAL MEDICAL PRACTITIONERS |
| 33 | Neonates: maternity: associated with the maternity WARD in that cots are in the maternity WARD nursery or in the WARD itself |
| 32 | |

| | |
|---|---|
| | Neonates: non-maternity: not associated with the maternity WARD and without designated cots for intensive care |
| 31 | Neonates: not associated with the maternity WARD and in which there are some designated cots for intensive care |
| 21 | Younger physically disabled PATIENTS: spinal units, only those units which are nationally recognised |
| 22 | Younger physically disabled PATIENTS: other units |
| 81 | Terminally ill/Palliative Care PATIENTS |
| 11 | General PATIENTS: for intensive therapy, including high dependency care |
| 12 | General PATIENTS: for normal therapy: where resources permit the admission of PATIENTS who might need all but intensive or high dependency therapy |
| 13 | General PATIENTS: for limited therapy: where nursing care rather than continuous medical care is provided. Such WARDS can be used only for PATIENTS carefully selected and restricted to a narrow range in terms of the extent and nature of disease |
| 71 | Home Leave, non-psychiatric |
| 72 | Home Leave, psychiatric |

**CLINICAL CARE INTENSITY will be replaced with WARD INTENDED CLINICAL CARE INTENSITY, which is the most recent approved national information standard to describe the required definition.**

---

**CLINICAL CLASSIFICATION CODE**

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Change to Attribute: Changed Dataset

A unique clinical classification identifier for a CODED CLINICAL ENTRY.

This could be OPCS Classification of Interventions and Procedures (OPCS-4) codes or International Classification of Diseases (ICD) codes.

See Clinical Coding for further information about the types of CODED CLINICAL ENTRIES.

---

**CLINICAL INTERVENTION TYPE**

---

Change to Attribute: Changed Description

The type of CLINICAL INTERVENTION.

*National Codes:*

| | |
|---|---|
| 01 | Anaesthetic Service (Retired November 2013) |
| 02 | Anti-Cancer Drug Cycle (Retired 1 September 2019 ) |
| 03 | Anti-Cancer Drug Fraction (Retired 1 January 2013) |
| 04 | Anti-Cancer Drug Programme (Retired 1 September 2019 ) |
| 05 | Anti-Cancer Drug Regimen |
| 06 | Brachytherapy Treatment Course (Retired 1 April 2020) |
| 07 | Contraceptive Service (Retired November 2013) |
| 08 | Dental Haemorrhage Service (Retired November 2013) |
| 09 | Dental Treatment (Retired 01 April 2014) |
| 10 | Drug Dosage and Administration (Retired 1 January 2013) |
| 11 | Drug Treatment (Retired April 2019) |
| 12 | Emergency Treatment Service (Retired November 2013) |
| 13 | Endocrine Therapy (Retired 1 January 2013) |
| 14 | Fraction |

15 Primary Hip Replacement Surgery
16 Imaging or Radiodiagnostic Event
17 Immunisation Dose Given (Retired April 2019)
18 Joint Replacement Surgery
19 Primary Knee Replacement Surgery
20 Labour and Delivery
21 Lithotripsy Course Attendance (Retired 1 April 2014)
22 Maternity Medical Service (Retired November 2013)
23 Minor Surgery Procedure (Retired November 2013)
24 Pathology Laboratory Investigation (Retired January 2015)
25 Patient Procedure
26 Post Mortem
27 Radiotherapy Treatment Course
28 Screening Test (Retired November 2013)
29 Teletherapy Treatment Course (Retired 1 April 2014)
30 Test Of Immunity (Retired November 2013)
31 Therapy After Discharge (Retired July 2012)
32 Thromboprophylaxis Regime
33 Unsealed Source Treatment Course (Retired 1 April 2014)
34 Vaccination Service (Retired November 2013)
35 Vasectomy Performed (Retired November 2013)
36 Clinical Investigation
37 Systemic Anti-Cancer Therapy Drug Cycle
38 Systemic Anti-Cancer Therapy Drug Programme (Retired 1 September 2019 )
39 Systemic Anti-Cancer Therapy Drug Regimen
40 Chemotherapy
41 Cytotoxic Chemotherapy
42 Hormone Therapy
43 Immunotherapy
44 Diagnostic Imaging (Retired January 2015)
45 6 - 8 Week Physical Examination (Retired January 2015)
46 Ultrasound Scan In Pregnancy (Retired January 2015)
47 Newborn Physical Examination (Retired January 2015)
48 Biological Therapy
49 Brachytherapy
50 Chemoradiotherapy
51 Cryotherapy
52 High Intensity Focused Ultrasound
53 Hyperbaric Oxygen Therapy
54 Laser Treatment
55 Light Therapy
56 Photodynamic Therapy
57 Proton Therapy
58 Psoralen and Ultraviolet A Therapy
59 Radiofrequency Ablation
60 Radioisotope Therapy
61 Radiosurgery
62 Radiotherapy
63 Teletherapy
64 Tissue Typing (Retired January 2015)
65 Blood Transfusion
66 Renal Dialysis
67 Antiretroviral Therapy
68 Drug Regimen

69 Ablative Therapy
70 Laparoscopy
71 Primary Ankle Replacement Surgery
72 Revision Ankle Replacement Surgery
73 Primary Elbow Replacement Surgery
74 Revision Elbow Replacement Surgery
75 Revision Hip Replacement Surgery
76 Revision Knee Replacement Surgery
77 Primary Shoulder Replacement Surgery
78 Revision Shoulder Replacement Surgery
79 Oxygen Therapy
80 Therapeutic Hypothermia
81 Parenteral Nutrition
82 Enteral Feeding
83 Radiotherapy Exposure
84 Mental Health Treatment (Retired 01 January 2016)
85 Restrictive Intervention
86 Adjunctive Therapy
87 Acute Oncology Assessment
88 Breast Triple Diagnostic Assessment
89 Diagnostic Procedure
90 Enhanced Supportive Care
91 Internet Enabled Therapy Programme
?? Remote Monitoring

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**CLINICAL INVESTIGATION RESULT VALUE**

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Change to Attribute: Changed Dataset

The recorded value for a CLINICAL INVESTIGATION RESULT ITEM.

A UNIT OF MEASUREMENT may be recorded for a CLINICAL INVESTIGATION RESULT VALUE.

---

**CLINICAL TERMINOLOGY CODE**

---

Change to Attribute: Changed Dataset

A unique clinical terminology identifier for a CODED CLINICAL ENTRY.

This could be Read Coded Clinical Terms, SNOMED CT concepts or defined in the National Interim Clinical Imaging Procedure Code Set.

See Clinical Coding for further information about the types of CODED CLINICAL ENTRIES.

Note: SNOMED CT is the Information Standard for clinical terminology for use within the NHS; it is planned that in time this will be the only terminology used by the NHS.

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**CLINIC OR FACILITY CODE**

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Change to Attribute: Changed Dataset

An identifier for a CLINIC OR FACILITY.

**CODED CLINICAL ENTRY SEQUENCE NUMBER**

Change to Attribute: Changed Dataset

The sequence number of a CODED CLINICAL ENTRY, recorded to enable correct sequential processing of data.

**COMMISSIONER REFERENCE IDENTIFIER**

Change to Attribute: New Attribute

The identifier of a SERVICE REQUEST allocated by the commissioner of a SERVICE.

**COMMISSIONER REFERENCE NUMBER will be replaced with COMMISSIONER REFERENCE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.**

**This attribute is also known by these names:**

| Context | Alias |
| --- | --- |
| plural | COMMISSIONER REFERENCE IDENTIFIERS |

**COMMISSIONER REFERENCE IDENTIFIER**

Change to Attribute: New Attribute

## COMMISSIONER REFERENCE IDENTIFIER

**Data Elements:**

| COMMISSIONER REFERENCE IDENTIFIER |
| --- |

**COMMISSIONER REFERENCE NUMBER**

Change to Attribute: Changed Description

A number (alphanumeric) allocated by the commissioner to a REFERRAL REQUEST.

**COMMISSIONER REFERENCE NUMBER will be replaced with COMMISSIONER REFERENCE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.**

**CONSULTATION MECHANISM**

Change to Attribute: Changed Dataset

~~**This item is being used for development purposes and has not yet been approved.**~~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.

A non-face to face consultation should directly support diagnosis and care planning and must replace a face to face Out-Patient Attendance Consultant, Clinic Attendance Nurse or Clinic Attendance Midwife, or other types of CARE CONTACT.

A record of the consultation must be retained in the PATIENT's records.

Contact with PATIENTS solely for the purpose of informing them of the outcome of Diagnostic Test results, with no other clinical interaction, are not classified as CARE CONTACTS.

*National Codes:*

| | |
|---|---|
| 01 | Face to face |
| 02 | Telephone |
| 03 | Telemedicine |
| 04 | Talk type for a PERSON unable to speak |
| 05 | Email |
| 09 | Text message (Asynchronous) |
| 10 | Instant messaging (Synchronous) |
| 11 | Video Consultation |
| 12 | Message Board (Asynchronous) |
| 13 | Chat Room (Synchronous) |
| 98 | Other (not listed) |

**CONSULTATION MEDIUM USED will be replaced with CONSULTATION MECHANISM, which is the most recent approved national information standard to describe the required definition.**

### CONSULTATION TYPE

Change to Attribute: Changed Dataset

The type of consultation between the CARE PROFESSIONAL and the PATIENT.

*National Codes:*

| | |
|---|---|
| 01 | Initial Consultation |
| 02 | Follow-up Consultation |

### CRITICAL CARE ACTIVITY CODE

Change to Attribute: Changed Dataset, Description

A type of CRITICAL CARE ACTIVITY provided to a PATIENT during a CRITICAL CARE PERIOD.

Note:

- ~~National Codes 80-97 should not be reported nationally until the functionality to do so becomes available in the next release of the Commissioning Data Sets and the associated XML Schema. Prior to this release, these codes must be recorded locally, however the National Codes 80-97 cannot be transmitted in the current version of the Commissioning Data Sets (Version 6-2). Further guidance can be found on the NHS Digital website at: SCCI0075 and SCCI0076.~~
- National Codes 80-97 cannot be reported nationally in Commissioning Data Sets version 6-2. Users of this Commissioning Data Set release must record these codes locally. Further guidance can be found on the NHS Digital website at: SCCI0075 and SCCI0076.
- User of Commissioning Data Sets version 6-3 are able to submit all National Codes.

*National Codes:*

| | |
|---|---|
| 01 | Respiratory support via a tracheal tube (Respiratory support via a tracheal tube provided) |
| 02 | Nasal Continuous Positive Airway Pressure (nCPAP) (PATIENT receiving nCPAP for any part of the day) |
| 03 | Surgery (PATIENT received surgery) |
| 04 | Exchange Transfusion (PATIENT received exchange transfusion) |
| 05 | Peritoneal Dialysis (PATIENT received Peritoneal Dialysis) |

06 Continuous infusion of inotrope, pulmonary vasodilator or prostaglandin (PATIENT received a continuous infusion of an inotrope, vasodilator (includes pulmonary vasodilators) or prostaglandin)
07 Parenteral Nutrition (PATIENT receiving Parenteral Nutrition (amino acids +/- lipids))
08 Convulsions (PATIENT having convulsions requiring treatment)
09 Oxygen Therapy (PATIENT receiving additional oxygen)
10 Neonatal abstinence syndrome (PATIENT receiving drug treatment for neonatal abstinence (withdrawal) syndrome)
11 Care of an intra-arterial catheter or chest drain (PATIENT receiving care of an intra-arterial catheter or chest drain)
12 Dilution Exchange Transfusion (PATIENT received Dilution Exchange Transfusion)
13 Tracheostomy cared for by nursing staff (PATIENT receiving care of tracheostomy cared for by nursing staff not by an external Carer (e.g. parent))
14 Tracheostomy cared for by external Carer (PATIENT receiving care of tracheostomy cared for by an external Carer (e.g. parent) not by a NURSE)
15 Recurrent apnoea (PATIENT has recurrent apnoea needing frequent intervention, i.e. over 5 stimulations in 8 hours, or resuscitation with IPPV two or more times in 24 hours)
16 Haemofiltration (PATIENT received Haemofiltration)
21 Carer Resident - Caring for Baby (External Carer (for example, parent) resident with the baby and reducing nursing required by caring for the baby)
22 Continuous monitoring (PATIENT requiring continuous monitoring (by mechanical monitoring equipment) of respiration or heart rate, or by transcutaneous transducers or by Saturation Monitors. Note: apnoea alarms and monitors are *excluded* as forms of continuous monitoring)
23 Intravenous glucose and electrolyte solutions (PATIENT being given intravenous glucose and electrolyte solutions)
24 Tube-fed (PATIENT being tube-fed)
25 Barrier nursed (PATIENT being barrier nursed)
26 Phototherapy (PATIENT receiving phototherapy)
27 Special monitoring (PATIENT receiving special monitoring of blood glucose or serum bilirubin measurement at a minimum frequency of more than one per calendar day)
28 Observations at regular intervals (PATIENT requiring recorded observations for Temperature, Heart Rate, Respiratory Rate, Blood Pressure or scoring for neonatal abstinence syndrome. Recorded observations must be at a minimum frequency of 4 hourly)
29 Intravenous medication (PATIENT receiving intravenous medication)
50 Continuous electrocardiogram monitoring
51 Invasive ventilation via endotracheal tube
52 Invasive ventilation via tracheostomy tube
53 Non-invasive ventilatory support
55 Nasopharyngeal airway
56 Advanced ventilatory support (Jet or Oscillatory ventilation)
57 Upper airway obstruction requiring nebulised Epinephrine/ Adrenaline
58 Apnoea requiring intervention
59 Acute severe asthma requiring intravenous bronchodilator therapy or continuous nebuliser
60 Arterial line monitoring
61 Cardiac pacing via an external box (pacing wires or external pads or oesophageal pacing)
62 Central venous pressure monitoring
63 Bolus intravenous fluids (> 80 ml/kg/day) in addition to maintenance intravenous fluids
64 Cardio-pulmonary resuscitation (CPR)
65 Extracorporeal membrane oxygenation (ECMO) or Ventricular Assist Device (VAD) or aortic balloon pump
66 Haemodialysis (acute PATIENTS only i.e. excluding chronic)
67 Plasma filtration or Plasma exchange
68 ICP-intracranial pressure monitoring
69 Intraventricular catheter or external ventricular drain
70 Diabetic ketoacidosis (DKA) requiring continuous infusion of insulin
71 Intravenous infusion of thrombolytic agent (limited to tissue plasminogen activator [tPA] and streptokinase)

| | |
|---|---|
| 72 | Extracorporeal liver support using Molecular Absorbent Liver Recirculating System (MARS) |
| 73 | Continuous pulse oximetry |
| 74 | PATIENT nursed in single occupancy cubicle |
| 80 | Heated Humidified High Flow Therapy (HHHFT) (PATIENT receiving HHHFT) |
| 81 | Presence of an umbilical venous line |
| 82 | Continuous infusion of insulin (PATIENT receiving a continuous infusion of insulin) |
| 83 | Therapeutic hypothermia (PATIENT receiving therapeutic hypothermia) |
| 84 | PATIENT has a Replogle tube in situ |
| 85 | PATIENT has an epidural catheter in situ |
| 86 | PATIENT has an abdominal silo |
| 87 | Administration of intravenous (IV) blood products |
| 88 | PATIENT has a central venous or long line (Peripherally Inserted Central Catheter line) in situ |
| 89 | PATIENT has an indwelling urinary or suprapubic catheter in situ |
| 90 | PATIENT has a trans-anastomotic tube in situ following oesophageal atresia repair |
| 91 | PATIENT has confirmed clinical seizure(s) today and/or continuous cerebral function monitoring (CFM) |
| 92 | PATIENT has a ventricular tap via needle or reservoir today |
| 93 | PATIENT has a stoma |
| 94 | PATIENT has arrhythmia requiring intravenous anti-arrhythmic therapy |
| 95 | PATIENT has reduced conscious level (Glasgow Coma Score 12 or below) and hourly (or more frequent) Glasgow Coma Score monitoring |
| 96 | Intravenous infusion of sedative agent (PATIENT receiving continuous intravenous infusion of sedative agent) |
| 97 | PATIENT has status epilepticus requiring treatment with continuous intravenous infusion |
| 99 | No Defined Critical Care Activity (PATIENT is not receiving any of the critical care interventions listed above (Excluding code 21). For example, PATIENT is on the Intensive Care Unit ready for discharge and is receiving normal care. This is the default code. |

---

**CRITICAL CARE ADMISSION SOURCE**

---

Change to Attribute: Changed Dataset
The primary ORGANISATION type that the PATIENT has been admitted from prior to the start of the CRITICAL CARE PERIOD.

*National Codes:*

| | |
|---|---|
| 01 | Same NHS Hospital Site |
| 02 | Other NHS Hospital Site (same or different NHS Trust) |
| 03 | Independent Hospital Provider in the UK |
| 04 | Non-hospital source within the UK (e.g. home) |
| 05 | Non UK source such as repatriation, military personnel or foreign national |

---

**CRITICAL CARE ADMISSION TYPE**

---

Change to Attribute: Changed Dataset
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'*.

*National Codes:*

| | |
|---|---|
| 01 | Unplanned local admission. All emergency or urgent PATIENTS referred to the unit only as a result of an unexpected acute illness occurring within the local area (hospitals within the Trust together with neighbouring community units and services). |
| 02 | |

Unplanned transfer in. All emergency or urgent PATIENTS referred to the unit as a result of an unexpected acute illness occurring outside the local area (including private and overseas Health Care Providers).

03 Planned transfer in (tertiary referral). A pre-arranged admission to the unit after treatment or initial stabilisation at another Health Care Provider (including private and overseas Health Care Providers) but requiring specialist or higher-level care that cannot be provided at the source hospital or unit.

04 Planned local surgical admission. A pre-arranged surgical admission from the local area to the to the unit, acceptance by the unit must have occurred prior to the start of the surgical procedure and the procedure will usually have been of an elective or scheduled nature. For example, following a major procedure, for a high risk medical condition associated with any level of surgery, admitted prior to elective surgery for optimisation, admitted for monitoring of pain control eg epidurals, or obstetric surgical cases admitted on a planned basis.

05 Planned local medical admission from the local area. Booked medical admission, for example, planned investigation or high risk medical treatment.

06 Repatriation. The PATIENT is normally resident in your local area and is being admitted or readmitted to your unit from another hospital (including overseas Health Care Providers). This situation will normally arise when a PATIENT is returning from tertiary or specialist care.

---

**CRITICAL CARE DISCHARGE DESTINATION**

---

Change to Attribute: Changed Dataset
The primary ORGANISATION type that the PATIENT has been discharged to at the end of the CRITICAL CARE PERIOD.

*National Codes:*

01 Same NHS Hospital Site
02 Other NHS Hospital Site (can be same Trust or a different NHS Trust)
03 Independent Hospital Provider in the UK
04 Non-hospital destination within the UK (e.g. home as coded in LOCATION)
05 Non United Kingdom destination (e.g. repatriation)
06 No CRITICAL CARE DISCHARGE DESTINATION, PATIENT died in unit

---

**CRITICAL CARE DISCHARGE LOCATION**

---

Change to Attribute: Changed Dataset
The principal LOCATION that the PATIENT is discharged to at the end of the CRITICAL CARE PERIOD.

*National Codes:*

01 WARD
02 Recovery only (when used to provide temporary critical care facility)
03 Other intermediate care or specialised treatment area but excluding temporary visits en route, e.g. imaging, Endoscopy, catheter suites and operating departments.
04 Adult level three critical care bed (e.g. in a flexibly configured unit)
05 Adult level two critical care bed (e.g. in a flexibly configured unit)
06 No discharge location, PATIENT died in unit
07 Obstetrics area
08 Paediatric critical care area (neonatal and paediatric care)
09 Home or other residence (e.g. nursing home, H.M. Prison, residential care)
10 Other non-hospital LOCATION

---

**CRITICAL CARE DISCHARGE READY DATE**

---

Change to Attribute: Changed Dataset
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**

---

Change to Attribute: Changed Dataset
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**

---

Change to Attribute: Changed Dataset
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.

*National Codes:*

| | |
|---|---|
| 01 | Fully ready for discharge |
| 02 | Discharge for Palliative Care |
| 03 | Early discharge due to shortage of critical care beds |
| 04 | Delayed discharge due to shortage of other WARD beds |
| 05 | Current level of care continuing in another LOCATION |
| 06 | More specialised care in another LOCATION |
| 07 | Self discharge against medical advice |
| 08 | PATIENT died (no organs donated) |
| 09 | PATIENT died (heart beating solid organ donor) |
| 10 | PATIENT died (cadaveric TISSUE donor) |
| 11 | PATIENT died (non heart beating solid organ donor) |

---

**CRITICAL CARE LEVEL**

---

Change to Attribute: Changed Dataset

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

*National Codes:*

| | |
|---|---|
| 00 | Level 0 (Patients whose needs can be met through normal WARD care in an acute hospital) |
| 01 | Level 1 (PATIENTS at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute WARD with additional advice and support from the critical care team.) |

| | |
|---|---|
| 02 | Level 2 (PATIENTS requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care.) |
| 03 | Level 3 (PATIENTS requiring advanced respiratory support alone or monitoring and support for two or more organ systems. This level includes all complex PATIENTS requiring support for multi-organ failure.) |

References:
Comprehensive Critical Care: a review of adult critical care services, Department of Health and Social Care May 2000 and Levels of critical care for adult PATIENTS, Intensive Care Society 2002.

---

#### CRITICAL CARE SOURCE LOCATION

---

Change to Attribute: Changed Dataset

The type of LOCATION the PATIENT was in prior to the start of the CRITICAL CARE PERIOD.

Notes:

- The following National Code has been updated in DCB0092-2062: Commissioning Data Sets: Emergency Care Data Set. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct:
  - 05 '*Emergency Care Department*'.

*National Codes:*

| | |
|---|---|
| 01 | Theatre and Recovery (following surgical and/or anaesthetic procedure) |
| 02 | Recovery only (when used to provide temporary critical care facility) |
| 03 | Other WARD (not critical care) |
| 04 | Imaging Department |
| 05 | Emergency Care Department |
| 06 | Other intermediate care or specialist treatment areas including endoscopy units and catheter suites |
| 07 | Obstetrics area |
| 08 | Clinic |
| 09 | Home or other residence (including nursing home, H.M. Prison or other residential care) |
| 10 | Adult level three critical care bed (ICU bed) |
| 11 | Adult level two critical care bed (HDU bed) |
| 12 | Paediatric critical care area (neonatal and paediatric care) |

---

#### CRITICAL CARE UNIT FUNCTION

---

Change to Attribute: Changed Dataset, Description

~~The principal type of Critical Care clinical service provided within the WARD to which a PATIENT was admitted to during a CRITICAL CARE PERIOD.~~The principal type of Critical Care clinical service provided within the WARD to which a PATIENT was admitted during a CRITICAL CARE PERIOD.

Further detail on CRITICAL CARE UNIT FUNCTIONS is described on CRITICAL CARE PERIOD.

Note:

- National Code descriptions have been updated to remove National Code headings and add prefixes where required. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.
- Facilities are described by the category of PATIENT predominantly treated, as follows:
  - Adult Facilities (PATIENTS more than 19 years old on admission predominate)
  - Children and Young People Facilities (PATIENTS aged greater than or equal to 29 days to less than 19 years predominate)
  - Neonatal Facilities (PATIENTS aged less than 29 days on admission predominate)

- Other settings

*National Codes:*

| | |
|---|---|
| 01 | Non-specific, general adult critical care PATIENTS predominate |
| 02 | Surgical adult PATIENTS (unspecified specialty) |
| 03 | Medical adult PATIENTS (unspecified specialty) |
| 05 | Neurosciences adult PATIENTS predominate |
| 06 | Cardiac surgical adult PATIENTS predominate |
| 07 | Thoracic surgical adult PATIENTS predominate |
| 08 | Burns and plastic surgery adult PATIENTS predominate |
| 09 | Spinal adult PATIENTS predominate |
| 10 | Renal adult PATIENTS predominate |
| 11 | Liver adult PATIENTS predominate |
| 12 | Obstetric and gynaecology adult critical care PATIENTS predominate |
| 90 | Adult: Non standard LOCATION using a WARD area |
| 04 | Paediatric Intensive Care Unit (Paediatric critical care PATIENTS predominate) |
| 16 | WARD for children and young people |
| 17 | High Dependency Unit for children and young people |
| 18 | Renal Unit for children and young people |
| 19 | Burns Unit for children and young people |
| 92 | Non standard LOCATION using the operating department for children and young people |
| 13 | Neonatal Intensive Care Unit (Neonatal critical care PATIENTS predominate) |
| 14 | Facility for Babies (Neonates) on a Neonatal Transitional Care WARD |
| 15 | Facility for Babies (Neonates) on a Maternity WARD |
| 91 | Other settings: non standard LOCATION using the operating department |

---

**DATA ABSENT REASON**

---

Change to Attribute: New Attribute

The reason why the normally expected content of a CODED CLINICAL ENTRY is missing.

**This attribute is also known by these names:**

| Context | Alias |
|---|---|
| plural | DATA ABSENT REASONS |

---

**DATA ABSENT REASON**

---

Change to Attribute: New Attribute

## DATA ABSENT REASON

**Data Elements:**

| DATA ABSENT REASON (FHIR R4) |
|---|

---

**DECIDED TO ADMIT DATE**

---

Change to Attribute: Changed Dataset

The date a DECISION TO ADMIT was made.

### DELIVERY METHOD

Change to Attribute: Changed Dataset

The method by which a baby is delivered, which is a REGISTRABLE BIRTH.

*National Codes:*

| | |
|---|---|
| 0 | Spontaneous vertex |
| 1 | Spontaneous other cephalic |
| 2 | Low forceps, not breech |
| 3 | Other forceps, not breech |
| 4 | Ventouse, vacuum extraction |
| 5 | Breech |
| 6 | Breech extraction |
| 7 | Elective caesarean section |
| 8 | Emergency caesarean section |
| 9 | Other (not listed) |

### DELIVERY PLACE CHANGE REASON

Change to Attribute: Changed Dataset

If the place of Delivery is different from the place originally intended, either in the type of place or geographically, the reasons for change should be classified as below.

*National Codes:*

| | |
|---|---|
| 1 | Decision made during pregnancy because of change of ADDRESS |
| 2 | Decision made during pregnancy for clinical reasons |
| 3 | Decision made during pregnancy for other reasons |
| 4 | Decision made during Labour for clinical reasons |
| 5 | Decision made during Labour for other reasons |
| 6 | Occurred unintentionally during Labour |

### DESTINATION OF DISCHARGE

Change to Attribute: Changed Dataset

~~**This item is being used for development purposes and has not yet been approved.**~~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.

*National Codes:*

| | |
|---|---|
| 19 | Usual place of residence unless listed below, for example, a private dwelling whether owner occupied or owned by Local Authority, housing association or other landlord. This includes wardened accommodation but not residential accommodation where health care is provided. It also includes PATIENTS with no fixed abode. |
| 29 | Temporary place of residence when usually resident elsewhere (includes hotel, residential Educational Establishment) |
| 30 | Repatriation from high security psychiatric accommodation in an NHS Hospital Provider (NHS Trust or NHS Foundation Trust) |
| 37 | Court |
| 40 | Penal establishment |

| | |
|---|---|
| 42 | Police Station / Police Custody Suite |
| 48 | High Security Psychiatric Hospital, Scotland |
| 49 | NHS other Hospital Provider - high security psychiatric accommodation |
| 50 | NHS other Hospital Provider - medium secure unit |
| 51 | NHS other Hospital Provider - WARD for general PATIENTS or the younger physically disabled |
| 52 | NHS other Hospital Provider - WARD for maternity PATIENTS or Neonates |
| 53 | NHS other Hospital Provider - WARD for PATIENTS who are mentally ill or have Learning Disabilities |
| 55 | Care Home With Nursing |
| 56 | Care Home Without Nursing |
| 66 | Local Authority foster care |
| 79 | PATIENT died or stillbirth |
| 84 | Independent Sector Healthcare Provider run hospital - medium secure unit |
| 87 | Independent Sector Healthcare Provider run hospital - excluding medium secure unit |
| 88 | Hospice |
| 89 | ORGANISATION responsible for forced repatriation |

**DISCHARGE DESTINATION will be replaced with DESTINATION OF DISCHARGE, which is the most recent approved national information standard to describe the required definition.**

#### DIAGNOSIS SCHEME IN USE

Change to Attribute: Changed Dataset

The type of CODED CLINICAL ENTRY used for the PATIENT DIAGNOSIS.

Notes:

- National Code 04 *'Read Coded Clinical Terms Version 2'* is **not** valid for the Mental Health Services Data Set
- National Code 05 *'Read Coded Clinical Terms Version 3 (CTV3)'* (previously known as 3.1) is **not** supported in the Commissioning Data Sets and Mental Health Services Data Set
- National Code 06 *'SNOMED CT®'* is **not** valid for Commissioning Data Set version 6-2.

*National Codes:*

| | |
|---|---|
| 01 | Accident & Emergency Diagnosis (Retired 01 November 2020) |
| 02 | ICD-10 |
| 03 | Read Code 4Byte Version (retired 1 October 2009) |
| 04 | Read Coded Clinical Terms Version 2 |
| 05 | Read Coded Clinical Terms Version 3 (CTV3) |
| 06 | SNOMED CT® |

#### DIRECT ACCESS REFERRAL INDICATOR

Change to Attribute: Changed Dataset
An indication of whether a PATIENT was referred to a Direct Access Service.

*National Codes:*

| | |
|---|---|
| Y | Referred to a Direct Access Service |
| N | Not referred to a Direct Access Service |

#### DISCHARGED TO NHS AT HOME SERVICE INDICATOR

Change to Attribute: New Attribute

An indication of whether a PATIENT was discharged from a Hospital Provider Spell to an NHS At Home Service.

*National Codes:*

| | |
|---|---|
| Y | Yes - Discharged to NHS At Home Service |
| N | No - Not discharged to NHS At Home Service |

**This attribute is also known by these names:**

| Context | Alias |
|---|---|
| plural | DISCHARGED TO NHS AT HOME SERVICE INDICATORS |

**DISCHARGED TO NHS AT HOME SERVICE INDICATOR**

Change to Attribute: New Attribute

## DISCHARGED TO NHS AT HOME SERVICE INDICATOR

**Data Elements:**

| DISCHARGED TO NHS AT HOME SERVICE INDICATOR |
|---|

**EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR**

Change to Attribute: New Attribute

An indication of whether a follow up CARE CONTACT is required at the end of the eMED3 Fit Note Applicable Period.

*National Codes:*

| | |
|---|---|
| Y | Yes - a follow up CARE CONTACT is required at the end of the eMED3 Fit Note Applicable Period |
| N | No - a follow up CARE CONTACT is not required at the end of the eMED3 Fit Note Applicable Period |

**This attribute is also known by these names:**

| Context | Alias |
|---|---|
| plural | EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATORS |

**EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR**

Change to Attribute: New Attribute

## EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR

**Data Elements:**

| EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR |
|---|

**ETHNIC CATEGORY 2021**

Change to Attribute: Changed Dataset

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.**

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**ETHNIC CATEGORY CODE 2001**

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Change to Attribute: Changed Dataset

The ethnicity of a PERSON, as specified by the PERSON.

ETHNIC CATEGORY CODE 2001 is the classification used for the 2001 census.

The Office for National Statistics has developed a further breakdown of the group from that given, which may be used locally.

Note: the National Code descriptions have been updated. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where they are not already correct.

*National Codes:*

| | |
|---|---|
| A | White - British |
| B | White - Irish |
| C | White - Any other White background |
| D | Mixed - White and Black Caribbean |
| E | Mixed - White and Black African |
| F | Mixed - White and Asian |
| G | Mixed - Any other mixed background |
| H | Asian or Asian British - Indian |
| J | Asian or Asian British - Pakistani |
| K | Asian or Asian British - Bangladeshi |
| L | Asian or Asian British - Any other Asian background |
| M | Black or Black British - Caribbean |
| N | Black or Black British - African |
| P | Black or Black British - Any other Black background |
| R | Other Ethnic Groups - Chinese |
| S | Other Ethnic Groups - Any other ethnic group |
| Z | Not stated |

National code Z - Not Stated should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to.

---

**EVENT DATE**

---

Change to Attribute: Changed Dataset

The date, month, year and century, or any combination of these elements, of an EVENT.

---

**EVENT TIME**

---

Change to Attribute: Changed Dataset

The time (using a 24 hour clock) at which an EVENT, or the action in an EVENT, takes place.

This may include representation of a time zone.

#### FIRST ATTENDANCE

Change to Attribute: Changed Dataset

An indication of whether a PATIENT is making a first attendance or contact; or a follow-up attendance or contact and whether the CONSULTATION MEDIUM USED national code was '*Face to face communication*' or '*Telephone*' or '*Telemedicine*'.

A first attendance is the first in a series, or only attendance of an APPOINTMENT which took place regardless of how many previous APPOINTMENTS were made which did not take place for whatever reason. All subsequent attendances in the series which take place should be recorded as follow-up.

Note:

- National Code 5 *'Referral to Treatment Clock Stop Administrative Event'* allows the Secondary Uses Service to build accurate PATIENT PATHWAYS for the reporting of 18 weeks activity. It flows through the CDS V6-2 Type 020 - Outpatient Commissioning Data Set structure.

*National Codes:*

| | |
|---|---|
| 1 | First attendance face to face |
| 2 | Follow-up attendance face to face |
| 3 | First telephone or Telemedicine consultation |
| 4 | Follow-up telephone or Telemedicine consultation |
| 5 | Referral To Treatment Clock Stop Administrative Event |

#### FIRST REGULAR DAY OR NIGHT ADMISSION

Change to Attribute: Changed Dataset

The first admission in a series of regular day/night admissions for a course of treatment.

If a PATIENT changes from a regular day to a regular night admission, the next admission after the change is not a first admission in a series unless a new course of treatment is started.

If a series of regular day or night admissions is interrupted by an ordinary admission then the next admission in the series is not a first admission unless a new course of treatment is started.

*National Codes:*

| | |
|---|---|
| 0 | First in a series |
| 1 | Subsequent to first in a series |

#### GENERAL MEDICAL PRACTITIONER PPD CODE

Change to Attribute: Changed Dataset

This is the NHS Prescription Services code to identify a GENERAL MEDICAL PRACTITIONER.

The DOCTOR INDEX NUMBER is passed to the NHS Prescription Services, which adds a leading character and a check digit to create the GENERAL MEDICAL PRACTITIONER PPD CODE. NHS Prescription Services use this for the issue of prescription pads etc.

For England and Wales, in addition to a GENERAL MEDICAL PRACTITIONER PPD CODE, a GENERAL MEDICAL PRACTITIONER may have one or more spurious GENERAL MEDICAL PRACTITIONER Code(s). These are allocated if a GENERAL MEDICAL PRACTITIONER works in additional General Medical Practitioner Practice. The spurious GENERAL MEDICAL PRACTITIONER Codes are not derived from the DOCTOR INDEX NUMBER, but do follow the same format as the GENERAL MEDICAL PRACTITIONER PPD CODE, and are allocated by the NHS Prescription Services. All spurious GENERAL MEDICAL PRACTITIONER Codes begin with either 'G6' or 'G7'.

**England and Wales General Medical Practitioner Code format**

| Practitioner Code Type | Character Position | | | | | | | | Allocated By | Allocated To | Known As | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | | | | |
| GENERAL MEDICAL PRACTITIONER PPD CODE | G | 0-9 | 0-9 | 0-9 | 0-9 | 0-9 | 0-9 | 0-9 | NHS Prescription Services | Prescribing GMPs in England & Wales | GMP | Derived from DOCTOR INDEX NUMBER - NHS Prescription Services add leading G and a check digit. Associated with practice. |

**Scottish General Medical Practitioner Code format**

| Practitioner Code Type | Character Position | | | | | | | | Allocated By | Allocated To | Known As | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | | | | |
| Scottish General Medical Practitioner Code | S | 0-9 | 0-9 | 0-9 | 0-9 | 0-9 | 0-9 | 0-9 | Information Standards Division (Scotland) | GMPs in Scotland | GMP | |

**Northern Ireland General Medical Practitioner Code format**

| Practitioner Code Type | Character Position | | | | | | | | Allocated By | Allocated To | Known As | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | | | | |
| Northern Ireland General Medical Practitioner Code | Z | E, N, S, W | 0-9 | 0-9 | 0-9 | 0-9 | 0-9 | 0 | Northern Ireland Dept of Health, Social Services and Public Safety | GMPs in Northern Ireland | GMP | |

---

**GESTATION LENGTH IN WEEKS**

Change to Attribute: Changed Dataset

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

The gestational age should be recorded in completed weeks: e.g. events occurring 280-286 days after the onset of the last menstrual period are considered to have occurred at 40 weeks gestation.

---

**INTENDED DELIVERY PLACE**

---

Change to Attribute: Changed Dataset

The Delivery place type where the pregnant woman plans to have her baby.

- The first INTENDED DELIVERY PLACE type is recorded, as designated by the CARE PROFESSIONAL in consultation with the PATIENT.
- The initial INTENDED DELIVERY PLACE may not be recorded since there may be no history of Antenatal care. For example, the pregnancy may not have been diagnosed or may have been concealed. In this case, National Code *'None of the above'* would be recorded.

*National Codes:*

| | |
|---|---|
| 1 | At a domestic ADDRESS |
| 2 | In NHS hospital - Delivery facilities associated with CONSULTANT WARD |
| 3 | In NHS hospital - Delivery facilities associated with GENERAL MEDICAL PRACTITIONER WARD |
| 0 | In NHS hospital - Delivery facilities associated with MIDWIFE WARD |
| 4 | In NHS hospital - Delivery facilities associated with CONSULTANT/ GENERAL MEDICAL PRACTITIONER/ MIDWIFE WARD inclusive of any combination of two of the professionals mentioned |
| 7 | In NHS hospital - WARD or unit without Delivery facilities |
| 5 | In private hospital |
| 6 | In other hospital or institution |
| 8 | None of the above |
| 9 | Not known |

---

**INTENDED MANAGEMENT**

---

Change to Attribute: Changed Dataset

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. It is not necessary to collect this information for maternity PATIENTS or for babies admitted to hospital shortly after birth.

*National Codes:*

| | |
|---|---|
| 1 | PATIENT to stay in hospital for at least one night |
| 2 | PATIENT not to stay in hospital overnight |
| 3 | PATIENT to be admitted for a planned sequence of admissions each involving at least one overnight stay |
| 4 | PATIENT to be admitted for a planned sequence of admissions which do not involve an overnight stay |
| 5 | PATIENT to be admitted regularly for a planned sequence of nights who returns home for the remainder of the 24 hour period |

---

**LABOUR OR DELIVERY ONSET METHOD**

---

Change to Attribute: Changed Dataset

The method by which the process of Labour began, or Delivery by caesarean section occurred.

Note:

- National Code 1 is not to be recorded if a planned elective caesarean section is carried out, see National Code 2.
- If an unplanned caesarean section is performed after Labour has started National Codes 1, 3, 4, and 5 should be used as applicable.
- If the methods at National Code 3, 4, or 5 have been used to accelerate rather than induce Labour, they should not be recorded under these codes.

*National Codes:*

| | |
|---|---|
| 1 | Spontaneous; the onset of regular contractions whether or not preceded by spontaneous rupture of the membranes |
| 2 | Any caesarean section carried out before the onset of Labour or a planned elective caesarean section carried out immediately following the onset of Labour, when the decision was made before Labour |
| 3 | Surgical induction; by amniotomy |
| 4 | Medical induction; including administration of agents either orally, intravenously or intravaginally with the intention of initiating Labour |
| 5 | Combination of surgical induction and medical induction |

---

**LAST EPISODE IN SPELL INDICATOR CODE**

---

Change to Attribute: Changed Dataset
An indication of whether the consultant episode is the final episode in the Hospital Provider Spell.

*National Codes:*

| | |
|---|---|
| 1 | This episode is the last episode in the Hospital Provider Spell |
| 2 | The episode is not the last episode in the Hospital Provider Spell |

---

**LENGTH OF STAY ADJUSTMENT**

---

Change to Attribute: Changed Dataset

The total number of days within a Consultant Episode (Hospital Provider) that a discrete period of ACTIVITY such as Rehabilitation or Specialist Palliative Care occurred, which requires an adjustment to the total length of stay for National Tariff Payment System purposes.

The LENGTH OF STAY ADJUSTMENT should be calculated using the National Tariff Payment System rules (i.e. count of midnights). The LENGTH OF STAY ADJUSTMENT REASON should also be recorded.

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.

---

**LIVE OR STILL BIRTH**

---

Change to Attribute: Changed Dataset

An indication of whether the birth was a live or stillbirth.

A stillbirth is a birth after a gestation of 24 weeks (168 days) where the baby shows no identifiable signs of life at delivery.

*National Codes:*

| | |
|---|---|
| 1 | Live |
| 2 | Stillbirth ante-partum |
| 3 | Stillbirth intra-partum |
| 4 | Stillbirth indeterminate |
| 5 | Baby born but died later (Retired May 2020) |

---

**LOCAL PATIENT IDENTIFIER**

---

Change to Attribute: Changed Dataset

A number used to identify a PATIENT uniquely within a Health Care Provider. It may be different from the PATIENT's casenote number and may be assigned automatically by the computer system.

Where care for NHS patients is sub-commissioned in the independent sector or overseas, the NHS commissioner PAS Number should be used. If no NHS PAS Number has been assigned the independent sector or overseas PAS Number should be used.

---

**LOCAL SUB-SPECIALTY CODE**

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Change to Attribute: Changed Dataset

A unique identifier for a LOCAL SUB-SPECIALTY.

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**MAIN SPECIALTY CODE**

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Change to Attribute: Changed Dataset

A unique code identifying each MAIN SPECIALTY designated by Royal Colleges. This is the same as the NHS OCCUPATION CODES describing specialties.

Specialties are divisions of clinical work which may be defined by body systems (dermatology), age (paediatrics), clinical technology (nuclear medicine), clinical function (rheumatology), group of diseases (oncology) or combinations of these factors. Only Specialty titles recognised by the Royal Colleges and Faculties should be used. This list is maintained by the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 and European Primary and Specialist Dental Qualifications Regulations 1998.

Each CONSULTANT should be assigned a MAIN SPECIALTY by the ORGANISATION to which the CONSULTANT is contracted. For physicians and surgeons with a generalist component to their work, the MAIN SPECIALTY should be general medicine or general surgery. The hallmark of a general physician or general surgeon is the continued care of unselected emergency referrals. The MAIN SPECIALTY is specific to a Health Care Provider. If, for example, a CONSULTANT physician working in two Health Care Providers has a generalist component to the work in one and not the other, general medicine is only assigned as the MAIN SPECIALTY in the former case. CONSULTANTS in general medicine or general surgery may also have specialist interests and these should be recorded as well as the MAIN SPECIALTY.

The initial source of the information should be the designation on the CONSULTANT's contract. This should be checked periodically against the work a CONSULTANT is actually doing so that the statistics can relate to a CONSULTANT's current type of work.

The MAIN SPECIALTY only should be used for the purpose of producing Specialty costing statistics and for Workforce statistics where links with ACTIVITY and finance are required. Other specialist interests of CONSULTANTS may be recorded for workforce planning purposes.

This will be used to indicate the skill level of medical and dental employees.

Pseudo MAIN SPECIALTY CODES should be used in Commissioning Data Set messages for lead CARE PROFESSIONALS other than CONSULTANT medical and dental staff e.g. 560, 950 and 960.

The MAIN SPECIALTY CODE for GENERAL PRACTITIONERS is General Medical Practice or General Dental Practice.

Joint Consultant Clinic ACTIVITY should be recorded against the MAIN SPECIALTY CODE of the CONSULTANT managing the clinic.

For further information, contact NHS Digital by email at: enquiries@nhsdigital.nhs.uk with the subject "Main Specialty and Treatment Function Codes".

**Further information on the groupings and each MAIN SPECIALTY CODE is provided at: Main Specialty and Treatment Function Codes Table.**

Note:

- New National Codes for MAIN SPECIALTY CODE were introduced from 2 April 2020 as part of the update to the DCB0028: Treatment Function and Main Specialty Standard. Submission of these codes for the Commissioning Data Sets is only possible where the healthcare provider has updated their CDS-XML schema version to CDS-XML version 6-2-0. Users of the original CDS-XML schema version 6-2 will be unable to submit the new codes introduced in the release of DCB0028: Treatment Function and Main Specialty Standard in April 2020.

*National Codes:*

| | |
|---|---|
| 100 | General Surgery |
| 101 | Urology |
| 107 | Vascular Surgery |
| 110 | Trauma and Orthopaedics |
| 120 | Ear Nose and Throat |
| 130 | Ophthalmology |
| 140 | Oral Surgery |
| 141 | Restorative Dentistry |
| 142 | Paediatric Dentistry |
| 143 | Orthodontics |
| 145 | Oral and Maxillofacial Surgery |
| 146 | Endodontics |
| 147 | Periodontics |
| 148 | Prosthodontics |
| 149 | Surgical Dentistry |
| 150 | Neurosurgery |
| 160 | Plastic Surgery |
| 170 | Cardiothoracic Surgery |
| 171 | Paediatric Surgery |
| 191 | Pain Management (Retired 1 April 2004) |
| 180 | Emergency Medicine |
| 190 | Anaesthetics |
| 192 | Intensive Care Medicine |
| 200 | Aviation and Space Medicine |
| 300 | General Internal Medicine |
| 301 | Gastroenterology |
| 302 | Endocrinology and Diabetes |
| 303 | Clinical Haematology |
| 304 | Clinical Physiology |
| 305 | Clinical Pharmacology |
| 310 | Audio Vestibular Medicine |

311 Clinical Genetics
312 CLINICAL CYTOGENETICS and MOLECULAR GENETICS (Retired 1 April 2010)
National Code 312 is retained for CONSULTANTS qualified in this Main Specialty prior to 1 April 2010
313 Clinical Immunology
314 Rehabilitation Medicine
315 Palliative Medicine
317 Allergy
320 Cardiology
321 Paediatric Cardiology
325 Sport and Exercise Medicine
326 Acute Internal Medicine
330 Dermatology
340 Respiratory Medicine
350 Infectious Diseases
352 Tropical Medicine
360 Genitourinary Medicine
361 Renal Medicine
370 Medical Oncology
371 Nuclear Medicine
400 Neurology
401 Clinical Neurophysiology
410 Rheumatology
420 Paediatrics
421 Paediatric Neurology
430 Geriatric Medicine
450 Dental Medicine
451 Special Care Dentistry
460 Medical Ophthalmology
500 Obstetrics and Gynaecology
National Code 500 is not acceptable for Central Returns including Hospital Episode Statistics
501 Obstetrics
502 Gynaecology
504 Community Sexual and Reproductive Health
510 Antenatal Clinic (Retired 1 April 2004)
520 Postnatal Clinic (Retired 1 April 2004)
560 Midwifery
600 General Medical Practice
601 General Dental Practice
610 Maternity Function (Retired 1 April 2004)
620 Other than Maternity (Retired 1 April 2004)
700 Learning Disability
710 Adult Mental Illness
711 Child and Adolescent Psychiatry
712 Forensic Psychiatry
713 Medical Psychotherapy
715 Old Age Psychiatry
800 Clinical Oncology
810 Radiology
820 General Pathology
821 Blood Transfusion
822 Chemical Pathology
823 Haematology
824 Histopathology
830 Immunopathology

831 Medical Microbiology and Virology
832 Neuropathology (Retired 1 April 2004)
833 Medical Microbiology
834 Medical Virology
900 Community Medicine
901 Occupational Medicine
902 Community Health Services Dental
903 Public Health Medicine
904 Public Health Dental
950 Nursing
960 Allied Health Professional
990 Joint Consultant Clinics (Retired 1 April 2004)

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**MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE**

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Change to Attribute: Changed Dataset

A code which identifies the MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION.

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

Where applicable, MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE is aligned with descriptors for "Mental Health Act legal status findings" in SNOMED CT® as follows:

SNOMED CT Refset Metadata:

- Refset FSN: Mental Health Act legal status findings simple reference set
- Refset Id: 999003071000000100

For further details relating to the SNOMED CT Refset Metadata, see the Data Dictionary for Care (DD4C) website at: Mental Health Act legal status findings.

*National Codes:*

01 Informal
02 Formally detained under Mental Health Act Section 2
03 Formally detained under Mental Health Act Section 3
04 Formally detained under Mental Health Act Section 4
05 Formally detained under Mental Health Act Section 5(2)
06 Formally detained under Mental Health Act Section 5(4)
07 Formally detained under Mental Health Act Section 35
08 Formally detained under Mental Health Act Section 36
09 Formally detained under Mental Health Act Section 37 with section 41 restrictions
10 Formally detained under Mental Health Act Section 37
12 Formally detained under Mental Health Act Section 38
13 Formally detained under Mental Health Act Section 44
14 Formally detained under Mental Health Act Section 46
15 Formally detained under Mental Health Act Section 47 with section 49 restrictions
16 Formally detained under Mental Health Act Section 47
17 Formally detained under Mental Health Act Section 48 with section 49 restrictions
18 Formally detained under Mental Health Act Section 48
19 Formally detained under Mental Health Act Section 135
20 Formally detained under Mental Health Act Section 136
31 Formally detained under Criminal Procedure(Insanity) Act 1964 as amended by the Criminal Procedures (Insanity and Unfitness to Plead) Act 1991

| | |
|---|---|
| 32 | Formally detained under other acts |
| 33 | Supervised Discharge (Mental Health (Patients in the Community) Act 1995) (Retired 03 November 2008 - but may apply to some patients until 3 May 2009) |
| 34 | Formally detained under Mental Health Act Section 45A (Retired 01 September 2014) |
| 35 | Subject to guardianship under Mental Health Act Section 7 |
| 36 | Subject to guardianship under Mental Health Act Section 37 |
| 37 | Formally detained under Mental Health Act Section 45A (Limited direction in force) |
| 38 | Formally detained under Mental Health Act Section 45A (Limitation direction ended) |

---

**METHOD OF ADMISSION**

---

Change to Attribute: Changed Dataset

~~**This item is being used for development purposes and has not yet been approved.**~~The method of admission to a Hospital Provider Spell.

Note: see ELECTIVE ADMISSION TYPE for a full definition of Elective Admission.

*National Codes:*

| | |
|---|---|
| 11 | Elective Admission: Waiting list |
| 12 | Elective Admission: Booked |
| 13 | Elective Admission: Planned |
| 21 | Emergency Admission: Emergency Care Department or acute or emergency dental SERVICE |
| 22 | Emergency Admission: GENERAL PRACTITIONER: after a request for immediate admission has been made direct to a Hospital Provider, i.e. not through a Bed bureau, by a GENERAL PRACTITIONER or deputy |
| 23 | Emergency Admission: Bed bureau |
| 24 | Emergency Admission: Consultant Clinic, of this or another Health Care Provider |
| 25 | Emergency Admission: Admission via Mental Health Crisis Resolution Team |
| 2A | Emergency Admission: Emergency Care Department of another provider where the PATIENT had not been admitted |
| 2B | Emergency Admission: Transfer of an admitted PATIENT from another Hospital Provider in an emergency |
| 2C | Emergency Admission: Baby born at home as intended |
| 2D | Emergency Admission: Other emergency admission |
| 31 | Maternity Admission: Admitted ante partum |
| 32 | Maternity Admission: Admitted post partum |
| 81 | Other Admission: Transfer of any admitted PATIENT from other Hospital Provider other than in an emergency |
| 82 | Other Admission: The birth of a baby in this Health Care Provider |
| 83 | Other Admission: Baby born outside the Health Care Provider except when born at home as intended |

**ADMISSION METHOD will be replaced with METHOD OF ADMISSION, which is the most recent approved national information standard to describe the required definition.**

---

**METHOD OF DISCHARGE**

---

Change to Attribute: Changed Dataset

~~**This item is being used for development purposes and has not yet been approved.**~~The method of discharge from a Hospital Provider Spell.

*National Codes:*

| | |
|---|---|
| 1 | PATIENT discharged on clinical advice or with clinical consent |
| 3 | PATIENT discharged by mental health review tribunal, Home Secretary or Court |
| 4 | PATIENT died |
| 5 | Stillbirth |
| 6 | PATIENT discharged him/herself |
| 7 | PATIENT discharged by a relative or advocate |

**DISCHARGE METHOD will be replaced with METHOD OF DISCHARGE, which is the most recent approved national information standard to describe the required definition.**

---

#### MULTI-PROFESSIONAL OR MULTI-DISCIPLINARY INDICATION CODE

---

Change to Attribute: Changed Dataset
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.

*National Codes:*

| | |
|---|---|
| 1 | Uni-Professional clinic attendance |
| 2 | Multi-Professional Consultation (National Tariff Payment System) clinic attendance |
| 3 | Multi-Disciplinary Consultation (National Tariff Payment System) clinic attendance |

**Note:**
**This data item is included in Commissioning Data Set version 6-2, but should not be submitted until further development by the Department of Health and Social Care has been undertaken.**

---

#### NEONATAL LEVEL OF CARE

---

Change to Attribute: Changed Dataset

The level of care received by a Neonate during a Neonatal Level Of Care Period. For all WARDS caring for Neonates, data should be collected daily about the level of care provided for each Neonate.

*National Codes:*

| | |
|---|---|
| 0 | Normal Care: Care given by the mother or mother substitute with medical and neonatal nursing advice if needed. |
| 1 | Special Care: Care given in a special care nursery, transitional care ward or Postnatal ward which provides care and treatment exceeding normal routine care. Some aspects of special care can be undertaken by a mother supervised by qualified nursing staff. Special nursing care includes support and education of the infant's parent(s). |
| 2 | Level 2 Intensive Care (High Dependency Intensive Care): Care given in an intensive or special care nursery which provides continuous skilled supervision by qualified and specially trained nursing staff who may care for more babies than in Level 1 Intensive Care. Medical supervision is not so immediate as in Level 1 Intensive Care. Care includes support of the infant's parent(s). |
| 3 | Level 1 Intensive Care (Maximal Intensive Care): Care given in an intensive care nursery which provides continuous skilled supervision by qualified and specially trained nursing and medical staff. Such care includes support of the infant's parent(s). |

---

#### NHS NUMBER

---

Change to Attribute: Changed Dataset

The NHS NUMBER, the primary identifier of a PERSON, is a unique identifier for a PATIENT within the NHS in England and Wales.

This will not vary by any ORGANISATION of which a PERSON is a PATIENT.

It is mandatory to record the NHS NUMBER. There are exceptions, such as emergency care, sexual health and major incidents, as defined in existing national policies.

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. There are 5 steps in the validation of the check digit:

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

**Digit Position**
(starting from the left) Factor:

| | |
|---|---|
| 1 | 10 |
| 2 | 9 |
| 3 | 8 |
| 4 | 7 |
| 5 | 6 |
| 6 | 5 |
| 7 | 4 |
| 8 | 3 |
| 9 | 2 |

**Step 2** Add the results of each multiplication together.

**Step 3** Divide the total by 11 and establish the remainder.

**Step 4** Subtract the remainder from 11 to give the check digit.

If the result is 11 then a check digit of 0 is used. If the result is 10 then the NHS NUMBER is invalid and not used.

**Step 5** Check the remainder matches the check digit. If it does not, the NHS NUMBER is invalid.

Further guidance is available from the NHS Digital website at: NHS Number.

Note:
This was e-GIF approved for use in NHS England.
e-GIF and the Government Data Standards Catalogue **have been archived** and are available for reference only.

---

#### NHS NUMBER STATUS INDICATOR CODE

---

Change to Attribute: Changed Dataset

The trace status of the NHS NUMBER.

Note:

- National Code 08 *'Trace postponed (baby under six weeks old)'* is **not** valid for the Improving Access to Psychological Therapies Data Set, Maternity Services Data Set and Mental Health Services Data Set.

*National Codes:*

| | |
|---|---|
| 01 | Number present and verified |
| 02 | Number present but not traced |
| 03 | Trace required |
| 04 | Trace attempted - No match or multiple match found |
| 05 | Trace needs to be resolved - (NHS NUMBER or PATIENT detail conflict) |
| 06 | Trace in progress |
| 07 | Number not present and trace not required |
| 08 | Trace postponed (baby under six weeks old) |

---

**NHS SERVICE AGREEMENT IDENTIFIER**

---

Change to Attribute: New Attribute

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 NUMBER will be replaced with NHS SERVICE AGREEMENT IDENTIFIER, which is the most recent approved national information standard to describe the required definition.**

**This attribute is also known by these names:**

| Context | Alias |
|---|---|
| plural | NHS SERVICE AGREEMENT IDENTIFIERS |

---

**NHS SERVICE AGREEMENT IDENTIFIER**

---

Change to Attribute: New Attribute

## NHS SERVICE AGREEMENT IDENTIFIER

**Data Elements:**

| NHS SERVICE AGREEMENT IDENTIFIER |
|---|

---

**NHS SERVICE AGREEMENT LINE IDENTIFIER**

---

Change to Attribute: New Attribute

A unique identifier for an NHS SERVICE AGREEMENT LINE.

**NHS SERVICE AGREEMENT LINE NUMBER will be replaced with NHS SERVICE AGREEMENT LINE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.**

**This attribute is also known by these names:**

| Context | Alias |
|---|---|
| plural | NHS SERVICE AGREEMENT LINE IDENTIFIERS |

---

**NHS SERVICE AGREEMENT LINE IDENTIFIER**

---

Change to Attribute: New Attribute

## NHS SERVICE AGREEMENT LINE IDENTIFIER

**Data Elements:**

| NHS SERVICE AGREEMENT LINE IDENTIFIER |
|---|

---

**NHS SERVICE AGREEMENT LINE NUMBER**

---

Change to Attribute: Changed Description

A number (alphanumeric) to provide a unique identifier for a line within a NHS SERVICE AGREEMENT.

**NHS SERVICE AGREEMENT LINE NUMBER will be replaced with NHS SERVICE AGREEMENT LINE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.**

---

**NHS SERVICE AGREEMENT NUMBER**

---

Change to Attribute: Changed Description

A number used to uniquely identify a NHS SERVICE AGREEMENT by an ORGANISATION acting as commissioner of patient care services.

**NHS SERVICE AGREEMENT NUMBER will be replaced with NHS SERVICE AGREEMENT IDENTIFIER, which is the most recent approved national information standard to describe the required definition.**

---

**NUMBER OF BABIES INDICATION CODE**

---

Change to Attribute: Changed Dataset
The number of REGISTRABLE BIRTHS (live or still born at a particular delivery).

*National Codes:*

| | |
|---|---|
| 1 | One |
| 2 | Two |
| 3 | Three |
| 4 | Four |
| 5 | Five |
| 6 | Six or more |

---

**OBSERVATION VALUE**

---

Change to Attribute: Changed Dataset

The value of a CLINICAL INVESTIGATION RESULT ITEM.

---

**OFFERED FOR ADMISSION DATE**

---

Change to Attribute: Changed Dataset

The date offered for admission to hospital to start a Hospital Provider Spell.

#### ORGANISATION CODE

Change to Attribute: Changed Dataset

An ORGANISATION CODE is a code which identifies an ORGANISATION uniquely.

ORGANISATION CODES are managed by:

- Organisation Data Service (ODS)
- NHS Prescription Services
- NHS Dental Services.

**Notes:**

- Organisation Data Service codes can be downloaded from Technology Reference Data Update Distribution (TRUD)
- Organisation Data Service contact details can be found at Contact Details.

**All NHS ORGANISATIONS are coded using coding frames, as shown in the tables at: Organisation Coding Frames.**

#### ORGANISATION IDENTIFIER

Change to Attribute: Changed Dataset

A unique identifier for an ORGANISATION.

Note:

- ORGANISATION IDENTIFIERS are governed by the fundamental standard for "Health and Social Care Organisation Reference Data" (HSC Org Ref Data).
- The standard only relates to ORGANISATION IDENTIFIERS which are maintained and published by the Organisation Data Service (ODS). See Health and Social Care Organisation Reference Data.

The Format/Length of a published code for an ORGANISATION is min an3 max an8.

#### ORGANISATION SITE IDENTIFIER

Change to Attribute: Changed Dataset

A unique identifier for an ORGANISATION SITE.

Note:

- ORGANISATION SITE IDENTIFIERS are governed by the fundamental standard for "Health and Social Care Organisation Reference Data" (HSC Org Ref Data).
- The standard only relates to ORGANISATION SITE IDENTIFIERS which are maintained and published by the Organisation Data Service (ODS). See Health and Social Care Organisation Reference Data.

The Format/Length of a published code for an ORGANISATION SITE is min an5 max an9.

#### ORGAN SUPPORT MAXIMUM

Change to Attribute: Changed Dataset

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 within the count.

ORGAN SUPPORT MAXIMUM is derived by counting the maximum number of ACTIVITY PROPERTIES where the ORGAN SYSTEM SUPPORTED is different, for each day of the CRITICAL CARE PERIOD and reporting the highest number.

Each ACTIVITY PROPERTY will have one or more ACTIVITY PROPERTY EFFECTIVE DATES and ACTIVITY PROPERTY END DATES within the CRITICAL CARE PERIOD. Both basic and advanced categories cannot be counted at the same time therefore the maximum number of systems supported is 7.

---

**ORGAN SYSTEM SUPPORTED**

---

Change to Attribute: Changed Dataset
The type of organ system supported within a CRITICAL CARE PERIOD. This may not necessarily be support for a failing organ. Basic respiratory support will frequently occur prior to advanced respiratory support. If they are both required on the same day, only advanced respiratory support must be recorded. Basic cardiovascular support will frequently occur prior to advanced cardiovascular support. If they are both required on the same day, only advanced cardiovascular support must be recorded.

*National Codes:*

01 Basic Respiratory Support. Indicated by one or more of the following:

- 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.
- 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).
- Physiotherapy or suction to clear secretions at least two hourly, whether via tracheostomy, minitracheostomy, or in the absence of an artificial airway.
- PATIENTS recently (within 24 hours) extubated after a period (greater than 24 hours) of mechanical ventilation via an endotracheal tube.
- Mask / hood continuous positive airway pressure (CPAP) or mask / hood Bi-level positive airway pressure ventilation (non-invasive ventilation).
- PATIENTS who are intubated to protect the airway but needing no ventilatory support.
- Continuous positive airway pressure (CPAP) via a tracheostomy. **Note:** The presence of a tracheostomy used for long term airway access only does not qualify for any respiratory support.

02 Advanced Respiratory Support. Indicated by:

- Invasive mechanical ventilatory support applied via a trans-laryngeal tracheal tube or applied via a tracheostomy
- Bi-level positive airway pressure applied via a trans-laryngeal tracheal tube or applied via a tracheostomy.
- Continuous positive airway pressure via a trans-laryngeal tracheal tube.
- Extracorporeal respiratory support.

03 Basic Cardiovascular Support. Indicated by one or more of the following:

- 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.
- Use of an arterial line for monitoring of arterial pressure and/or sampling of arterial blood.
- Single intravenous vasoactive drug used to support or control arterial pressure, cardiac output or organ perfusion.
- Single intravenous rhythm controlling drug to support or control cardiac arrhythmias.

04 Advanced Cardiovascular Support. Indicated by one or more of the following:

- Multiple intravenous vasoactive and/or rhythm controlling drugs when used simultaneously to support or control arterial pressure, cardiac output or organ perfusion (eg inotropes, amiodarone, nitrates). To qualify for advanced support status, at least one drug needs to be vasoactive.
- Continuous observation of cardiac output and derived indices (e.g. pulmonary artery catheter, lithium dilution, pulse contour analyses, oesophageal doppler).
- Intra aortic balloon pumping and other assist devices.
- Insertion of a temporary cardiac pacemaker (criteria valid for each day of connection to a functioning external pacemaker unit).

05 Renal Support. In the context of critical illness, this is indicated by:

- Acute renal replacement therapy (e.g. haemodialysis, haemofiltration etc.) or the provision of renal replacement therapy to a chronic renal failure patient who is requiring other acute organ support in a critical care situation.

06 Neurological Support. Indicated by one or more of the following:

- Central nervous system 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.)
- Invasive neurological monitoring e.g. intracranial pressure, jugular bulb sampling, external ventricular drain.
- Continuous intravenous medication to control seizures and/or continuous cerebral monitoring.
- Therapeutic hypothermia using cooling protocols or devices.

07 Gastrointestinal Support. Indicated by:

- Feeding with parenteral or enteral nutrition (implies methods of feeding other than normal oral intake).

08 Dermatological Support. Indicated by one or more of the following:

- PATIENTS with major skin rashes, exfoliation or burns (eg greater than 30% body surface area affected).
- 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).

09 Liver Support. Indicated by:

- Acute on chronic Hepatocellular failure requiring management of coagulopathy and/or portal hypertension (including liver purification and detoxification techniques), or
- 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).

---

**OUT-PATIENT ATTENDANCE OUTCOME**

---

Change to Attribute: New Attribute

The outcome of a Care Professional Out-Patient Attendance.

*National Codes:*

| | |
|---|---|
| 1 | PATIENT discharged from the care of the CARE PROFESSIONAL without Personalised Out-Patient Follow Up |
| 2 | PATIENT given a Timed Out-Patient Follow Up Appointment while at the out-patient attendance without Personalised Out-Patient Follow Up |
| 3 | PATIENT to be given a Timed Out-Patient Follow Up Appointment at a later date without Personalised Out-Patient Follow Up |
| 4 | PATIENT moved to a Personalised Out-Patient Follow Up Pathway |
| 5 | PATIENT discharged to a Personalised Out-Patient Follow Up Pathway |

**This attribute is also known by these names:**

| Context | Alias |
|---|---|
| | |

| plural | OUT-PATIENT ATTENDANCE OUTCOMES |
|---|---|

**OUT-PATIENT ATTENDANCE OUTCOME**

Change to Attribute: New Attribute

# OUT-PATIENT ATTENDANCE OUTCOME

**Data Elements:**

| OUT-PATIENT ATTENDANCE OUTCOME |
|---|

**OVERSEAS VISITOR CHARGING CATEGORY**

Change to Attribute: Changed Dataset

The charging category relating to an OVERSEAS VISITOR STATUS.

See Overseas Visitor Charging Category for more information.

*National Codes:*

| | |
|---|---|
| A | Standard NHS-funded PATIENT |
| B | Immigration Health Surcharge payee |
| C | Charge-exempt Overseas Visitor (European Economic Area) |
| D | Chargeable European Economic Area PATIENT |
| E | Charge-exempt Overseas Visitor (non-European Economic Area) |
| F | Chargeable non-European Economic Area PATIENT |
| P | Decision Pending on OVERSEAS VISITOR CHARGING CATEGORY |

OVERSEAS VISITOR STATUS information must be collected in accordance with the Overseas Visitor Charging Category Information Standard: DCB3017.

**PATIENT CLASSIFICATION**

Change to Attribute: Changed Dataset

A coded classification of PATIENTS who have been admitted to a Hospital Provider Spell.

*National Codes:*

1 **Ordinary admission**
A PATIENT not admitted electively, and any PATIENT admitted electively with the expectation that they will remain in hospital for at least one night, including a PATIENT admitted with this intention who leaves hospital for any reason without staying overnight. A PATIENT admitted electively with the intent of not staying overnight, but who does not return home as scheduled, should be counted as an ordinary admission

2 **Day case admission**
A PATIENT admitted electively during the course of a day with the intention of receiving care who does not require the use of a Hospital Bed overnight and who returns home as scheduled. If this original intention is not fulfilled and the PATIENT stays overnight, such a PATIENT should be counted as an ordinary admission

3 **Regular day admission**
A PATIENT admitted electively during the day, as part of a planned series of regular admissions for an on-going regime of broadly similar treatment and who is discharged the same day. If the intention is not fulfilled and one of these admissions should involve a stay of at least 24 hours, such an admission should be classified as an ordinary admission. The series of regular admissions ends when the PATIENT no longer requires frequent admissions

4 **Regular night admission**
A PATIENT admitted electively for the night, as part of a planned series of regular admissions for an on-going regime of broadly similar treatment and who is discharged in the morning. If the intention is not fulfilled and one of these admissions should involve a stay of at least 24 hours, such an admission should be classified as an ordinary admission. The series of regular admissions ends when the patient no longer requires frequent admissions

5 **Mother and baby using delivery facilities only**
Mother and baby using Delivery facilities only and not using a Hospital Bed in the Antenatal or Postnatal WARDS during the stay in hospital

---

**PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR**

---

Change to Attribute: New Attribute

An indication of whether a PATIENT is on a Patient Initiated Out-Patient Follow-Up Pathway.

*National Codes:*

| | |
|---|---|
| Y | Yes - PATIENT is on a Patient Initiated Out-Patient Follow-Up Pathway |
| N | No - PATIENT is not on a Patient Initiated Out-Patient Follow-Up Pathway |

**This attribute is also known by these names:**

| Context | Alias |
|---|---|
| plural | PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATORS |

---

**PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR**

---

Change to Attribute: New Attribute

# PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR

**Data Elements:**

| PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR AT CDS ACTIVITY DATE |
|---|

---

**PATIENT PATHWAY IDENTIFIER**

---

Change to Attribute: Changed Dataset
An identifier, which together with the ORGANISATION CODE / ORGANISATION IDENTIFIER of the issuer, uniquely identifies a PATIENT PATHWAY.

This is a specific type of the attribute ACTIVITY IDENTIFIER.

Where a pathway is initiated by a SERVICE REQUEST using the Choose and Book system, the PATIENT PATHWAY will be uniquely identified by the Unique Booking Reference Number (UBRN) of the first referral and the ORGANISATION CODE of Choose and Book which is X09.

Where the pathway is initiated by some other method, the PATIENT PATHWAY IDENTIFIER will be allocated by the ORGANISATION receiving the SERVICE REQUEST which together with that ORGANISATION's ORGANISATION CODE / ORGANISATION IDENTIFIER will uniquely identify the PATIENT PATHWAY.

---

**PATIENT SUBJECT TO REMOTE MONITORING INDICATOR**

---

Change to Attribute: New Attribute

An indication of whether a PATIENT is subject to Remote Monitoring.

*National Codes:*

| | |
|---|---|
| Y | Yes - PATIENT is subject to Remote Monitoring |
| N | No - PATIENT is not subject to Remote Monitoring |

**This attribute is also known by these names:**

| Context | Alias |
|---|---|
| plural | PATIENT SUBJECT TO REMOTE MONITORING INDICATORS |

**PATIENT SUBJECT TO REMOTE MONITORING INDICATOR**

Change to Attribute: New Attribute

## PATIENT SUBJECT TO REMOTE MONITORING INDICATOR

**Data Elements:**

| |
|---|
| PATIENT SUBJECT TO REMOTE MONITORING INDICATOR AT CDS ACTIVITY DATE |

**PERSON AGE**

Change to Attribute: Changed Dataset

The age in years of the PERSON.

**PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE**

Change to Attribute: New Attribute

The expiry date of a Personalised Out-Patient Follow Up Pathway.

**This attribute is also known by these names:**

| Context | Alias |
|---|---|
| plural | PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATES |

**PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE**

Change to Attribute: New Attribute

## PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE

**Data Elements:**

| |
|---|
| PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE |

**PERSON BIRTH DATE**

Change to Attribute: Changed Dataset

The date on which a PERSON was born or is officially deemed to have been born.

Note:
This was e-GIF approved for use in NHS England.
e-GIF and the Government Data Standards Catalogue **have been archived** and are available for reference only.

---

**PERSON BIRTH TIME**

---

Change to Attribute: Changed Dataset

The time at which a PERSON was born or is deemed to have been born.

---

**PERSON MARITAL STATUS**

---

Change to Attribute: Changed Dataset

An indicator to identify the legal marital status of a PERSON.

*National Codes:*

| | |
|---|---|
| S | Single |
| M | Married/Civil Partner |
| D | Divorced/Person whose Civil Partnership has been dissolved |
| W | Widowed/Surviving Civil Partner |
| P | Separated |
| N | Not disclosed |

**Previous specification, now obsolete and not for use:**

| | |
|---|---|
| 1 | Single (Retired 2006-10-01) |
| 2 | Married/separated (Retired 2006-10-01) |
| 3 | Divorced (Retired 2006-10-01) |
| 4 | Widowed (Retired 2006-10-01) |

---

**PERSON NAME WORD TEXT**

---

Change to Attribute: Changed Dataset

The character or string of characters comprising an element of a PERSON's name which has been recorded for at least one PERSON (e.g. 'Dr', 'John', 'Smith').

This can be a PERSON NAME STRUCTURED or PERSON NAME UNSTRUCTURED.

---

**PERSON PHENOTYPIC SEX CLASSIFICATION**

---

Change to Attribute: Changed Dataset

A classification of PERSON PHENOTYPIC SEX.

*National Codes:*

| | |
|---|---|
| 1 | Male |
| 2 | Female |
| 9 | Indeterminate (unable to be classified as either male or female) |

**PERSON GENDER CODE will be replaced with PERSON STATED GENDER CODE or PERSON PHENOTYPIC SEX CLASSIFICATION, which is the most recent approved national information standard to describe the required definition.**

---

**PERSON PROPERTY ASSIGNMENT PERIOD DURATION**

---

Change to Attribute: New Attribute

The duration of a PERSON PROPERTY ASSIGNMENT PERIOD.

---

**PERSON PROPERTY ASSIGNMENT PERIOD DURATION**

---

Change to Attribute: New Attribute

## PERSON PROPERTY ASSIGNMENT PERIOD DURATION

**Data Elements:**

| EMED3 FIT NOTE DURATION |
|---|

---

**PERSON PROPERTY ASSIGNMENT PERIOD TYPE**

---

Change to Attribute: Changed Description

The type of PERSON PROPERTY ASSIGNMENT PERIOD.

*National Codes:*

| | |
|---|---|
| 01 | Care Cluster Assignment Period |
| 02 | Mental Health Act Legal Status Classification Assignment Period |
| ?? | eMED3 Fit Note Applicable Period |

---

**PERSON PROPERTY EFFECTIVE END DATE**

---

Change to Attribute: Changed Dataset

The date when a PERSON PROPERTY is no longer applicable to the PATIENT.

---

**PERSON PROPERTY EFFECTIVE START DATE**

---

Change to Attribute: Changed Dataset

The date when a PERSON PROPERTY became effective for a PATIENT.

Examples may be the date when the PATIENT experienced a symptom or gave up smoking.

---

**PERSON PROPERTY OBSERVED DATE**

---

Change to Attribute: Changed Dataset

The date when the PERSON PROPERTY was observed by a PERSON.

#### PERSON PROPERTY OBSERVED TIME

Change to Attribute: Changed Dataset

The time when the PERSON PROPERTY was observed by a PERSON.

#### PERSON PROPERTY RECORDED DATE

Change to Attribute: Changed Dataset

The date when the PERSON PROPERTY was recorded by a PERSON.

#### PERSON PROPERTY RECORDED TIME

Change to Attribute: Changed Dataset

The time when the PERSON PROPERTY was recorded by a PERSON.

This may include a representation of a time zone.

In a computerised system this data would be derived from the time the information was entered.

#### PERSON SCORE

Change to Attribute: Changed Dataset

The score taken from an ASSESSMENT TOOL.

This could be for an individual element of, or question within, an ASSESSMENT TOOL, a subtotal or total score.

The purpose of the PERSON SCORE is to measure changes in health and wellbeing.

#### PERSON STATED GENDER CODE

Change to Attribute: Changed Dataset

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.

*National Codes:*

| | |
|---|---|
| 1 | Male |
| 2 | Female |
| 9 | Indeterminate (unable to be classified as either male or female) |

**PERSON GENDER CODE will be replaced with PERSON STATED GENDER CODE or PERSON PHENOTYPIC SEX CLASSIFICATION, which is the most recent approved national information standard to describe the required definition.**

**PLANNED ACTIVITY DATE**

Change to Attribute: Changed Dataset

Any date that is of relevance to a PLANNED ACTIVITY.

The specific nature of the date will be identified by the PLANNED ACTIVITY DATE TYPE.

**PLANNED ACTIVITY DATE TYPE**

Change to Attribute: Changed Description

The type of date that defines the usage with regard to the PLANNED ACTIVITY.

A PLANNED ACTIVITY may have many dates associated with it but may only have one date of a particular type.

*National Codes:*

| | |
|---|---|
| 01 | Planned Discharge Date (Hospital Provider Spell) |
| 02 | Estimated Discharge Date (Hospital Provider Spell) |
| 03 | Intended Smoking Quit Date |
| 04 | NHS Continuing Healthcare Care Package Review Date |
| ?? | Personalised Out-Patient Follow Up Pathway Review Date |

**POSTCODE**

Change to Attribute: Changed Dataset

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

POSTCODES may also be used to identify a GEOGRAPHIC AREA.

Note:
This was e-GIF approved for use in NHS England.
e-GIF and the Government Data Standards Catalogue **have been archived** and are available for reference only.

**PRESENT ON ADMISSION INDICATOR**

Change to Attribute: Changed Dataset, Description

An indication of whether a PATIENT DIAGNOSIS was already present when the PATIENT started a Hospital Provider Spell.

Note: PRESENT ON ADMISSION INDICATOR is only required for PATIENTS with a PATIENT 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 SNOMED CT-coded Comorbidity data structure to submit this data in CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set / CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set, which is the preferred mechanism of data submission.

*National Codes:*

| | |
|---|---|
| Y | PATIENT DIAGNOSIS already present |
| N | PATIENT DIAGNOSIS not already present |

~~**Note:**~~
~~**This data item is included in Commissioning Data Set version 6-2, but should not be submitted until further development by NHS Digital has been undertaken.**~~

---

**PRIORITY TYPE**

---

Change to Attribute: Changed Dataset

The priority of a SERVICE REQUEST.

In the case of SERVICES to be provided by a CONSULTANT, it is as assessed by or on behalf of the CONSULTANT.

- PRIORITY TYPE National Code *'Urgent'* should be used where the SERVICE REQUEST is defined as clinically urgent, but it does not fall under the criteria for *'Two Week Wait'* (see below).

- PRIORITY TYPE National Code *'Two Week Wait'* should be used where either:
  - the SERVICE REQUEST meets the criteria for an urgent referral for suspected cancer.
    These referrals should be made in accordance with the National Institute for Health and Care Excellence (NICE) clinical guidelines on referral for suspected cancer.
    For further information, see the National Institute for Health and Care Excellence website at: NICE guidance.
    **or**
  - the PATIENT has been referred urgently for breast symptoms, but the referral does not meet the criteria for urgent referrals for suspected cancer.

*National Codes:*

| | |
|---|---|
| 1 | Routine |
| 2 | Urgent |
| 3 | Two Week Wait |

---

**PROCEDURE SCHEME IN USE**

---

Change to Attribute: Changed Dataset

The type of CODED CLINICAL ENTRY used for the CLINICAL INTERVENTION.

Notes:

- The following National Codes are **not** valid for the Community Services Data Set, Maternity Services Data Set and Mental Health Services Data Set:
  - 01 *'Accident & Emergency Treatment'*
  - 02 *'OPCS-4'*
- National Code 05 *'Read Coded Clinical Terms Version 3 (CTV3)'* (previously known as 3.1) is **not** supported in the Commissioning Data Sets
- National Code 06 *'SNOMED CT®'* is **not** valid for Commissioning Data Set version 6-2.

*National Codes:*

| | |
|---|---|
| 01 | Accident & Emergency Treatment |
| 02 | OPCS-4 |
| 03 | Read Code 4Byte Version (retired 1 October 2009) |
| 04 | Read Coded Clinical Terms Version 2 |
| 05 | Read Coded Clinical Terms Version 3 (CTV3) |

06 SNOMED CT®

**PROFESSIONAL REGISTRATION BODY CODE**

Change to Attribute: Changed Dataset

A code which identifies the PROFESSIONAL REGISTRATION BODY.

Notes:

- The National Code description for 05 '*Social Care Wales*' has been updated as a result of the work undertaken for the development of the National Workforce Data Set. The Maternity Services Data Set specification will be updated in the next version of the Information Standards where it is not already correct.
- National Code 17 '*General Osteopathic Council*' is **not** valid for use in the Maternity Services Data Set.
- National Code 18 '*Social Work England*' is **not** valid for use in the Community Services Data Set, Maternity Services Data Set and Mental Health Services Data Set.

*National Codes:*

| | |
|---|---|
| 01 | General Chiropractic Council |
| 02 | General Dental Council |
| 03 | General Medical Council |
| 04 | General Optical Council |
| 05 | Social Care Wales |
| 06 | Scottish Social Services Council (Retired 01 April 2013) |
| 07 | General Social Care Council (for England) (Retired 01 August 2012) |
| 08 | Health and Care Professions Council |
| 09 | Nursing and Midwifery Council |
| 10 | Royal Pharmaceutical Society (Retired 27 September 2010) |
| 11 | British Psychological Society (Retired 01 October 2017) |
| 12 | Association for Operating Department Practitioners (Retired January 2015) |
| 13 | Association of Chartered Certified Accountants (Retired 01 October 2017) |
| 14 | Chartered Institute of Personnel and Development (Retired 01 October 2017) |
| 15 | Chartered Institute of Management Accountants (Retired 01 October 2017) |
| 16 | General Pharmaceutical Council |
| 17 | General Osteopathic Council |
| 18 | Social Work England |

**PROFESSIONAL REGISTRATION ENTRY IDENTIFIER**

Change to Attribute: Changed Dataset

The registration identifier allocated by an ORGANISATION.

Examples include:

- GENERAL DENTAL COUNCIL REGISTRATION NUMBER
- GENERAL MEDICAL COUNCIL REFERENCE NUMBER.

**PROVIDER REFERENCE IDENTIFIER**

Change to Attribute: New Attribute

The reference identifier agreed locally between a Health Care Provider and the Commissioner of a SERVICE PROVIDED UNDER AGREEMENT.

**PROVIDER REFERENCE NUMBER will be replaced with PROVIDER REFERENCE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.**

**This attribute is also known by these names:**

| Context | Alias |
| --- | --- |
| plural | PROVIDER REFERENCE IDENTIFIERS |

**PROVIDER REFERENCE IDENTIFIER**

Change to Attribute: New Attribute

## PROVIDER REFERENCE IDENTIFIER

**Data Elements:**

| PROVIDER REFERENCE IDENTIFIER |
| --- |

**PROVIDER REFERENCE NUMBER**

Change to Attribute: Changed Description

The number convention agreed locally between a provider and Commissioner for use within a Commissioning Data Set message. **PROVIDER REFERENCE NUMBER will be replaced with PROVIDER REFERENCE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.**

**PSYCHIATRIC PATIENT STATUS**

Change to Attribute: Changed Dataset

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.

PSYCHIATRIC PATIENT STATUS should be recorded against the first CONSULTANT episode in one of the psychiatric specialties but not for subsequent psychiatric consultant episodes or for any non-psychiatric episodes.

This information is used to indicate the turnover period within the SERVICE and identify, where possible, all first time psychiatric admissions and re-admissions.

Where a PATIENT has a history of admissions to several Hospital Providers, then priority between National Codes 1 and 2 should be given to the current Hospital Provider, and National Code 1 selected, irrespective of whether or not the last admission was to the same Hospital Provider.

*National Codes:*

- 0 No known previous Hospital Provider Spells with a Consultant Episode (Hospital Provider) within a psychiatric speciality within any Health Care Provider
- 1 One or more previous Hospital Provider Spells involving a Consultant Episode (Hospital Provider) within a psychiatric specialty with this Health Care Provider
- 2 One or more previous Hospital Provider Spells involving a Consultant Episode (Hospital Provider) within a psychiatric specialty with another Health Care Provider, but none with this Health Care Provider

**RECORD IDENTIFIER**

Change to Attribute: Changed Dataset

The unique identifier, used in conjunction with ORGANISATION CODE (CODE OF PROVIDER) or ORGANISATION IDENTIFIER (CODE OF PROVIDER), to identify a record within a data set submission.

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**REFERRAL REQUEST RECEIVED DATE**

---

Change to Attribute: Changed Dataset

The date the REFERRAL REQUEST was received by the Health Care Provider.

The waiting time for a first Out-Patient Appointment should be calculated from the date when the REFERRAL REQUEST is received.

- For electronic REFERRAL REQUESTS the REFERRAL REQUEST RECEIVED DATE is the date the REFERRAL REQUEST is received electronically by the Health Care Provider
- For Choose and Book, the referral is received when the PATIENT's Unique Booking Reference Number (UBRN) is used to book the first Out-Patient Appointment slot (i.e. converted).

Where an electronic REFERRAL REQUEST made through Choose and Book is rejected by the chosen provider, the ORIGINAL REFERRAL REQUEST RECEIVED DATE should be used when the PATIENT is subsequently re-referred to another service, so that PATIENTS are not unfairly disadvantaged when their waiting time calculations are made.

In the circumstance that a PATIENT calls the national Choose and Book Appointments Line and an APPOINTMENT SLOT is not available with the chosen Health Care Provider, the national Choose and Book Appointments Line will electronically forward the REFERRAL REQUEST details to the chosen Health Care Provider so the Health Care Provider can liaise directly with the PATIENT to arrange their Out-Patient Appointment. The REFERRAL REQUEST RECEIVED DATE will be the date that the Health Care Provider receives electronic notification from the national Choose and Book Appointments Line that the PATIENT has experienced slot unavailability. (Note that this is NOT the date that the Health Care Provider opens or actions the electronic notification).

For written REFERRAL REQUESTS letters must be opened and date stamped on the day of receipt. It is this date that must be entered on any Patient Administration System (PAS) or similar system, not the date on which the information is fed into the system if this is later than the date of receipt.

If the REFERRAL REQUEST takes the form of a phone call followed by a letter, record the date when the letter arrives. If there is no following letter, the date of the verbal request should be recorded.

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**REFERRAL TO TREATMENT PERIOD END DATE**

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Change to Attribute: Changed Dataset
The end date of a REFERRAL TO TREATMENT PERIOD.

This is a specific type of the attribute ACTIVITY DATE.

REFERRAL TO TREATMENT PERIOD END DATE will be one of the following:

- the ACTIVITY DATE:
  - when the PATIENT is admitted for First Definitive Treatment. If the start of a PATIENT's treatment is cancelled (by the Health Care Provider or PATIENT) after admission, the REFERRAL TO TREATMENT PERIOD will continue.
  - for First Definitive Treatment undertaken in an outpatient setting.
  - for First Definitive Treatment undertaken by an NHS Allied Health Professional Service (Referral To Treatment Measurement).
  - when the decision not to treat is made, with no further action at this time communicated to the PATIENT. This will include Discharge After Patient Did Not Attend and discharge back to primary care for treatment.
  - when the PATIENT declines offered treatment.
  - when the PATIENT did not attend for the first ACTIVITY during a REFERRAL TO TREATMENT PERIOD. See REFERRAL TO TREATMENT PERIOD for guidance on PATIENTS who do not attend.
  - the clinical decision is made (and agreed with the PATIENT) that Active Monitoring will begin. If a PATIENT subsequently requires further treatment this decision would start a new REFERRAL TO

TREATMENT PERIOD as part of the same PATIENT PATHWAY. This includes any treatment that is planned for a specific date in the future as ongoing monitoring.
    - a clinical decision is made and has been communicated to the PATIENT, and subsequently their GENERAL PRACTITIONER and/or other referring CARE PROFESSIONAL without undue delay, to add the PATIENT to a transplant list.

**or**

- the PERSON DEATH DATE.

In the event that a PATIENT is booked into the wrong clinic and needs to be re-referred to the right one, this will not end the REFERRAL TO TREATMENT PERIOD or restart it. The start of the REFERRAL TO TREATMENT PERIOD is still the original REFERRAL REQUEST RECEIVED DATE.

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**REFERRAL TO TREATMENT PERIOD START DATE**

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Change to Attribute: Changed Dataset

The start date of a REFERRAL TO TREATMENT PERIOD.

This is a specific type of the attribute ACTIVITY DATE.

A REFERRAL TO TREATMENT PERIOD START DATE will be one of the following:

- **Initial Referral:**
    - the REFERRAL REQUEST RECEIVED DATE of a SERVICE REQUEST for a particular condition.
    - This will include a PATIENT being re-referred in to a Consultant Led Service or an Interface Service or an NHS Allied Health Professional Service (Referral To Treatment Measurement) as a new referral including after a Discharge After Patient Did Not Attend. The REFERRAL TO TREATMENT PERIOD STATUS is '*National Code 10 - first activity*'
- **Following an APPOINTMENT that the PATIENT did not attend:**
    - the APPOINTMENT ACCEPTED DATE (or the INVITATION OFFER DATE SENT of the first APPOINTMENT OFFER where the APPOINTMENT OFFER is sent) for the first APPOINTMENT following the PATIENT not attending an APPOINTMENT or elective admission. See REFERRAL TO TREATMENT PERIOD and Discharge After Patient Did Not Attend for guidance on PATIENTS who do not attend
    - The APPOINTMENT DATE of the APPOINTMENT that the PATIENT did not attend should be used where it is not possible to identify the APPOINTMENT ACCEPTED DATE or the INVITATION OFFER DATE SENT. The REFERRAL TO TREATMENT PERIOD STATUS is '*National Code 10 - first activity*'
- **Following active monitoring:**
    - the ACTIVITY DATE of a CARE ACTIVITY when a decision to treat was made following Active Monitoring and the REFERRAL TO TREATMENT PERIOD STATUS is '*National Code 11 - active monitoring end*'
    - This will include a decision to start a substantively new or different treatment that does not already form part of that PATIENT's agreed CARE PLAN.
- **On identifying a separate condition:**
    - the REFERRAL REQUEST RECEIVED DATE of a SERVICE REQUEST when a decision has been made to refer the PATIENT directly to a Consultant Led Service or an NHS Allied Health Professional Service (Referral To Treatment Measurement) for a separate condition (the REFERRAL TO TREATMENT PERIOD STATUS for the first CARE ACTIVITY with the new CONSULTANT or NHS Allied Health Professional Service (Referral To Treatment Measurement) is '*National Code 12 - consultant or NHS Allied Health Professional Service (Referral To Treatment) referral*').

**Referral To Treatment Consultant Led Waiting Times:**

For most PATIENTS, the start of the REFERRAL TO TREATMENT PERIOD begins with a SERVICE REQUEST from a GENERAL MEDICAL PRACTITIONER to a CONSULTANT.

SERVICE REQUESTS to CONSULTANTS who provide care SERVICES in community settings also start REFERRAL TO TREATMENT PERIODS and the REFERRAL REQUEST RECEIVED DATE will be the start of the REFERRAL TO TREATMENT PERIOD.

A REFERRAL TO TREATMENT PERIOD may also start from SERVICE REQUESTS to CONSULTANTS from GENERAL DENTAL PRACTITIONERS, General Practitioners with Extended Roles, OPTOMETRISTS and Orthoptists, National Screening Programmes, Specialist NURSES, other CARE PROFESSIONALS where commissioning ORGANISATIONS have approved these mechanisms locally.

An 18-week clock also starts upon a self referral by a PATIENT to the above services, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a CARE PROFESSIONAL.

A REFERRAL TO TREATMENT PERIOD will also start where PATIENTS are transferred to an elective Consultant Led Service through SERVICE REQUESTS from Emergency Care Departments including Minor injuries units, Walk In Centres and Urgent Treatment Centres.

**Allied Health Professional Referral To Treatment Measurement:**

Further guidance relating to the Allied Health Professional Referral To Treatment can be found on the Department of Health and Social Care part of the gov.uk website at: Allied health professional referral to treatment revised guide.

**Intermediate Care Measurement:**

Further guidance relating to the Intermediate Care Waiting Time Measurements can be found on the NHS Digital website at: Community Services Data Set user guidance.

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**REFERRAL TO TREATMENT PERIOD STATUS**

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Change to Attribute: Changed Dataset

The status of an ACTIVITY (or anticipated ACTIVITY) for the REFERRAL TO TREATMENT PERIOD decided by the lead CARE PROFESSIONAL.

Notes:

- National Code 33 *'End of the REFERRAL TO TREATMENT PERIOD: Did not attend - the PATIENT did not attend the first CARE ACTIVITY after the referral'* may only be used where:
  - The PATIENT did not attend their first APPOINTMENT following the REFERRAL REQUEST that started the REFERRAL TO TREATMENT PERIOD, provided that the Health Care Provider can demonstrate that the APPOINTMENT was clearly communicated to the PATIENT.
    - REFERRAL TO TREATMENT PERIODS with REFERRAL TO TREATMENT PERIOD STATUS of National Code 33 are excluded from the measurement of the 18 weeks Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement and the count of Allied Health Professional Referral To Treatment Measurement REFERRAL TO TREATMENT PERIODS.
- National Code 34 *'End of the REFERRAL TO TREATMENT PERIOD: Decision not to treat - decision not to treat made or no further contact required'* includes a:
  - Discharge After Patient Did Not Attend the second or a subsequent CARE ACTIVITY after the referral
  - Change resulting in care no longer being commissioned by the English NHS
  - Referral to a Consultant Led Service during a Referral To Treatment Period Excluded From Target for the same condition, disease or injury. A new REFERRAL TO TREATMENT PERIOD will start.
- Where the REFERRAL TO TREATMENT PERIOD STATUS is National Code 99 *'REFERRAL TO TREATMENT PERIOD STATUS not yet known'*, the status is treated as if the ACTIVITY is a subsequent ACTIVITY during a REFERRAL TO TREATMENT PERIOD. In this case the REFERRAL TO TREATMENT PERIOD STATUS should be corrected once it is possible to determine the correct value.
- National Code descriptions have been updated to remove National Code headings and add prefixes where required. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.
  - The explanation of the National Code description prefixes are:
    - First ACTIVITY: The first ACTIVITY in a REFERRAL TO TREATMENT PERIOD where the First Definitive Treatment will be a subsequent ACTIVITY
    - Subsequent ACTIVITY: Subsequent ACTIVITY during a REFERRAL TO TREATMENT PERIOD

- End of the REFERRAL TO TREATMENT PERIOD: ACTIVITY that ends the REFERRAL TO TREATMENT PERIOD
- Not part of a REFERRAL TO TREATMENT PERIOD: ACTIVITY that is not part of a REFERRAL TO TREATMENT PERIOD.

*National Codes:*

| | |
|---|---|
| 10 | First ACTIVITY in a REFERRAL TO TREATMENT PERIOD |
| 11 | First ACTIVITY at the start of a new REFERRAL TO TREATMENT PERIOD following Active Monitoring |
| 12 | First ACTIVITY at the start of a new REFERRAL TO TREATMENT PERIOD following a decision to refer directly to the CONSULTANT or NHS Allied Health Professional Service (Referral To Treatment Measurement) for a separate condition |
| 20 | Subsequent ACTIVITY during a REFERRAL TO TREATMENT PERIOD - further ACTIVITIES anticipated |
| 21 | Subsequent ACTIVITY by another Health Care Provider following a transfer to another Health Care Provider during a REFERRAL TO TREATMENT PERIOD anticipated |
| 30 | End of the REFERRAL TO TREATMENT PERIOD: Start of First Definitive Treatment |
| 31 | End of the REFERRAL TO TREATMENT PERIOD: Start of Active Monitoring initiated by the PATIENT |
| 32 | End of the REFERRAL TO TREATMENT PERIOD: Start of Active Monitoring initiated by the CARE PROFESSIONAL |
| 33 | End of the REFERRAL TO TREATMENT PERIOD: Did not attend - the PATIENT did not attend the first CARE ACTIVITY after the referral |
| 34 | End of the REFERRAL TO TREATMENT PERIOD: Decision not to treat - decision not to treat made or no further contact required |
| 35 | End of the REFERRAL TO TREATMENT PERIOD: PATIENT declined offered treatment |
| 36 | End of the REFERRAL TO TREATMENT PERIOD: PATIENT died before treatment |
| 90 | Not part of a REFERRAL TO TREATMENT PERIOD: After treatment - First Definitive Treatment occurred previously (e.g. admitted as an emergency from A&E or the ACTIVITY is after the start of treatment) |
| 91 | Not part of a REFERRAL TO TREATMENT PERIOD: CARE ACTIVITY during Active Monitoring |
| 92 | Not part of a REFERRAL TO TREATMENT PERIOD: Not yet referred for treatment, undergoing diagnostic tests by GENERAL PRACTITIONER before referral |
| 98 | Not part of a REFERRAL TO TREATMENT PERIOD: ACTIVITY not applicable to REFERRAL TO TREATMENT PERIODS |
| 99 | REFERRAL TO TREATMENT PERIOD STATUS not yet known |

---

**REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR**

---

Change to Attribute: New Attribute

An indication of whether a PATIENT was referred by a First Contact Practitioner.

*National Codes:*

| | |
|---|---|
| Y | Yes - PATIENT referred by a First Contact Practitioner |
| N | No - PATIENT not referred by a First Contact Practitioner |

**This attribute is also known by these names:**

| Context | Alias |
|---|---|
| plural | REFERRED BY FIRST CONTACT PRACTITIONER INDICATORS |

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**REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR**

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Change to Attribute: New Attribute

## REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR

**Data Elements:**

| REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR |
|---|

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**REHABILITATION ASSESSMENT TEAM TYPE**

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Change to Attribute: Changed Dataset

An indication of whether the CARE PROFESSIONAL TEAM undertaking a Rehabilitation Assessment, is specialised or non-specialised.

This information is recorded for the purposes of the National Tariff Payment System.

*National Codes:*

| | |
|---|---|
| 1 | Specialised Rehabilitation Team |
| 2 | Non-specialised Rehabilitation Team |

**Note:**
**This data item is included in Commissioning Data Set version 6-2, but should not be submitted until further development by the Department of Health and Social Care has been undertaken.**

---

**RESPONSIBLE CARE PROFESSIONAL INDICATOR**

---

Change to Attribute: New Attribute

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.

National Codes:

| | |
|---|---|
| Y | Yes - the CARE PROFESSIONAL has overall clinical responsibility for the PATIENT |
| N | No - the CARE PROFESSIONAL does not have overall clinical responsibility for the PATIENT |

**This attribute is also known by these names:**

| Context | Alias |
|---|---|
| plural | RESPONSIBLE CARE PROFESSIONAL INDICATORS |

---

**RESPONSIBLE CARE PROFESSIONAL INDICATOR**

---

Change to Attribute: New Attribute

## RESPONSIBLE CARE PROFESSIONAL INDICATOR

**Data Elements:**

| RESPONSIBLE CARE PROFESSIONAL INDICATOR |
|---|

---

**RESUSCITATION METHOD CODE**

---

Change to Attribute: Changed Dataset

An indicator of whether resuscitation was:

- by positive pressure and
- administered using drugs.

RESUSCITATION METHOD CODE records the means by which regular respiration of the baby was attempted and is not recorded for stillbirths.

For local purposes, the actual drugs administered should be specified.

*National Codes:*

| | |
|---|---|
| 1 | Positive pressure nil, drugs nil |
| 2 | Positive pressure nil, drugs administered |
| 3 | Positive pressure by mask, drugs nil |
| 4 | Positive pressure by mask, drugs administered |
| 5 | Positive pressure by endotracheal tube, drugs nil |
| 6 | Positive pressure by endotracheal tube, drugs administered |

---

**SERVICE REQUEST IDENTIFIER**

---

Change to Attribute: Changed Dataset
The unique identifier for a SERVICE REQUEST.

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**SERVICE TYPE REQUESTED**

---

Change to Attribute: Changed Dataset

The terms of reference for the REFERRAL REQUEST.

*National Codes:*

| | |
|---|---|
| 1 | Advice/consultation |
| 2 | Specific procedure |
| 3 | Other |

---

**SEX OF PATIENTS**

---

Change to Attribute: Changed Description

The sex of PATIENTS intended to use a WARD indicated in the WARD OPERATIONAL PLANS, with the addition of Home Leave.

Note:

- National Code 9 '*Home Leave*' is **not** valid for the Mental Health Services Data Set.

*National Codes:*

| | |
|---|---|
| 1 | Male |
| 2 | Female |
| 8 | Not specified |
| 9 | Home Leave |

**SEX OF PATIENTS will be replaced with WARD INTENDED SEX OF PATIENTS, which is the most recent approved national information standard to describe the required definition.**

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**SOURCE OF REFERRAL FOR OUT-PATIENTS**

---

Change to Attribute: Changed Dataset

The source of referral of each Consultant Out-Patient Episode.

Notes:

- National Code 12 *'referral from a General Practitioner with an Extended Role (GPwER) or Dentist with Enhanced Skills (DES)'* has been updated in Data Dictionary Change Notice 1752 "Practitioners with a Special Interest Name Change". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.
- National Code descriptions have been updated to remove National Code headings and add prefixes where required. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.
  - The explanation of the National Code description prefixes are:
    - CONSULTANT initiated: Initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode
    - CONSULTANT not initiated: Not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode.
- Where a PATIENT is referred by a GENERAL PRACTITIONER acting in the capacity of a General Practitioner with an Extended Role (GPwER), National Code 12 *'CONSULTANT not initiated following a referral from a General Practitioner with an Extended Role (GPwER) or Dentist with Enhanced Skills (DES)'* should be used.
- Where a PATIENT is referred by that GENERAL PRACTITIONER acting in their capacity as an ordinary GENERAL MEDICAL PRACTITIONER, or as an ordinary GENERAL DENTAL PRACTITIONER, National Code 03 *'CONSULTANT not initiated following a referral from a GENERAL MEDICAL PRACTITIONER'* or National Code 92 *'CONSULTANT not initiated following a referral from a GENERAL DENTAL PRACTITIONER'* should be used as appropriate.
- Two Week Wait Referrals made by Specialist NURSES in Primary Care, under the authority of the GENERAL MEDICAL PRACTITIONER leading their team, should continue to be classified as referrals from the GENERAL PRACTITIONER (National Code 03 *'CONSULTANT not initiated following a referral from a GENERAL MEDICAL PRACTITIONER'*. Referrals from Specialist NURSES in Secondary Care should be classified as National Code 13 *'CONSULTANT not initiated following a referral from a Specialist NURSE (Secondary Care)'*
- The following National Codes have been updated in DCB0092-2062: Commissioning Data Sets: Emergency Care Data Set. The Data Set specifications that contain these items will be updated in the next version of the Information Standard where it is not already correct:
  - 10 *'CONSULTANT initiated following an Emergency Care Attendance (including Minor Injuries Units, Walk In Centres and Urgent Treatment Centres)'*
  - 04 *'CONSULTANT not initiated following a referral from a General Practitioner with an Extended Role (GPwER) or Dentist with Enhanced Skills (DES)'*
  - 05 *'CONSULTANT not initiated following a referral from a CONSULTANT, other than in an Emergency Care Department'*.

*National Codes:*

| | |
|---|---|
| 01 | CONSULTANT initiated following an emergency admission |
| 02 | CONSULTANT initiated following a Domiciliary Consultation |
| 10 | CONSULTANT initiated following an Emergency Care Attendance (including Minor Injuries, Walk In Centres and Urgent Treatment Centres) |
| 11 | CONSULTANT initiated: Other (not listed) |
| 03 | CONSULTANT not initiated following a referral from a GENERAL MEDICAL PRACTITIONER |
| 92 | CONSULTANT not initiated following a referral from a GENERAL DENTAL PRACTITIONER |
| 12 | CONSULTANT not initiated following a referral from a General Practitioner with an Extended Role (GPwER) or Dentist with Enhanced Skills (DES) |
| 04 | CONSULTANT not initiated following a referral from an Emergency Care Department (including Minor Injuries Units, Walk In Centres and Urgent Treatment Centres) |
| 05 | CONSULTANT not initiated following a referral from a CONSULTANT, other than in an Emergency Care Department |
| 06 | CONSULTANT not initiated following a self-referral |
| 07 | CONSULTANT not initiated following a referral from a Prosthetist |
| 13 | CONSULTANT not initiated following a referral from a Specialist NURSE (Secondary Care) |
| 14 | CONSULTANT not initiated following a referral from an Allied Health Professional |
| 15 | CONSULTANT not initiated following a referral from an OPTOMETRIST |
| 16 | CONSULTANT not initiated following a referral from an Orthoptist |

| | |
|---|---|
| 17 | CONSULTANT not initiated following a referral from a National Screening Programme |
| 93 | CONSULTANT not initiated following a referral from a Community Dental Service |
| 97 | CONSULTANT not initiated following a referral: Other (not listed) |

### SPECIALISED SERVICE CODE

Change to Attribute: Changed Dataset

The type of Specialised Service provided in a SERVICE PROVIDED UNDER AGREEMENT.

The SPECIALISED SERVICE CODE National Codes are published by NHS England and NHS Improvement and can be accessed at: Directly commissioned services reporting requirements.

### STATUS OF PERSON CONDUCTING DELIVERY

Change to Attribute: Changed Dataset

This is normally the status of the individual who delivers the baby. When the Delivery is carried out by a student, the individual supervising the Delivery should be the one recorded as conducting it. This may be different for each birth in a multiple birth.

*National Codes:*

| | |
|---|---|
| 1 | Hospital Doctor |
| 2 | GENERAL MEDICAL PRACTITIONER |
| 3 | MIDWIFE |
| 8 | Other |

### TREATMENT FUNCTION CODE

Change to Attribute: Changed Dataset

TREATMENT FUNCTION CODE is a unique identifier for a TREATMENT FUNCTION.

TREATMENT FUNCTION CODE is recorded to report the specialised service within which the PATIENT is treated.

It is based on MAIN SPECIALTY but also includes approved sub-specialties and treatment specialties used by lead CARE PROFESSIONALS including CONSULTANTS.

TREATMENT FUNCTION, rather than the Royal College or Faculty specialty, is required on most activity returns and in the Commissioning Data Sets.

TREATMENT FUNCTION CODES should be used for all data sets/collections unless otherwise stated e.g. National Workforce Data Set uses MAIN SPECIALTY CODES.

GENERAL MEDICAL PRACTITIONER, NURSE and Allied Health Professional/ Biomedical Scientist/ Clinical Scientist ACTIVITY should be recorded against the TREATMENT FUNCTION under which the PATIENT is treated.

Joint Consultant Clinic ACTIVITY should be recorded against the TREATMENT FUNCTION which best describes the specialised service.

**Assigning a Treatment Function Code:**

- Assigning a TREATMENT FUNCTION CODE for a SERVICE is a decision which must be made locally. For national reporting purposes, only the TREATMENT FUNCTION CODES listed in the table below must be used.

- Recording of activity according to TREATMENT FUNCTION CODES is not on the basis of the procedure carried out, but should be allocated according to whether a specialised SERVICE exists within the Health Care Provider for that TREATMENT FUNCTION CODE, such as a CLINIC OR FACILITY.
- TREATMENT FUNCTION CODES have not been mapped to procedures or MAIN SPECIALTY.
- TREATMENT FUNCTION CODE should be assigned irrespective of the type of CARE PROFESSIONAL responsible. This is also applicable where the name of the TREATMENT FUNCTION CODE suggests it is limited for use by a particular Healthcare Profession.
- A change in TREATMENT FUNCTION CODE, but no change in responsible CARE PROFESSIONAL, does not initiate a new episode of care. For the Commissioning Data Sets, the ACTIVITY TREATMENT FUNCTION CODE reported should be that which is recorded at the CDS ACTIVITY DATE.

For further information, contact NHS Digital by email at: enquiries@nhsdigital.nhs.uk with the subject "Main Specialty and Treatment Function Codes".

**Further information on the groupings and scope of each TREATMENT FUNCTION CODE is provided at: Main Specialty and Treatment Function Codes Table.**

Note:

- New National Codes for TREATMENT FUNCTION CODE were introduced from 2 April 2020 as part of the update to the DCB0028: Treatment Function and Main Specialty Standard. Submission of these codes for the Commissioning Data Sets is only possible where the healthcare provider has updated their CDS-XML schema version to CDS-XML version 6-2-0. Users of the original CDS-XML schema version 6-2 will be unable to submit the new codes introduced in the release of DCB0028: Treatment Function and Main Specialty Standard in April 2020 or the addendum to DCB0028 released in January 2021 to add a new TREATMENT FUNCTION CODE to represent Post-COVID-19 Syndrome Services.

*National Codes:*

| | |
|---|---|
| 100 | General Surgery Service |
| 101 | Urology Service |
| 102 | Transplant Surgery Service |
| 103 | Breast Surgery Service |
| 104 | Colorectal Surgery Service |
| 105 | Hepatobiliary and Pancreatic Surgery Service |
| 106 | Upper Gastrointestinal Surgery Service |
| 107 | Vascular Surgery Service |
| 108 | Spinal Surgery Service |
| 109 | Bariatric Surgery Service |
| 110 | Trauma and Orthopaedic Service |
| 111 | Orthopaedic Service |
| 113 | Endocrine Surgery Service |
| 115 | Trauma Surgery Service |
| 120 | Ear Nose and Throat Service |
| 130 | Ophthalmology Service |
| 140 | Oral Surgery Service |
| 141 | Restorative Dentistry Service |
| 143 | Orthodontic Service |
| 144 | Maxillofacial Surgery Service |
| 145 | Oral and Maxillofacial Surgery Service |
| 150 | Neurosurgical Service |
| 160 | Plastic Surgery Service |
| 161 | Burns Care Service |
| 170 | Cardiothoracic Surgery Service |
| 172 | Cardiac Surgery Service |
| 173 | Thoracic Surgery Service |
| 174 | Cardiothoracic Transplantation Service |
| 191 | Pain Management Service |

142 Paediatric Dentistry Service
171 Paediatric Surgery Service
211 Paediatric Urology Service
212 Paediatric Transplantation Surgery Service
213 Paediatric Gastrointestinal Surgery Service
214 Paediatric Trauma and Orthopaedic Service
215 Paediatric Ear Nose and Throat Service
216 Paediatric Ophthalmology Service
217 Paediatric Oral and Maxillofacial Surgery Service
218 Paediatric Neurosurgery Service
219 Paediatric Plastic Surgery Service
220 Paediatric Burns Care Service
221 Paediatric Cardiac Surgery Service
222 Paediatric Thoracic Surgery Service
223 Paediatric Epilepsy Service
230 Paediatric Clinical Pharmacology Service
240 Paediatric Palliative Medicine Service
241 Paediatric Pain Management Service
242 Paediatric Intensive Care Service
250 Paediatric Hepatology Service
251 Paediatric Gastroenterology Service
252 Paediatric Endocrinology Service
253 Paediatric Clinical Haematology Service
254 Paediatric Audio Vestibular Medicine Service
255 Paediatric Clinical Immunology and Allergy Service
256 Paediatric Infectious Diseases Service
257 Paediatric Dermatology Service
258 Paediatric Respiratory Medicine Service
259 Paediatric Nephrology Service
260 Paediatric Medical Oncology Service
261 Paediatric Inherited Metabolic Medicine Service
262 Paediatric Rheumatology Service
263 Paediatric Diabetes Service
264 Paediatric Cystic Fibrosis Service
270 Paediatric Emergency Medicine Service
280 Paediatric Interventional Radiology Service
290 Community Paediatric Service
291 Paediatric Neurodisability Service
321 Paediatric Cardiology Service
421 Paediatric Neurology Service
180 Emergency Medicine Service
190 Anaesthetic Service
192 Intensive Care Medicine Service
200 Aviation and Space Medicine Service
300 General Internal Medicine Service
301 Gastroenterology Service
302 Endocrinology Service
303 Clinical Haematology Service
304 Clinical Physiology Service
305 Clinical Pharmacology Service
306 Hepatology Service
307 Diabetes Service
308 Blood and Marrow Transplantation Service
309 Haemophilia Service

| | |
|---|---|
| 310 | Audio Vestibular Medicine Service |
| 311 | Clinical Genetics Service |
| 313 | Clinical Immunology and Allergy Service |
| 314 | Rehabilitation Medicine Service |
| 315 | Palliative Medicine Service |
| 316 | Clinical Immunology Service |
| 317 | Allergy Service |
| 318 | Intermediate Care Service |
| 319 | Respite Care Service |
| 320 | Cardiology Service |
| 322 | Clinical Microbiology Service |
| 323 | Spinal Injuries Service |
| 324 | Anticoagulant Service |
| 325 | Sport and Exercise Medicine Service |
| 326 | Acute Internal Medicine Service |
| 327 | Cardiac Rehabilitation Service |
| 328 | Stroke Medicine Service |
| 329 | Transient Ischaemic Attack Service |
| 330 | Dermatology Service |
| 331 | Congenital Heart Disease Service |
| 333 | Rare Disease Service |
| 335 | Inherited Metabolic Medicine Service |
| 340 | Respiratory Medicine Service |
| 341 | Respiratory Physiology Service |
| 342 | Pulmonary Rehabilitation Service |
| 343 | Adult Cystic Fibrosis Service |
| 344 | Complex Specialised Rehabilitation Service |
| 345 | Specialist Rehabilitation Service |
| 346 | Local Specialist Rehabilitation Service |
| 347 | Sleep Medicine Service |
| 348 | Post-COVID-19 Syndrome Service |
| 350 | Infectious Diseases Service |
| 352 | Tropical Medicine Service |
| 360 | Genitourinary Medicine Service |
| 361 | Renal Medicine Service |
| 370 | Medical Oncology Service |
| 371 | Nuclear Medicine Service |
| 400 | Neurology Service |
| 401 | Clinical Neurophysiology Service |
| 410 | Rheumatology Service |
| 420 | Paediatric Service |
| 422 | Neonatal Critical Care Service |
| 424 | Well Baby Service |
| 430 | Elderly Medicine Service |
| 431 | Orthogeriatric Medicine Service |
| 450 | Dental Medicine Service |
| 451 | Special Care Dentistry Service |
| 460 | Medical Ophthalmology Service |
| 461 | Ophthalmic and Vision Science Service |
| 501 | Obstetrics Service |
| 502 | Gynaecology Service |
| 503 | Gynaecological Oncology Service |
| 504 | Community Sexual and Reproductive Health Service |
| 505 | Fetal Medicine Service |

| | |
|---|---|
| 510 | Retired but retained for historical purposes |
| 520 | Retired but retained for historical purposes |
| 560 | Midwifery Service |
| 610 | Retired but retained for historical purposes |
| 620 | Retired but retained for historical purposes |
| 656 | Clinical Psychology Service |
| 700 | Learning Disability Service |
| 710 | Adult Mental Health Service |
| 711 | Child and Adolescent Psychiatry Service |
| 712 | Forensic Psychiatry Service |
| 713 | Medical Psychotherapy Service |
| 715 | Old Age Psychiatry Service |
| 720 | Eating Disorders Service |
| 721 | Addiction Service |
| 722 | Liaison Psychiatry Service |
| 723 | Psychiatric Intensive Care Service |
| 724 | Perinatal Mental Health Service |
| 725 | Mental Health Recovery and Rehabilitation Service |
| 726 | Mental Health Dual Diagnosis Service |
| 727 | Dementia Assessment Service |
| 730 | Neuropsychiatry Service |
| 800 | Clinical Oncology Service |
| 811 | Interventional Radiology Service |
| 812 | Diagnostic Imaging Service |
| 822 | Chemical Pathology Service |
| 832 | Retired but retained for historical purposes |
| 834 | Medical Virology Service |
| 650 | Physiotherapy Service |
| 651 | Occupational Therapy Service |
| 652 | Speech and Language Therapy Service |
| 653 | Podiatry Service |
| 654 | Dietetics Service |
| 655 | Orthoptics Service |
| 657 | Prosthetics Service |
| 658 | Orthotics Service |
| 659 | Dramatherapy Service |
| 660 | Art Therapy Service |
| 661 | Music Therapy Service |
| 662 | Optometry Service |
| 663 | Podiatric Surgery Service |
| 670 | Urological Physiology Service |
| 673 | Vascular Physiology Service |
| 675 | Cardiac Physiology Service |
| 677 | Gastrointestinal Physiology Service |
| 840 | Audiology Service |
| 920 | Diabetic Education Service |
| 990 | Retired but retained for historical purposes |

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**UCUM UNIT OF MEASUREMENT**

---

Change to Attribute: Changed Dataset

The UNIT OF MEASUREMENT using the Unified Code for Units of Measure (UCUM) code system.

For further information on the Unified Code for Units of Measure (UCUM) code system, see the Unified Code for Units of Measure website.

---

**UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)**

---

Change to Attribute: Changed Dataset
The unique booking reference number assigned by the Choose and Book system when a PATIENT accepts an APPOINTMENT DATE OFFERED of an APPOINTMENT OFFER where the offer was made via the Choose and Book system.

When a PATIENT accepts an APPOINTMENT DATE OFFERED, the unique booking reference number issued and used during the booking process is considered to be 'converted' i.e. an APPOINTMENT has been created and recorded; and the PATIENT has been placed on an Out-Patient Waiting List even if subsequently the PATIENT does not attend or cancels the APPOINTMENT.

UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) should only be recorded where the type of booking system is the Choose and Book system.

---

**UNIT BED CONFIGURATION**

---

Change to Attribute: Changed Dataset
The main composition of critical care bed types for the WARD.

*National Codes:*

| | |
|---|---|
| 02 | Level 2 beds only where patients require more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care |
| 03 | Level 3 beds only. Level 3 care is defined as patients needing advanced respiratory support alone or support of at least two organ systems. Note basic respiratory and basic cardiovascular support occurring on one day count as one organ. This level includes beds for all complex patients requiring support for multi-organ failure. |
| 05 | Flexible critical care beds where there is a mix of level 2 and level 3 beds |
| 90 | Temporary use of non critical care bed |

---

**WAITING TIME MEASUREMENT TYPE**

---

Change to Attribute: Changed Dataset

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.

Notes:

- National Code 01 '*Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement*' is **not** valid for the Mental Health Services Data Set
- The following National Codes are **only** valid for the Community Services Data Set:
  - National Code 05 '*Crisis Response Intermediate Care Within 2 Hours Waiting Time Measurement*'
  - National Code 06 '*Other Intermediate Care Within 2 Days Waiting Time Measurement*'
  - National Code 07 '*Crisis Response Intermediate Care Waiting Time Measurement*'
  - National Code 08 '*Other Intermediate Care Waiting Time Measurement*'.

*National Codes:*

01

| | |
|---|---|
| | Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement |
| 02 | Allied Health Professional Referral To Treatment Measurement |
| 03 | Improving Access to Psychological Therapies Referral To Treatment Measurement (Retired 1 April 2020) |
| 04 | Early Intervention in Psychosis Waiting Time Measurement (Retired 1 April 2020) |
| 05 | Crisis Response Intermediate Care Within 2 Hours Waiting Time Measurement |
| 06 | Other Intermediate Care Within 2 Days Waiting Time Measurement |
| 07 | Crisis Response Intermediate Care Waiting Time Measurement |
| 08 | Other Intermediate Care Waiting Time Measurement |
| 09 | Other Referral To Treatment Measurement Type (not listed) |

**WARD CODE**

Change to Attribute: Changed Dataset

A unique identification of a WARD within a Health Care Provider.

**WARD DAY PERIOD AVAILABILITY**

Change to Attribute: Changed Description

For WARDS this is the number of day periods in a week for which it is planned to be available. Where a WARD is closed availability will be zero.

*National Codes:*

| | |
|---|---|
| 0 | Zero days |
| 1 | One day |
| 2 | Two days |
| 3 | Three days |
| 4 | Four days |
| 5 | Five days |
| 6 | Six days |
| 7 | Seven days |

**WARD DAY PERIOD AVAILABILITY will be replaced with WARD INTENDED DAY PERIOD AVAILABILITY, which is the most recent approved national information standard to describe the required definition.**

**WARD INTENDED AGE GROUP**

Change to Attribute: New Attribute

The age group of PATIENTS intended to use a WARD, as indicated in the WARD OPERATIONAL PLAN.

*National Codes:*

| | |
|---|---|
| 1 | Neonates |
| 2 | Children and/or adolescents |
| 3 | Elderly |
| 8 | Any age |

**AGE GROUP INTENDED will be replaced with WARD INTENDED AGE GROUP, which is the most recent approved national information standard to describe the required definition.**

**This attribute is also known by these names:**

| Context | Alias |
|---|---|
| plural | WARD INTENDED AGE GROUPS |

---

**WARD INTENDED AGE GROUP**

---

Change to Attribute: New Attribute

## WARD INTENDED AGE GROUP

**Data Elements:**

| WARD INTENDED AGE GROUP |
|---|

---

**WARD INTENDED CLINICAL CARE INTENSITY**

---

Change to Attribute: New Attribute

The level of resources and intensity of care which is intended to be provided in a WARD.

*National Codes:*

| | |
|---|---|
| 51 | Mental Illness intensive care: specially designated ward for PATIENTS needing containment and more intensive management (e.g. Psychiatric Intensive Care Unit (PICU)). This is not to be confused with intensive nursing where PATIENTS may require one to one nursing while on a standard WARD |
| 52 | Mental Illness short stay: PATIENTS intended to stay less than a year |
| 53 | Mental Illness long stay: PATIENTS intended to stay a year or more |
| 61 | Learning Disability PATIENTS in a designated or interim secure unit |
| 62 | Learning Disability PATIENTS intending to stay less than a year |
| 63 | Learning Disability PATIENTS intending to stay a year or more |
| 41 | Only for maternity PATIENTS looked after by CONSULTANTS |
| 43 | Only for maternity PATIENTS looked after by GENERAL MEDICAL PRACTITIONERS |
| 42 | Joint use for maternity PATIENTS looked after by CONSULTANTS and GENERAL MEDICAL PRACTITIONERS |
| 33 | Neonates: maternity: associated with the maternity WARD in that cots are in the maternity WARD nursery or in the WARD itself |
| 32 | Neonates: non-maternity: not associated with the maternity WARD and without designated cots for intensive care |
| 31 | Neonates: not associated with the maternity WARD and in which there are some designated cots for intensive care |
| 21 | Younger physically disabled PATIENTS: spinal units, only those units which are nationally recognised |
| 22 | Younger physically disabled PATIENTS: other units |
| 81 | Terminally ill/Palliative Care PATIENTS |
| 11 | General PATIENTS: for intensive therapy, including high dependency care |
| 12 | General PATIENTS: for normal therapy: where resources permit the admission of PATIENTS who might need all but intensive or high dependency therapy |
| 13 | General PATIENTS: for limited therapy: where nursing care rather than continuous medical care is provided. Such WARDS can be used only for PATIENTS carefully selected and restricted to a narrow range in terms of the extent and nature of disease |

**CLINICAL CARE INTENSITY will be replaced with WARD INTENDED CLINICAL CARE INTENSITY, which is the most recent approved national information standard to describe the required definition.**

**This attribute is also known by these names:**

| Context | Alias |
| --- | --- |
| plural | WARD INTENDED CLINICAL CARE INTENSITIES |

---

**WARD INTENDED CLINICAL CARE INTENSITY**

---

Change to Attribute: New Attribute

## WARD INTENDED CLINICAL CARE INTENSITY

**Data Elements:**

| WARD INTENDED CLINICAL CARE INTENSITY |
| --- |

---

**WARD INTENDED DAY PERIOD AVAILABILITY**

---

Change to Attribute: New Attribute

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*'.

*National Codes:*

| | |
| --- | --- |
| 0 | Zero days |
| 1 | One day |
| 2 | Two days |
| 3 | Three days |
| 4 | Four days |
| 5 | Five days |
| 6 | Six days |
| 7 | Seven days |

**WARD DAY PERIOD AVAILABILITY will be replaced with WARD INTENDED DAY PERIOD AVAILABILITY, which is the most recent approved national information standard to describe the required definition.**

**This attribute is also known by these names:**

| Context | Alias |
| --- | --- |
| plural | WARD INTENDED DAY PERIOD AVAILABILITIES |

---

**WARD INTENDED DAY PERIOD AVAILABILITY**

---

Change to Attribute: New Attribute

## WARD INTENDED DAY PERIOD AVAILABILITY

**Data Elements:**

| WARD INTENDED DAY PERIOD AVAILABILITY |
| --- |

---

**WARD INTENDED NIGHT PERIOD AVAILABILITY**

---

Change to Attribute: New Attribute

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*'.

*National Codes:*

| | |
|---|---|
| 0 | Zero nights |
| 1 | One night |
| 2 | Two nights |
| 3 | Three nights |
| 4 | Four nights |
| 5 | Five nights |
| 6 | Six nights |
| 7 | Seven nights |

**WARD NIGHT PERIOD AVAILABILITY will be replaced with WARD INTENDED NIGHT PERIOD AVAILABILITY, which is the most recent approved national information standard to describe the required definition.**

**This attribute is also known by these names:**

| Context | Alias |
|---|---|
| plural | WARD INTENDED NIGHT PERIOD AVAILABILITIES |

---

**WARD INTENDED NIGHT PERIOD AVAILABILITY**

---

Change to Attribute: New Attribute

## WARD INTENDED NIGHT PERIOD AVAILABILITY

**Data Elements:**

| WARD INTENDED NIGHT PERIOD AVAILABILITY |
|---|

---

**WARD INTENDED SEX OF PATIENTS**

---

Change to Attribute: New Attribute

The sex of PATIENTS intended to use a WARD, as indicated in the WARD OPERATIONAL PLAN.

*National Codes:*

| | |
|---|---|
| 1 | Male |
| 2 | Female |
| 8 | Not specified |

**SEX OF PATIENTS will be replaced with WARD INTENDED SEX OF PATIENTS, which is the most recent approved national information standard to describe the required definition.**

---

**WARD INTENDED SEX OF PATIENTS**

---

Change to Attribute: New Attribute

## WARD INTENDED SEX OF PATIENTS

**Data Elements:**

| WARD INTENDED SEX OF PATIENTS |
|---|

---

#### WARD NIGHT PERIOD AVAILABILITY

Change to Attribute: Changed Description

For WARDS this is the number of night periods in a week for which it is planned to be available. Where a WARD is closed availability will be zero.

*National Codes:*

| | |
|---|---|
| 0 | Zero nights |
| 1 | One night |
| 2 | Two nights |
| 3 | Three nights |
| 4 | Four nights |
| 5 | Five nights |
| 6 | Six nights |
| 7 | Seven nights |

**WARD NIGHT PERIOD AVAILABILITY will be replaced with WARD INTENDED NIGHT PERIOD AVAILABILITY, which is the most recent approved national information standard to describe the required definition.**

#### WARD SECURITY LEVEL

Change to Attribute: Changed Dataset

The level of security for a WARD.

*National Codes:*

0 **General (non-secure)**
Non secure accommodation or accommodation that only has normal levels of security such as general WARDS

1 **Low Secure**
Low secure WARDS/units deliver comprehensive, multidisciplinary, treatment and care by qualified staff for PATIENTS who demonstrate disturbed behaviour in the context of a serious mental disorder and who require the provision of security. This includes (but is not limited to) Psychiatric Intensive Care Unit (PICU), low secure forensic services, challenging behaviour services, and secure rehabilitation services.

2 **Medium Secure**
Medium secure WARDS/units deliver comprehensive, multidisciplinary treatment and care by qualified staff for PATIENTS who demonstrate disturbed behaviour in the context of a serious mental disorder and who may present a serious risk to others.

3 **High Secure**
High secure WARDS/hospitals provide comprehensive, multidisciplinary treatment and care by qualified staff for PATIENTS who demonstrate disturbed behaviour in the context of a serious mental disorder and have been assessed as presenting a grave and immediate danger to others. The Hospital must be part of an NHS Trust approved by the Secretary of State to provide high security psychiatric services.

#### WITHHELD IDENTITY REASON

Change to Attribute: Changed Dataset
A code used in the Data Group 'Withheld Identity Structure' in the Commissioning Data Sets (version 6-2 onwards) to allow 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.

*National Codes:*

01 Record anonymised for legal/statutory reasons

02 Record anonymised at request of Caldicott Guardian
03 Record anonymised at request of PATIENT
97 Record anonymised for other reason

### ACTIVITY DATE (CRITICAL CARE)

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
ACTIVITY DATE (CRITICAL CARE) is the same as attribute ACTIVITY DATE where the CARE ACTIVITY is during a CRITICAL CARE PERIOD.

ACTIVITY DATE (CRITICAL CARE) is the date the PATIENT receives care which is a CRITICAL CARE ACTIVITY.

### ACTIVITY LOCATION TYPE CODE

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | an3 |
| National Codes: | See ACTIVITY LOCATION TYPE CODE |
| Default Codes: | |

**Notes:**
ACTIVITY LOCATION TYPE CODE is the same as attribute ACTIVITY LOCATION TYPE CODE.

**Use in Commissioning Data Set Version 6-2 onwards**

Where Out-Patient Clinics are held on WARDS (such as Pre-assessment Clinics), these should be categorised as ACTIVITY LOCATION TYPE CODE National Code E01 'Out-Patient Clinic' and not National Code E02 'WARD'. This will allow Ward Attendances to be differentiated from Out-Patient Clinics in the CDS V6-2 Type 020 - Outpatient Commissioning Data Set flow.

For ACTIVITY falling under Allied Health Professional Referral To Treatment Measurement, ACTIVITY LOCATION TYPE CODE may be submitted to allow identification of Allied Health Professional ACTIVITY taking place on WARDS, which is not related to the Hospital Provider Spell for the PATIENT being seen by the Allied Health Professional. For example, if a Podiatrist were asked to see a PATIENT who was currently admitted for a condition where the agreed care pathway did not include Podiatry services, then an Out-Patient Appointment Non-Consultant should be recorded, with the ACTIVITY LOCATION TYPE CODE of E02 'WARD'.

For specific National Code usage in different data sets, see ACTIVITY LOCATION TYPE CODE.

### ACTIVITY TREATMENT FUNCTION CODE

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | an3 |
| National Codes: | See TREATMENT FUNCTION CODE |
| Default Codes: | 199 - Non-UK provider; TREATMENT FUNCTION not known, treatment mainly surgical<br>499 - Non-UK provider; TREATMENT FUNCTION not known, treatment mainly medical |

**Notes:**
ACTIVITY TREATMENT FUNCTION CODE is the same as attribute TREATMENT FUNCTION CODE.

The default codes 199 and 499 are only applicable for overseas health care providers.

ACTIVITY TREATMENT FUNCTION CODE is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

---

#### ADMINISTRATIVE CATEGORY CODE

---

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See ADMINISTRATIVE CATEGORY CODE |
| Default Codes: | 98 - Not applicable |
| | 99 - ADMINISTRATIVE CATEGORY CODE not known |

**Notes:**
ADMINISTRATIVE CATEGORY CODE is the same as ADMINISTRATIVE CATEGORY CODE.

Note: the Default Code description for 99 - Not known has been updated. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

#### ADMINISTRATIVE CATEGORY CODE (ON ADMISSION)

---

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See ADMINISTRATIVE CATEGORY CODE |
| Default Codes: | 98 - Not applicable |
| | 99 - ADMINISTRATIVE CATEGORY CODE not known |

**Notes:**
ADMINISTRATIVE CATEGORY CODE (ON ADMISSION) is the same as attribute ADMINISTRATIVE CATEGORY CODE.

ADMINISTRATIVE CATEGORY CODE (ON ADMISSION) is used to record the ADMINISTRATIVE CATEGORY CODE at the start of the Hospital Provider Spell.

Note: the Default Code description for 99 - Not known has been updated. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

#### ADMISSION SOURCE (HOSPITAL PROVIDER SPELL)

---

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See ADMISSION SOURCE |
| Default Codes: | 98 - Not applicable |
| | 99 - ADMISSION SOURCE not known |

**Notes:**
ADMISSION SOURCE (HOSPITAL PROVIDER SPELL) is the same as attribute ADMISSION SOURCE.

~~**This item is being used for development purposes and has not yet been approved.**~~ADMISSION SOURCE (HOSPITAL PROVIDER SPELL) is the source of admission to a Hospital Provider Spell in a Hospital Site.

ADMISSION SOURCE (HOSPITAL PROVIDER SPELL) is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of Healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

**SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL) will be replaced with ADMISSION SOURCE (HOSPITAL PROVIDER SPELL) ADMISSION SOURCE (HOSPITAL PROVIDER SPELL), which is the most recent approved national information standard to describe the required definition.**

---

#### ADVANCED CARDIOVASCULAR SUPPORT DAYS

---

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | max an3 |
| National Codes: | |
| Default Codes: | 998 - 998 or more days of advanced cardiovascular support |
| | 999 - Occurred but day count not known |

**Notes:**
ADVANCED CARDIOVASCULAR SUPPORT DAYS is the same as attribute ACTIVITY DURATION.

ADVANCED CARDIOVASCULAR SUPPORT DAYS is the total number of days that the PATIENT received advanced cardiovascular support during a CRITICAL CARE PERIOD, ranging from 0 to 997 days.

ADVANCED CARDIOVASCULAR SUPPORT DAYS 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 '*Advanced Cardiovascular Support*' within the CRITICAL CARE PERIOD.

ADVANCED CARDIOVASCULAR SUPPORT DAYS is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

#### ADVANCED RESPIRATORY SUPPORT DAYS

---

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | max an3 |
| National Codes: | |
| Default Codes: | 998 - 998 or more days of advanced respiratory support |
| | 999 - Occurred but day count not known |

**Notes:**
ADVANCED RESPIRATORY SUPPORT DAYS is the same as attribute ACTIVITY DURATION.

ADVANCED RESPIRATORY SUPPORT DAYS is the total number of days that the PATIENT received advanced respiratory support during a CRITICAL CARE PERIOD, ranging from 0 to 997 days.

ADVANCED RESPIRATORY SUPPORT DAYS 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 '*Advanced Respiratory Support*' within the CRITICAL CARE PERIOD.

ADVANCED RESPIRATORY SUPPORT DAYS is used by the Secondary Uses Service to derive the **Healthcare Resource Group** **4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

**AGE AT CDS ACTIVITY DATE**

---

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | max an3 |
| National Codes: | |
| Default Codes: | 999 - Not known i.e. date of birth not known and age cannot be estimated |

**Notes:**
AGE AT CDS ACTIVITY DATE is the same as attribute PERSON AGE.

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.

AGE AT CDS ACTIVITY DATE is used by the Secondary Uses Service to derive the **Healthcare Resource Group** **4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

**AGE ON ADMISSION**

---

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | max an3 |
| National Codes: | |
| Default Codes: | 999 - Not known i.e. date of birth not known and age cannot be estimated |

**Notes:**
AGE ON ADMISSION is the same as attribute PERSON AGE.

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).

AGE ON ADMISSION is used by the Secondary Uses Service to derive the **Healthcare Resource Group** **4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

#### AMBULANCE CALL IDENTIFIER

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | max an20 |
| National Codes: | |
| Default Codes: | |

**Notes:**
AMBULANCE CALL IDENTIFIER is the same as attribute AMBULANCE CALL IDENTIFIER.

---

#### ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY CODE

Change to Data Element: Changed Dataset, Description

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See ANAESTHETIC OR ANALGESIC CATEGORY |
| ~~Default Codes:~~ | ~~9 - Not known: a validation error~~ |
| Default Codes: | 9 - ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY CODE not known |

**Notes:**
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

Change to Data Element: Changed Dataset, Description

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See ANAESTHETIC OR ANALGESIC CATEGORY |
| ~~Default Codes:~~ | ~~9 - Not known: a validation error~~ |
| Default Codes: | 9 - ANAESTHETIC GIVEN POST LABOUR OR DELIVERY CODE not known |

**Notes:**
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.

---

#### APPOINTMENT BOOKED REASON

Change to Data Element: New Data Element

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See APPOINTMENT BOOKED REASON |
| Default Codes: | |

**Notes:**
APPOINTMENT BOOKED REASON is the same as attribute APPOINTMENT BOOKED REASON.

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.

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | APPOINTMENT BOOKED REASONS |

**APPOINTMENT BOOKED REASON**

Change to Data Element: New Data Element

## APPOINTMENT BOOKED REASON

**Attribute:**

APPOINTMENT BOOKED REASON

**APPOINTMENT DATE**

Change to Data Element: Changed Dataset, Description

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
APPOINTMENT DATE is the same as attribute APPOINTMENT DATE.

**Usage in the CDS:**
~~The Outpatient and Future Outpatient CDS Types use the APPOINTMENT DATE as the "CDS ORIGINATING DATE" as a mandatory requirement of the CDS Exchange Protocol, see CDS ACTIVITY DATE.~~The Outpatient (CDS version 6-2 and CDS version 6-3) and Future Outpatient (CDS version 6-2 only) CDS Types use the APPOINTMENT DATE as the "CDS ORIGINATING DATE" as a mandatory requirement of the CDS Bulk/Net Update Protocols, see CDS ACTIVITY DATE.

~~For the Future Outpatient CDS where no APPOINTMENT DATE is available from the healthcare system, a default date value of 2999-12-31 may be applied. Care must be taken to generate the correct CDS Exchange Protocol when using this default value.~~For the CDS V6-2 Type 021 - Future Outpatient Commissioning Data Set, where no APPOINTMENT DATE is available from the healthcare system, a default date value of 2999-12-31 may be applied. Care must be taken to generate the correct CDS Bulk/Net Update Protocol when using this default value.

~~When submitting a Referral To Treatment Clock Stop Administrative Event via the CDS V6-2 Type 020 - Outpatient Commissioning Data Set, APPOINTMENT DATE is equivalent to the REFERRAL TO TREATMENT PERIOD END DATE carried in the record.~~When submitting a Referral To Treatment Clock Stop Administrative Event via the CDS V6-2 Type 020 - Outpatient Commissioning Data Set or CDS V6-3 Type 020 - Outpatient Commissioning Data Set , APPOINTMENT DATE is equivalent to the REFERRAL TO TREATMENT PERIOD END DATE carried in the record.

**APPOINTMENT TIME**

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | an8 HH:MM:SS |
| National Codes: | |
| Default Codes: | |

**Notes:**
APPOINTMENT TIME is the same as attribute APPOINTMENT TIME.

#### ASSESSMENT TOOL (SNOMED CT EXPRESSION)

Change to Data Element: Changed Dataset

| Format/Length: | See SNOMED CT EXPRESSION |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
ASSESSMENT TOOL (SNOMED CT EXPRESSION) is the same as attribute CLINICAL TERMINOLOGY CODE.

~~**This item is being used for development purposes and has not yet been approved.**~~ASSESSMENT TOOL (SNOMED CT EXPRESSION) is a structured combination of one or more SNOMED CT® concept identifiers which are used to identify an ASSESSMENT TOOL.

For further information on SNOMED CT EXPRESSIONS, see the SNOMED CT® Glossary at: Expression.

#### ASSESSMENT TOOL COMPLETION TIMESTAMP

Change to Data Element: Changed Dataset

**This item is being used for development purposes and has not yet been approved.**

#### ATTENDANCE STATUS

Change to Data Element: Changed Dataset, Description

| Format/Length: | an1 |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
ATTENDANCE STATUS is the same as attribute ATTENDED OR DID NOT ATTEND.

~~**This item is being used for development purposes and has not yet been approved.**~~*Permitted National Codes:*

| | |
|---|---|
| 5 | Attended on time or, if late, before the relevant CARE PROFESSIONAL was ready to see the PATIENT |
| 6 | Arrived late, after the relevant CARE PROFESSIONAL was ready to see the PATIENT, but was seen |
| 7 | PATIENT arrived late and could not be seen |
| 2 | APPOINTMENT cancelled by, or on behalf of, the PATIENT |
| 3 | Did not attend - no advance warning given |
| 4 | APPOINTMENT cancelled or postponed by the Health Care Provider |

**ATTENDED OR DID NOT ATTEND CODE will be replaced with ATTENDANCE STATUS, which is the most recent approved national information standard to describe the required definition.**

#### BASIC CARDIOVASCULAR SUPPORT DAYS

Change to Data Element: Changed Dataset

| Format/Length: | max an3 |
|---|---|
| National Codes: | |
| Default Codes: | 998 - 998 or more days of basic cardiovascular support |
| | 999 - Occurred but day count not known |

**Notes:**
BASIC CARDIOVASCULAR SUPPORT DAYS is the same as attribute ACTIVITY DURATION.

BASIC CARDIOVASCULAR SUPPORT DAYS is the total number of days that the PATIENT received basic cardiovascular support during a CRITICAL CARE PERIOD, ranging from 0 to 997 days.

BASIC CARDIOVASCULAR SUPPORT DAYS 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 '*Basic Cardiovascular Support*' within the CRITICAL CARE PERIOD.

BASIC CARDIOVASCULAR SUPPORT DAYS is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

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**BASIC RESPIRATORY SUPPORT DAYS**

---

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | max an3 |
| National Codes: | |
| Default Codes: | 998 - 998 or more days of basic respiratory support |
| | 999 - Occurred but day count not known |

**Notes:**
BASIC RESPIRATORY SUPPORT DAYS is the same as attribute ACTIVITY DURATION.

BASIC RESPIRATORY SUPPORT DAYS is the total number of days that the PATIENT received basic respiratory support during a CRITICAL CARE PERIOD, ranging from 0 to 997 days.

BASIC RESPIRATORY SUPPORT DAYS 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 '*Basic Respiratory Support*' within the CRITICAL CARE PERIOD.

BASIC RESPIRATORY SUPPORT DAYS is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

**BIRTH ORDER**

---

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | n1 |
| National Codes: | |
| Default Codes: | 8 - Not applicable |
| | 9 - BIRTH ORDER not known |

**Notes:**
BIRTH ORDER is the same as attribute BIRTH ORDER.

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.

Note: the Default Code description for 9 - Not known has been updated. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

#### BIRTH WEIGHT

---

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | max an4 |
| National Codes: | |
| Default Codes: | 9999 - Weight not known |

**Notes:**
BIRTH WEIGHT is the same as attribute CLINICAL INVESTIGATION RESULT VALUE.

BIRTH WEIGHT is the result of the Clinical Investigation which measures the Birth Weight, where the UNIT OF MEASUREMENT is *'Grams (g)'*.

The range is 1 to 9998.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

#### CARE CONTACT IDENTIFIER (AMBULANCE SERVICE)

---

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | max an20 |
| National Codes: | |
| Default Codes: | |

**Notes:**
CARE CONTACT IDENTIFIER (AMBULANCE SERVICE) is the same as attribute ACTIVITY IDENTIFIER for a CARE CONTACT allocated by the Ambulance Service.

CARE CONTACT IDENTIFIER (AMBULANCE SERVICE) is an identifier allocated to each Ambulance Incident for each PATIENT.

The PATIENT can have more than one CARE CONTACT IDENTIFIER (AMBULANCE SERVICE) if the PATIENT is treated more than once in separate Ambulance Incidents.

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#### CARE PROFESSIONAL MAIN SPECIALTY CODE

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Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | an3 |
| National Codes: | See MAIN SPECIALTY CODE |
| Default Codes: | 199 - Non-UK provider; specialty function not known, treatment mainly surgical |
| | 499 - Non-UK provider; specialty function not known, treatment mainly medical |

**Notes:**
CARE PROFESSIONAL MAIN SPECIALTY CODE is the same as attribute MAIN SPECIALTY CODE.

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.

All Non-Consultant Led Activity is identified by a pseudo CARE PROFESSIONAL MAIN SPECIALTY CODE of:

- 560 - Non-Consultant Led Activity - Midwife
- 950 - Non-Consultant Led Activity - Nursing
- 960 - Non-Consultant Led Activity - Allied Health Professional.

The default codes 199 and 499 are only applicable for overseas providers.

CARE PROFESSIONAL MAIN SPECIALTY CODE is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

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#### CARER SUPPORT INDICATOR

---

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See CARER SUPPORT INDICATOR |
| Default Codes: | |

**Notes:**
CARER SUPPORT INDICATOR is the same as attribute CARER SUPPORT INDICATOR.

---

#### CDS ACTIVITY DATE

---

Change to Data Element: Changed Dataset, Description

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
CDS ACTIVITY DATE is the same as attribute ACTIVITY DATE.

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.

The CDS ACTIVITY DATE is held in the Commissioning Data Set Transaction Header Group and is a mandatory data element for all uses of the Commissioning Data Set for both Bulk Update and Net Change Protocols, see the Commissioning Data Set Submission Protocol supporting information.

For Bulk Update use, see:

- CDS V6-2 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol
- CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol
- CDS V6-2-2 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol
- CDS V6-2-3 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

For Net Change Use, see:

- CDS V6-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol
- CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol
- CDS V6-2-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol
- ~~CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol~~
- CDS V6-2-3 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

~~Note:~~Note: CDS Type 010 *'Accident and Emergency Attendance'* was retired from 1 November 2020 and is no longer accepted for submission to the Secondary Uses Service.

~~CDS Type 010 *'Accident and Emergency Attendance'* will no longer be accepted from 01 November 2020.~~

The CDS ACTIVITY DATE has an associated "CDS Originating Date" specifically identified for each CDS Type as follows:

| CDS TYPE | DESCRIPTION | CDS ORIGINATING DATE (used to populate the CDS ACTIVITY DATE) |
|---|---|---|
| ~~010~~ | ~~Accident and Emergency Attendance~~ | |
| 010 | Accident and Emergency Attendance (Retired 1 November 2020) | |
| 011 | Emergency Care Attendance | EMERGENCY CARE ARRIVAL DATE, EMERGENCY CARE ARRIVAL TIME |
| 020 | Outpatient (known in the Schema as Care Activity) | APPOINTMENT DATE |
| 021 | Future Outpatient (known in the Schema as Future Care Activity) | APPOINTMENT DATE |
| 030 | EAL End Of Period Census - STANDARD | DECIDED TO ADMIT DATE |
| 040 | EAL End Of Period Census - OLD | NHS SERVICE AGREEMENT CHANGE DATE |
| 050 | EAL End Of Period Census - NEW | NHS SERVICE AGREEMENT CHANGE DATE |
| 060 | EAL Event During Period - ADD | DECIDED TO ADMIT DATE |
| 070 | EAL Event During Period - REMOVE | ELECTIVE ADMISSION LIST REMOVAL DATE |
| 080 | EAL Event During Period - OFFER | OFFERED FOR ADMISSION DATE |
| 090 | EAL Event During Period - AVAILABLE / UNAVAILABLE | SUSPENSION START DATE |
| 100 | EAL Event During Period - OLD SERVICE AGREEMENT | NHS SERVICE AGREEMENT CHANGE DATE |
| 110 | EAL Event During Period - NEW SERVICE AGREEMENT | NHS SERVICE AGREEMENT CHANGE DATE |
| 120 | Finished Birth Episode | END DATE (EPISODE) |
| 130 | Finished General Episode | END DATE (EPISODE) |
| 140 | Finished Delivery Episode | END DATE (EPISODE) |
| ~~150~~ | ~~Other Birth~~ | ~~DELIVERY DATE~~ |
| ~~160~~ | ~~Other Delivery~~ | ~~DELIVERY DATE~~ |
| 150 | Other Birth | DELIVERY DATE (CDS V6-2) / DELIVERY TIMESTAMP (CDS V6-3) |
| 160 | Other Delivery | DELIVERY DATE (VDS V6-2) / DELIVERY TIMESTAMP (CDS V6-3) |
| 170 | Detained and/or Long-Term Psychiatric Census | DETAINED AND (OR) LONG TERM PSYCHIATRIC CENSUS DATE |
| 180 | Unfinished Birth Episode | START DATE (EPISODE) |
| 190 | Unfinished General Episode | START DATE (EPISODE) |
| 200 | Unfinished Delivery Episode | START DATE (EPISODE) |

**Usage:**
The CDS ACTIVITY DATE is validated by the Secondary Uses Service and Commissioning Data Set Interchanges are rejected if the date is not present, invalid or not compatible with the Commissioning Data Set Submission Protocol controls being used.

In particular, when using the Commissioning Data Set Bulk Replacement Update Mechanism, the CDS ACTIVITY DATE and its "CDS Originating Date" are used by the Secondary Uses Service to validate that the CDS Type date applicability falls within the CDS REPORT PERIOD START DATE and the CDS REPORT PERIOD END DATE.

### CDS APPLICABLE DATE

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
CDS APPLICABLE DATE is the same as attribute EVENT DATE.

CDS APPLICABLE DATE is 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.

**Usage:**
CDS APPLICABLE DATE is mandatory when used with the Commissioning Data Set Net Change Update Mechanism. It is not required when the Commissioning Data Set Bulk Replacement Update Mechanism is used. See the Commissioning Data Set Submission Protocol.

The CDS APPLICABLE DATE (and the CDS APPLICABLE TIME if supplied) is stored in the Secondary Uses Service database and in the event of multiple submissions of the same uniquely identified Commissioning data (even in separate interchanges).

The Secondary Uses Service database update process is then able to use this date and time to ensure correct updating of the Commissioning data in the correct relative date/time sequence.

### CDS APPLICABLE TIME

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | an8 HH:MM:SS |
| National Codes: | |
| Default Codes: | |

**Notes:**
CDS APPLICABLE TIME is the same as attribute EVENT TIME.

CDS APPLICABLE TIME is 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.

**Usage:**
CDS APPLICABLE TIME is mandatory when used with the Commissioning Data Set Net Change Update Mechanism. It is not required when the CDS Bulk Replacement Update Mechanism is used. See the Commissioning Data Set Submission Protocol.

The CDS APPLICABLE TIME (and CDS APPLICABLE DATE if supplied) is stored in the Secondary Uses Service database and in the event of multiple submissions of the same uniquely identified Commissioning data (even in separate interchanges), the Secondary Uses Service database update process is then able to use the date and time to ensure correct updating of the Commissioning data in the correct relative date/time sequence.

### CDS BULK REPLACEMENT GROUP CODE

Change to Data Element: Changed Dataset, Description

| Format/Length: | an3 |
|---|---|
| National Codes: | See CDS BULK REPLACEMENT GROUP CODE |
| Default Codes: | |

**Notes:**
CDS BULK REPLACEMENT GROUP CODE is the same as attribute CDS BULK REPLACEMENT GROUP CODE.

CDS BULK REPLACEMENT GROUP CODE is not required when the Commissioning Data Set Net Change Update Mechanism is used.

The Commissioning Data Set Bulk Replacement Update Mechanism process identifies previously transferred CDS Types that are to be replaced by the submitted Commissioning Data Set interchange. To do this the CDS BULK REPLACEMENT GROUP CODE must be used together with the following data items:

- CDS REPORT PERIOD START DATE
- CDS REPORT PERIOD END DATE
- CDS INTERCHANGE SENDER IDENTITY
- ~~CDS PRIME RECIPIENT IDENTITY~~

~~For submissions of CDS V6-2, CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set and CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set, the CDS PRIME RECIPIENT IDENTITY is Mandatory for submission in the CDS Type 005B - CDS Transaction Header Group - Bulk Update Protocol and CDS Type 005N - CDS Transaction Header Group - Net Change Protocol. However, it no longer forms part of the key for the process of determining duplicate records within the Secondary Uses Service.~~

~~Note that the CDS PRIME RECIPIENT IDENTITY continues to be used to determine data access requirements within the Secondary Uses Service.~~

It is particularly important when using the Commissioning Data Set Bulk Replacement Update Mechanism for a CDS BULK REPLACEMENT GROUP CODE to contain all the relevant CDS Types for the extracted time period in a single Commissioning Data Set Interchange, e.g. the Finished General Episodes, Finished Delivery Episodes and Finished Birth Episodes in a Finished Episode Group.

For specific National Code usage in different data sets, see CDS BULK REPLACEMENT GROUP CODE.

---

#### CDS EXTRACT DATE

---

Change to Data Element: Changed Dataset

| Format/Length: | an10 CCYY-MM-DD |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
CDS EXTRACT DATE is the same as attribute EVENT DATE.

CDS EXTRACT DATE is 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.

**Usage:**
CDS EXTRACT DATE is mandatory when used with the Commissioning Data Set Bulk Replacement Update Mechanism. It is not required when the Commissioning Data Set Net Change Update Mechanism is used, see the Commissioning Data Set Submission Protocol.

The CDS EXTRACT DATE (and CDS EXTRACT TIME if supplied) is used by the Secondary Uses Service to detect duplicate Interchanges of a similarly defined Bulk Update submission of Commissioning Data Sets.

The Secondary Uses Service processes and stores the date and time information to ensure correct updating of the Commissioning Data Set data in the correct relative date/time sequence.

---

#### CDS EXTRACT TIME

---

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | an8 HH:MM:SS |
| National Codes: | |
| Default Codes: | |

**Notes:**
CDS EXTRACT TIME is the same as attribute EVENT TIME.

CDS EXTRACT TIME is the time (with an associated CDS EXTRACT DATE) at which the Commissioning data extract was undertaken.

**Usage:**
CDS EXTRACT TIME is mandatory when using the Commissioning Data Set Bulk Replacement Update Mechanism and is used to ensure that submissions are processed in the correct relative sequence. See the Commissioning Data Set Submission Protocol.

The sender of Commissioning Data Set data should determine the most useful point of the system's processes to generate this time value to provide a useful reference/audit control point.

---

#### CDS INTERCHANGE APPLICATION REFERENCE

---

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | min an1 max an14 |
| National Codes: | |
| Default Codes: | |

**Notes:**
CDS INTERCHANGE APPLICATION REFERENCE is the same as attribute CDS INTERCHANGE APPLICATION REFERENCE.

**Usage:**
This facility enables submitted interchanges to be marked to enable interchange content to be identified and recorded.
All Commissioning Data Set Interchanges must contain this data element.

**CDS XML Schema Interchanges:**
Commissioning Data Set XML Schema interchanges submitted may contain the optional CDS INTERCHANGE APPLICATION REFERENCE.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

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#### CDS INTERCHANGE CONTROL COUNT

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Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | max n7 |
| National Codes: | |
| Default Codes: | |

**Notes:**
CDS INTERCHANGE CONTROL COUNT is the same as attribute CDS INTERCHANGE CONTROL COUNT.

**Usage:**
Senders of Commissioning Data Set Interchanges must generate this data. Recipients of Commissioning Data Set Interchanges are advised to recount the received Commissioning Data Set messages and match this control count to ensure all Commissioning Data Set data submitted has been correctly received.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

**CDS INTERCHANGE CONTROL REFERENCE**

---

Change to Data Element: Changed Dataset, Description

| | |
|---|---|
| Format/Length: | max n7 |
| National Codes: | |
| Default Codes: | |

**Notes:**
CDS INTERCHANGE CONTROL REFERENCE is the same as attribute CDS INTERCHANGE CONTROL REFERENCE.

For each Interchange submitted, the CDS INTERCHANGE CONTROL REFERENCE must be incremented by 1. The maximum value supported is n7 and wrap around from 9999999 to 1 must be supported.

**Usage:**
CDS INTERCHANGE CONTROL REFERENCE is a mandatory data element when submitting Commissioning Data Set Interchanges and is used to uniquely identify and if required, to sequence check Commissioning Data Set submissions.

For Commissioning Data Sets 6-2, 6-2-1, 6-2-2 and 6-2-3, the XML schemas allow a maximum of an14 alphanumeric characters. This Format/Length was defined historically, but the Secondary Uses Service has always allowed a maximum of 7 numeric characters with a maximum value of 99999999. In Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements" this anomaly has been corrected. ~~Future XML schemas will be amended to carry the correct format/length of max n7.~~ From Commissioning Data Set version 6-3 onwards, the XML schema has been amended to carry the correct format/length of max n7.

This control reference data may also be presented on Secondary Uses Service (SUS) service messages and audit logs, etc.

**CDS XML Schema Interchanges:**
All CDS XML Schema interchanges submitted must contain a CDS INTERCHANGE CONTROL REFERENCE.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

**CDS INTERCHANGE DATE OF PREPARATION**

---

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |

| Default Codes: | |
|---|---|

**Notes:**
CDS INTERCHANGE DATE OF PREPARATION is the same as attribute EVENT DATE.

CDS INTERCHANGE DATE OF PREPARATION is the date when the Commissioning Data Set Interchange data was created.

**Usage:**
CDS INTERCHANGE DATE OF PREPARATION is a mandatory data element when submitting Commissioning data.

**CDS XML Schema Interchanges:**
All Commissioning Data Set XML Schema interchanges submitted must contain a CDS INTERCHANGE DATE OF PREPARATION.

---

#### CDS INTERCHANGE RECEIVER IDENTITY

---

Change to Data Element: Changed Dataset

| Format/Length: | min an1 max an15 |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
CDS INTERCHANGE RECEIVER IDENTITY is the same as attribute CDS INTERCHANGE RECEIVER IDENTITY.

**Usage:**
The collection facility for Commissioning data is the Secondary Uses Service.

**CDS XML Schema Interchanges:**
All Commissioning Data Set XML Schema interchanges submitted must contain the CDS INTERCHANGE RECEIVER IDENTITY of the Secondary Uses Service.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

#### CDS INTERCHANGE SENDER IDENTITY

---

Change to Data Element: Changed Dataset

| Format/Length: | min an1 max an15 |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
CDS INTERCHANGE SENDER IDENTITY is the same as attribute CDS INTERCHANGE SENDER IDENTITY.

**Usage:**
CDS INTERCHANGE SENDER IDENTITY is a mandatory data element when submitting Commissioning Data Set interchanges.
Every ORGANISATION must register its CDS INTERCHANGE SENDER IDENTITY for use with the Secondary Uses Service.

Where an ORGANISATION acts on behalf of another NHS ORGANISATION, care must be taken to ensure the correct use of the identity. For data submitted to the service, the CDS INTERCHANGE SENDER IDENTITY is the Electronic Data Interchange (EDI) address of the sending site.

**CDS XML Schema Interchanges:**
All Commissioning Data Set XML Schema interchanges submitted must contain a CDS INTERCHANGE SENDER IDENTITY.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

#### CDS INTERCHANGE TEST INDICATOR

---

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See CDS INTERCHANGE TEST INDICATOR |
| Default Codes: | |

**Notes:**
CDS INTERCHANGE TEST INDICATOR is the same as attribute CDS INTERCHANGE TEST INDICATOR.

**Usage:**
This optional test facility enables interchanges submitted to be marked and therefore processed as Test or Production data.

Whilst CDS INTERCHANGE TEST INDICATOR is optional it is highly recommended that correct values be completed in the data.

On receipt of a Test Interchange, the processes are as follows:

- All normal validation processes will be carried out
- The Interchange data will not be entered into the Secondary Uses Service database.

**CDS XML Schema Interchanges:**
All Commissioning Data Set XML Schema interchanges submitted may contain a CDS INTERCHANGE TEST INDICATOR.

---

#### CDS INTERCHANGE TIME OF PREPARATION

---

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | an8 HH:MM:SS |
| National Codes: | |
| Default Codes: | |

**Notes:**
CDS INTERCHANGE TIME OF PREPARATION is the same as attribute EVENT TIME.

CDS INTERCHANGE TIME OF PREPARATION is the time when the Commissioning Data Set Interchange data was created.

**Usage:**
CDS INTERCHANGE TIME OF PREPARATION is a mandatory data element when submitting Commissioning Data Set Interchanges.

**CDS XML Schema Interchanges:**
All Commissioning Data Set XML Schema interchanges submitted to the service must contain a CDS INTERCHANGE TIME OF PREPARATION.

---

#### CDS MESSAGE REFERENCE

---

Change to Data Element: Changed Dataset, Description

| Format/Length: | max n7 |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
CDS MESSAGE REFERENCE is the same as attribute CDS MESSAGE REFERENCE.

**Usage:**
Each message within an interchange the CDS MESSAGE REFERENCE is assigned to provide a unique identity (within an interchange).

For Commissioning Data Sets 6-2, 6-2-1, 6-2-2 and 6-2-3, the XML schemas allow a maximum of an14 alphanumeric characters. This Format/Length was defined historically, but the Secondary Uses Service has always allowed a maximum of 7 numeric characters with a maximum value of 99999999. In Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements" this anomaly has been corrected. ~~Future XML schemas will be amended to carry the correct format/length of max n7.~~ From Commissioning Data Set version 6-3 onwards, the XML schema has been amended to carry the correct format/length of max n7.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

**CDS MESSAGE TYPE**

---

Change to Data Element: Changed Dataset

| Format/Length: | an6 |
|---|---|
| National Codes: | See CDS MESSAGE TYPE |
| Default Codes: | |

**Notes:**
CDS MESSAGE TYPE is the same as attribute CDS MESSAGE TYPE.

**Usage:**
Commissioning Data Set XML Schema interchanges should only contain multiple message of the same CDS MESSAGE TYPE.

---

**CDS MESSAGE VERSION NUMBER**

---

Change to Data Element: Changed Dataset

| Format/Length: | an8 |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
CDS MESSAGE VERSION NUMBER is the same as attribute CDS MESSAGE VERSION NUMBER

**Usage:**
Interchanges must only contain Commissioning Data Set Messages of the same CDS MESSAGE VERSION NUMBER and each and every CDS Type must contain a CDS MESSAGE VERSION NUMBER.

---

**CDS PRIME RECIPIENT IDENTITY**

---

Change to Data Element: Changed Description

| Format/Length: | an3 or an5 |
|---|---|
| National Codes: | |
| Default Codes: | TDH00 - Overseas Visitor exempt from charges |

**Notes:**
CDS PRIME RECIPIENT IDENTITY is the same as attribute ORGANISATION CODE.

CDS PRIME RECIPIENT IDENTITY is the mandatory NHS ORGANISATION CODE (or valid Organisation Data Service Default Code) representing the ORGANISATION determined to be the Commissioning Data Set Prime Recipient of the Commissioning Data Set Message as indicated in the Commissioning Data Set Addressing Grid.

CDS PRIME RECIPIENT IDENTITY is only used in Commissioning Data Set version 6-2.

**Usage:**
~~The CDS PRIME RECIPIENT IDENTITY must be allocated on the first creation and submission of a CDS Type for a PATIENT and **must not change even if the ADDRESS or ORGANISATION CODE (RESIDENCE RESPONSIBILITY) of the PATIENT changes during the lifetime of the Commissioning Data Set record** otherwise duplicate Commissioning Data Set data may be lodged in the Secondary Uses Service database.~~For submissions of CDS Version 6-2, CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set Type 011 and CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set, the CDS PRIME RECIPIENT IDENTITY is Mandatory for submission in the CDS Type 005B - CDS Transaction Header Group - Bulk Update Protocol and CDS Type 005N - CDS Transaction Header Group - Net Change Protocol. However, it no longer forms part of the key for the process of determining duplicate records within the Secondary Uses Service. Note that the CDS PRIME RECIPIENT IDENTITY continues to be used to determine data access requirements within the Secondary Uses Service for Commissioning Data Set version 6-2 submissions.

~~CDS PRIME RECIPIENT IDENTITY is a mandatory data item crucial for the correct indexing of the database and must not be changed during the life of the associated Commissioning Data Set. It does not identify the first or most important recipient of data, i.e. there is no inference of primacy of one recipient over another.~~CDS PRIME RECIPIENT IDENTITY does not identify the first or most important recipient of data, i.e. there is no inference of primacy of one recipient over another.

Organisation Data Service Default Codes for CDS PRIME RECIPIENT IDENTITIES are detailed in the Commissioning Data Set Addressing Grid.

Please note that the following Organisation Data Service Default Codes must not be used in the Commissioning Data Set (CDS) header because they are not default Commissioner codes:

- Q99 - High Level Health Geography/Primary Care Organisation of Residence Not Known
  - for the CDS PRIME RECIPIENT IDENTITY, a valid ORGANISATION CODE (RESIDENCE RESPONSIBILITY) must be reported
- X98 - Primary Care Organisation Not Applicable (Overseas Visitors)
  - for the CDS PRIME RECIPIENT IDENTITY, the Commissioning Data Set Addressing Grid confirms the correct code that should be reported for Overseas Visitors who are exempt from charges.

**CDS PRIME RECIPIENT IDENTITY will be replaced with ORGANISATION IDENTIFIER (CDS RECIPIENT), which is the most recent approved national information standard to describe the required definition.**

---

**CDS PROTOCOL IDENTIFIER CODE**

Change to Data Element: Changed Dataset

| Format/Length: | an3 |
|---|---|
| National Codes: | See CDS PROTOCOL IDENTIFIER CODE |
| Default Codes: | |

**Notes:**
CDS PROTOCOL IDENTIFIER CODE is the same as attribute CDS PROTOCOL IDENTIFIER CODE.

---

**CDS RECORD IDENTIFIER**

---

Change to Data Element: Changed Dataset, Description

| Format/Length: | min an1 max an35 |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
CDS RECORD IDENTIFIER is the same as attribute RECORD IDENTIFIER.

CDS RECORD IDENTIFIER may also be referred to as the **CDS-RID**.

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.

The CDS RECORD IDENTIFIER consists of the following components:

| REF | RID COMPONENT | FORMAT | CODES / VALUES |
|---|---|---|---|
| ~~1~~ | ~~CDS SENDER IDENTITY/ORGANISATION IDENTIFIER (CDS SENDER)~~ | ~~an5~~ | ~~As generated in the CDS V6-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol or the CDS V6-2 Type 005N - CDS Transaction Header Group - Net Change Protocol~~<br>~~*Or*~~<br>~~As generated in the CDS V6-2-1 Type 005B - CDS Transaction Header Group - Bulk Update Protocol or the CDS V6-2-1 Type 005N - CDS Transaction Header Group - Net Change Protocol~~<br>~~*Or*~~<br>~~As generated in the CDS V6-2-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol or the CDS V6-2-2 Type 005N - CDS Transaction Header Group - Net Change Protocol~~<br>~~*Or*~~<br>~~As generated in the CDS V6-2-3 Type 005B - CDS Transaction Header Group - Bulk Update Protocol or CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol~~ |
| 1 | CDS SENDER IDENTITY/ORGANISATION IDENTIFIER (CDS SENDER) | an5 | As generated in the CDS V6-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol or the CDS V6-2 Type 005N - CDS Transaction Header Group - Net Change Protocol<br>*Or*<br>As generated in the CDS V6-2-1 Type 005B - CDS Transaction Header Group - Bulk Update Protocol or the CDS V6-2-1 Type 005N - CDS Transaction Header Group - Net Change Protocol<br>*Or*<br>As generated in the CDS V6-2-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol or the CDS V6-2-2 Type 005N - CDS Transaction Header Group - Net Change Protocol<br>*Or*<br>As generated in the CDS V6-3 Type 005B - Commissioning |

| | | | Data Set Transaction Header Group - Bulk Update Protocol or CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol |
|---|---|---|---|
| 2 | Not Used | an2 | Set = Blank |
| ~~3~~ | ~~CDS INTERCHANGE CONTROL REFERENCE~~ | ~~max n7~~ | ~~As generated in the CDS V6-2 Type 001 - CDS Interchange Header~~ |
| ~~4~~ | ~~CDS MESSAGE REFERENCE~~ | ~~max n7~~ | ~~As generated in the CDS V6-2 Type 003 - CDS Message Header~~ |
| 3 | CDS INTERCHANGE CONTROL REFERENCE | max n7 | As generated in the CDS V6-2 Type 001 - CDS Interchange Header or CDS V6-3 Type 001 - CDS Interchange Header |
| 4 | CDS MESSAGE REFERENCE | max n7 | As generated in the CDS V6-2 Type 003 - CDS Message Header or CDS V6-3 Type 003 - CDS Message Header |

**Usage:**

The CDS-RID is an optional reference assigned to each record by the Commissioning Data Set sender to aid the identification and cross-referencing of data between the sender and the receiver(s) of the Commissioning Data Set data.

**CDS XML Schema Interchanges:**

~~The CDS-RID data element is carried in the CDS Message Header (CDS V6-2 Type 003 - CDS Message Header).~~The CDS-RID data element is carried in the CDS Message Header (CDS V6-2 Type 003 - CDS Message Header /CDS V6-2-1 Type 003 - CDS Message Header /CDS V6-2-2 Type 003 - CDS Message Header /CDS V6-2-3 Type 003 - CDS Message Header /CDS V6-3 Type 003 - CDS Message Header).

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

**CDS REPORT PERIOD END DATE**

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
CDS REPORT PERIOD END DATE is the same as attribute EVENT DATE.

CDS REPORT PERIOD END DATE defines the End Date (for the date range of the data being exchanged) for the Commissioning Data Set Bulk Replacement Update time period.

**Usage:**
CDS REPORT PERIOD END DATE is a mandatory data item when the Commissioning Data Set Bulk Replacement Update Mechanism is used. It is not required when the Commissioning Data Set Net Change Update Mechanism is used.
The CDS REPORT PERIOD END DATE must be a valid date and must not be before the CDS REPORT PERIOD START DATE.

See the supporting information in the Commissioning Data Set Submission Protocol for further details.

**CDS REPORT PERIOD START DATE**

Change to Data Element: Changed Dataset

| Format/Length: | an10 CCYY-MM-DD |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
CDS REPORT PERIOD START DATE is the same as attribute EVENT DATE.

CDS REPORT PERIOD START DATE defines the Start Date (for the date range of the data being exchanged) for the Bulk Replacement Update time period.

**Usage:**
CDS REPORT PERIOD START DATE is a mandatory data item when the Commissioning Data Set Bulk Replacement Update Mechanism is used. It is not required when the Commissioning Data Set Net Change Update Mechanism is used.
The CDS REPORT PERIOD START DATE must be a valid date and cannot be after the CDS REPORT PERIOD END DATE.

See the supporting information in the Commissioning Data Set Submission Protocol for further details.

---

**CDS TYPE CODE**

---

Change to Data Element: Changed Dataset

| Format/Length: | an3 |
|---|---|
| National Codes: | See CDS TYPE CODE |
| Default Codes: | |

**Notes:**
CDS TYPE CODE is the same as attribute CDS TYPE CODE.

For specific National Code usage in different data sets, see CDS TYPE CODE.

---

**CDS UNIQUE IDENTIFIER**

---

Change to Data Element: Changed Dataset, Description

| Format/Length: | min an1 max an35 |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
CDS UNIQUE IDENTIFIER is the same as attribute RECORD IDENTIFIER.

CDS UNIQUE IDENTIFIER provides a unique identity for the life-time of an episode carried in a Commissioning Data Set message.

Note that the CDS UNIQUE IDENTIFIER must be constructed without the use of PATIENT Confidential Information. ~~This includes PATIENT Identifiers such as NHS NUMBER or LOCAL PATIENT IDENTIFIER, as well as any text which may identify the PATIENT DIAGNOSIS of the PATIENT or any PATIENT procedures being undertaken.~~ This includes PATIENT Identifiers such as NHS NUMBER or LOCAL PATIENT IDENTIFIER (EXTENDED), as well as any text which may identify the PATIENT DIAGNOSIS of the PATIENT or any PATIENT procedures being undertaken.

See the Commissioning Data Set Submission Protocol for detailed information.

**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.**

The CDS UNIQUE IDENTIFIER has three components. The recommended constructs are given below.

**For All CDS Types EXCEPT the EAL CDS Types:**

| REF | UID | FORMAT | CODES / VALUES | COMMENT |
|---|---|---|---|---|
| 1 | **NHS Organisation Code Type** | an1 | A = Pre 1996 ORGANISATION CODE<br>B = Post 1996 NHS ORGANISATION CODE / ORGANISATION IDENTIFIER | Mandatory For all CDS Types |
| 2 | **Provider Code** | an5 | The NHS ORGANISATION CODE / ORGANISATION IDENTIFIER of the Provider at the time of, or at the start of, the period covered by the activity reported by the CDS Message. | Mandatory for all CDS Types |
| 3a | **Application Specific CDS Identity** | an29 | A code of up to **29 alpha-numeric characters** generated by the Sender's application to uniquely identify the CDS within its CDS Type or family of CDS Types | Mandatory for all CDS Types<br>**Except for EAL CDS Types** |

**~~For EAL End Of Period (EOP) CDS Types only:~~For EAL End Of Period (EOP) CDS Types only (CDS 6-2 only):**

| REF | UID | FORMAT | CODES / VALUES | COMMENT |
|---|---|---|---|---|
| 1 | **NHS Organisation Code Type** | an1 | A = Pre 1996 ORGANISATION CODE<br>B = Post 1996 NHS ORGANISATION CODE / ORGANISATION IDENTIFIER | Mandatory For all CDS Types |
| 2 | **Provider Code** | an5 | The NHS ORGANISATION CODE / ORGANISATION IDENTIFIER of the Provider at the time of, or at the start of, the period covered by the activity reported by the CDS Message. | Mandatory for all CDS Types |
| 3b | **Application Specific CDS Identity** | an9 | A code of up to **9 alpha-numeric characters** generated by the Sender's application to uniquely identify the EAL End Of period census CDS Types with the same Admission List Entry. Additional data positions must be left blank. | **Mandatory for all EAL EOP CDS Types** |
| 3c | **Filler** | an20 | Additional data positions must be left blank. | |

**~~For EAL Event During Period (EDP) CDS Types only:~~For EAL Event During Period (EDP) CDS Types only (CDS 6-2 only):**

| REF | UID | FORMAT | CODES / VALUES | COMMENT |
|---|---|---|---|---|
| 1 | **NHS Organisation Code Type** | an1 | A = Pre 1996 ORGANISATION CODE<br>B = Post 1996 NHS ORGANISATION CODE / ORGANISATION IDENTIFIER | **Mandatory For all CDS Types** |
| 2 | **Provider Code** | an5 | The NHS ORGANISATION CODE / ORGANISATION IDENTIFIER of the Provider at the time of, or at the start | **Mandatory for all CDS Types** |

| | | | of, the period covered by the activity reported by the CDS Message. | |
|---|---|---|---|---|
| 3d | **Application Specific CDS Identity** | an9 | A code of up to **5 alpha-numeric characters padded with 4 trailing spaces to 9 characters**. Generated by the Sender's application to uniquely identify the EAL Event During Period Census CDS Types with the same Admission List Entry. | **Mandatory for all EAL EDP CDS Types** |
| 3e | **Filler** | an3 | A code of **3 alpha-numeric characters** generated by the Sender's application to identify **the event** within the EAL Entry. Even if the events are of different types, they must have different identifiers. | **Mandatory for all EAL EDP CDS Types** |
| 3f | **Filler** | an17 | Additional data positions must be left blank. | |

**Usage:**
~~CDS UNIQUE IDENTIFIER is a mandatory data item when the Net Change Update Mechanism is used and strongly recommended for use with the Bulk Replacement Update Mechanism.~~

***~~However it is strongly advised that users of the Bulk Replacement Mechanism maintain a correctly generated CDS UNIQUE IDENTIFIER within the Commissioning data.~~***CDS UNIQUE IDENTIFIER is a mandatory data item when the Net Change Update Mechanism is used. ***It is strongly advised that users of the Bulk Replacement Mechanism maintain a correctly generated CDS UNIQUE IDENTIFIER within the Commissioning Data Set data. This will establish a migration path towards the use of the Net Change Mechanism and will also then minimise the risk of creating duplicate Commissioning Data Set data in the Secondary Uses Service database.***

- Note that senders of Commissioning Data Set data remain directly responsible for the integrity of the CDS UNIQUE IDENTIFIER
- It is a mandatory requirement for all submissions using the Net Change Update Mechanism that these two components are constructed correctly to ensure uniqueness of CDS UNIQUE IDENTIFIERS across the NHS.
- ~~The structure of 3b and 3c allows the EAL End of Period Census and the EAL Event During Period Census for the same EAL Entry to be linked.~~
- The structure of 3b and 3c allows the EAL End of Period Census and the EAL Event During Period Census for the same EAL Entry to be linked (CDS 6-2 only).

There are circumstances in patient care application systems where the control of the UID key integrity may be suspect. These issues include:

a) Episode deletion (not resulting in a Commissioning Data Set deletion of previously submitted data sent to the original Commissioner);
b) Episode re-sequencing (not resulting in a corresponding Commissioning Data Set records being sent);
c) Service agreement alterations not resulting in correct adjustments - Old Service Agreement deletion / New Service Agreement addition
d) Re-admissions causing duplicate keys on the Secondary Uses Service database.

Each use of an NHS ORGANISATION CODE within a Commissioning Data Set message must be associated with the release version of the NHS Organisation Code scheme. At present this may be derived locally by NHS IT systems.

The following values have been informally used in many Commissioning Data Set implementations and are recommended to be used:

| | |
|---|---|
| A or O* | Signifying "OLD" (pre-April 1996) to denote an ORGANISATION CODE issued before, and in use up to the 1996 major re-issue |
| B or N* | Signifying "NEW" (post-April 1996) to denote an ORGANISATION CODE / ORGANISATION IDENTIFIER issued from April 1996 |

* The values of **A and B** must be used in the formatting of the CDS UNIQUE IDENTIFIER.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

#### CDS UPDATE TYPE

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See CDS UPDATE TYPE |
| Default Codes: | |

**Notes:**
CDS UPDATE TYPE is the same as attribute CDS UPDATE TYPE.

**Usage:**
CDS UPDATE TYPE is a mandatory data item when using the Net Change Update Mechanism. It is not required when using the Bulk Replacement Update Mechanism.

#### CLINIC CODE

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | max an12 |
| National Codes: | |
| Default Codes: | |

**Notes:**
CLINIC CODE is the same as attribute CLINIC OR FACILITY CODE.

For Commissioning Data Set version 6-2, CLINIC CODE identifies the CLINIC OR FACILITY where an Out-Patient Appointment took place.

CLINIC CODE is an optional item in the Commissioning Data Set version 6-2, and is for local use only. However it must NOT contain any text which may identify the PATIENT DIAGNOSIS of the PATIENTS using the CLINIC OR FACILITY (for example, it must not include the acronym 'HIV') or the Patient Procedure being undertaken (for example using the acronym 'TOP' for terminations of pregnancy). Use of such identifiers contravenes the legal requirements for withholding identifiable information about PATIENTS with identified conditions. See Security Issues and Patient Confidentiality for further details.

#### CODED CLINICAL ENTRY SEQUENCE NUMBER

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | min n1 max n5 |
| National Codes: | |
| Default Codes: | |

**Notes:**
CODED CLINICAL ENTRY SEQUENCE NUMBER is the same as attribute CODED CLINICAL ENTRY SEQUENCE NUMBER.

#### CODED DIAGNOSIS TIMESTAMP

Change to Data Element: Changed Dataset

| Format/Length: | max an25 |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
CODED DIAGNOSIS TIMESTAMP is the same as attribute PERSON PROPERTY OBSERVED DATE and PERSON PROPERTY OBSERVED TIME for the PATIENT DIAGNOSIS.

~~**This item is being used for development purposes and has not yet been approved.**~~CODED DIAGNOSIS TIMESTAMP is the date, time and time zone that the PATIENT DIAGNOSIS was observed by a CARE PROFESSIONAL.

A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time.

In most cases offset time is restricted to:

- +01:00
- +00:00
- -00:00

Examples of valid formats are:

- 2020-08-21T10:15:20+01:00 British Summer Time (GMT + 1 Hour)
- 2020-08-21T10:15:20+00:00 Greenwich Mean Time
- 2020-08-21T10:15:20-00:00 Greenwich Mean Time
- 2020-08-21T09:18:00Z Greenwich Mean Time.

---

**CODED FINDING TIMESTAMP**

Change to Data Element: Changed Dataset

| Format/Length: | max an25 |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
CODED FINDING TIMESTAMP is the same as attribute PERSON PROPERTY RECORDED DATE and PERSON PROPERTY RECORDED TIME.

CODED FINDING TIMESTAMP is the date, time and time zone that the Clinical Finding was recorded by a CARE PROFESSIONAL.

A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time.

In most cases offset time is restricted to:

- +01:00
- +00:00
- -00:00

Examples of valid formats are:

- 2020-08-21T10:15:20+01:00 British Summer Time (GMT + 1 Hour)
- 2020-08-21T10:15:20+00:00 Greenwich Mean Time
- 2020-08-21T10:15:20-00:00 Greenwich Mean Time
- 2020-08-21T09:18:00Z Greenwich Mean Time.

#### CODED OBSERVATION TIMESTAMP

Change to Data Element: Changed Dataset

| Format/Length: | max an25 |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
CODED OBSERVATION TIMESTAMP is the same as attribute PERSON PROPERTY RECORDED DATE and PERSON PROPERTY RECORDED TIME.

CODED OBSERVATION TIMESTAMP is the date, time and time zone that the Observable Entity was recorded by a CARE PROFESSIONAL.

A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time.

In most cases offset time is restricted to:

- +01:00
- +00:00
- -00:00

Examples of valid formats are:

- 2020-08-21T10:15:20+01:00 British Summer Time (GMT + 1 Hour)
- 2020-08-21T10:15:20+00:00 Greenwich Mean Time
- 2020-08-21T10:15:20-00:00 Greenwich Mean Time
- 2020-08-21T09:18:00Z Greenwich Mean Time.

#### CODED PROCEDURE TIMESTAMP

Change to Data Element: Changed Dataset

| Format/Length: | max an25 |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
CODED PROCEDURE TIMESTAMP is the same as attribute ACTIVITY DATE and ACTIVITY TIME where the ACTIVITY DATE TYPE and ACTIVITY TIME TYPE is National Code '*Procedure Date*' and '*Procedure Time*'.

~~**This item is being used for development purposes and has not yet been approved.**~~CODED PROCEDURE TIMESTAMP is the date, time and time zone that the Patient Procedure was performed by a CARE PROFESSIONAL.

A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time.

In most cases offset time is restricted to:

- +01:00
- +00:00
- -00:00

Examples of valid formats are:

- 2020-08-21T10:15:20+01:00 British Summer Time (GMT + 1 Hour)
- 2020-08-21T10:15:20+00:00 Greenwich Mean Time
- 2020-08-21T10:15:20-00:00 Greenwich Mean Time
- 2020-08-21T09:18:00Z Greenwich Mean Time.

---

**COMMISSIONER REFERENCE IDENTIFIER**

---

Change to Data Element: New Data Element

| | |
|---|---|
| Format/Length: | max an20 |
| National Codes: | |
| Default Codes: | 8 - Not Applicable<br>9 - COMMISSIONER REFERENCE IDENTIFIER not known |

**Notes:**
COMMISSIONER REFERENCE IDENTIFIER is the same as attribute COMMISSIONER REFERENCE IDENTIFIER.

**COMMISSIONER REFERENCE NUMBER will be replaced with COMMISSIONER REFERENCE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | COMMISSIONER REFERENCE IDENTIFIERS |

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**COMMISSIONER REFERENCE IDENTIFIER**

---

Change to Data Element: New Data Element

## COMMISSIONER REFERENCE IDENTIFIER

**Attribute:**

| COMMISSIONER REFERENCE IDENTIFIER |
|---|

---

**COMMISSIONER REFERENCE NUMBER**

---

Change to Data Element: Changed Description, linked Attribute

| | |
|---|---|
| Format/Length: | max an17 |
| National Codes: | |
| Default Codes: | 8 - Not applicable<br>9 - COMMISSIONER REFERENCE NUMBER not known |

**Notes:**
COMMISSIONER REFERENCE NUMBER is the same as attribute COMMISSIONER REFERENCE NUMBER.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

**COMMISSIONER REFERENCE NUMBER will be replaced with COMMISSIONER REFERENCE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.**

#### COMMISSIONER REFERENCE NUMBER

Change to Data Element: Changed Description, linked Attribute

## COMMISSIONER REFERENCE NUMBER

**Attribute:**

| COMMISSIONER REFERENCE NUMBER |
|---|

#### COMMISSIONING SERIAL NUMBER

Change to Data Element: Changed Description

| | |
|---|---|
| Format/Length: | max an6 |
| National Codes: | |
| Default Codes: | |

**Notes:**
COMMISSIONING SERIAL NUMBER is the same as attribute NHS SERVICE AGREEMENT NUMBER.

From 01/04/2001 this data item will be used to identify PATIENTS treated under Non-Contract Activities. NHS Trusts and NHS Foundation Trusts are required to insert the letters 'OAT' (mandated input as capitals) in the first three characters of the COMMISSIONING SERIAL NUMBER field of the Admitted Patient Care Commissioning Data Set. The remaining three characters will continue to be defined locally, see DSCN 17/2000.

From 01/04/2005 an '=' (equals) as the last significant character in this six character field will indicate an episode that should be excluded from the National Tariff Payment System tariff.

The position of the last character depends on any preceding characters eg 1st character if field is otherwise blank, 4th character if following 'OAT', up to a maximum of 6th position. This provides a general exclusion facility for unusual circumstances or where more specific rules regarding coding in other fields cannot be implemented due to local software restrictions.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

**COMMISSIONING SERIAL NUMBER will be replaced with NHS SERVICE AGREEMENT IDENTIFIER, which is the most recent approved national information standard to describe the required definition.**

#### COMORBIDITY (SNOMED CT EXPRESSION)

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | See SNOMED CT EXPRESSION |
| National Codes: | |
| Default Codes: | |

**Notes:**
**COMORBIDITY (SNOMED CT EXPRESSION) is the same as attribute CLINICAL TERMINOLOGY CODE.**

~~**This item is being used for development purposes and has not yet been approved.**~~**COMORBIDITY (SNOMED CT EXPRESSION) is a structured combination of one or more SNOMED CT® concept identifiers which are used to describe a comorbid condition for a PERSON.**

**A SNOMED CT Refset describing comorbid conditions is available for reference purposes if required; but COMORBIDITY (SNOMED CT EXPRESSION) is not limited to the use of these concepts.**

**SNOMED CT Refset Metadata:**

- Refset FSN: Comorbid conditions for selection simple reference set (foundation metadata concept)
- Refset Id: 991381000000107

For further details relating to the SNOMED CT Refset Metadata, see the Data Dictionary for Care (DD4C) website at: Comorbid conditions for selection.

For further information on SNOMED CT EXPRESSIONS, see the SNOMED CT® Glossary at: Expression.

---

**CONSULTATION MECHANISM**

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See CONSULTATION MECHANISM |
| Default Codes: | |

**Notes:**
**CONSULTATION MECHANISM is the same as attribute CONSULTATION MECHANISM.**

**CONSULTATION MEDIUM USED will be replaced with CONSULTATION MECHANISM, which is the most recent approved national information standard to describe the required definition.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | CONSULTATION MECHANISMS |

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**CONSULTATION MECHANISM**

**Change to Data Element: New Data Element**

## CONSULTATION MECHANISM

**Attribute:**

| CONSULTATION MECHANISM |
|---|

---

**CONSULTATION MEDIUM USED**

**Change to Data Element: Changed Description**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See CONSULTATION MEDIUM USED |
| Default Codes: | |

**Notes:**
**CONSULTATION MEDIUM USED is the same as attribute CONSULTATION MEDIUM USED.**

**For specific National Code usage in different data sets, see CONSULTATION MEDIUM USED.**

**CONSULTATION MEDIUM USED will be replaced with CONSULTATION MECHANISM, which is the most recent approved national information standard to describe the required definition.**

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#### CONSULTATION TYPE

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See CONSULTATION TYPE |
| Default Codes: | |

**Notes:**
**CONSULTATION TYPE is the same as attribute CONSULTATION TYPE.**

#### CRITICAL CARE ACTIVITY CODE

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See CRITICAL CARE ACTIVITY CODE |
| Default Codes: | |

**Notes:**
**CRITICAL CARE ACTIVITY CODE is the same as attribute CRITICAL CARE ACTIVITY CODE.**

**For specific National Code usage in different data sets, see CRITICAL CARE ACTIVITY CODE.**

#### CRITICAL CARE ADMISSION SOURCE

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See CRITICAL CARE ADMISSION SOURCE |
| Default Codes: | |

**Notes:**
**CRITICAL CARE ADMISSION SOURCE is the same as attribute CRITICAL CARE ADMISSION SOURCE.**

#### CRITICAL CARE ADMISSION TYPE

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See CRITICAL CARE ADMISSION TYPE |
| Default Codes: | |

**Notes:**
**CRITICAL CARE ADMISSION TYPE is the same as attribute CRITICAL CARE ADMISSION TYPE.**

#### CRITICAL CARE DISCHARGE DATE

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
**CRITICAL CARE DISCHARGE DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'End Date'* for the CRITICAL CARE PERIOD.**

**CRITICAL CARE DISCHARGE DATE may be the:**

- **date the PATIENT is discharged from the critical care unit**
- **date the PATIENT died or**
- **date of declaration of brainstem death.**

**CRITICAL CARE DISCHARGE DATE is used by the Secondary Uses Service to derive the Healthcare Resource Group 4. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.**

**For further information, please refer to the NHS Digital website at: Payment by Results Guidance.**

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#### CRITICAL CARE DISCHARGE DESTINATION

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**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See CRITICAL CARE DISCHARGE DESTINATION |
| Default Codes: | |

**Notes:**
**CRITICAL CARE DISCHARGE DESTINATION is the same as attribute CRITICAL CARE DISCHARGE DESTINATION.**

**Note: the Format/Length has been updated. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.**

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#### CRITICAL CARE DISCHARGE LOCATION

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**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See CRITICAL CARE DISCHARGE LOCATION |
| Default Codes: | |

**Notes:**
**CRITICAL CARE DISCHARGE LOCATION is the same as attribute CRITICAL CARE DISCHARGE LOCATION.**

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#### CRITICAL CARE DISCHARGE READY DATE

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
**CRITICAL CARE DISCHARGE READY DATE is the same as attribute CRITICAL CARE DISCHARGE READY DATE.**

---

#### CRITICAL CARE DISCHARGE READY TIME

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an8 HH:MM:SS |
| National Codes: | |
| Default Codes: | |

**Notes:**
**CRITICAL CARE DISCHARGE READY TIME is the same as attribute CRITICAL CARE DISCHARGE READY TIME.**

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#### CRITICAL CARE DISCHARGE STATUS

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an2 |

| | |
|---|---|
| National Codes: | See CRITICAL CARE DISCHARGE STATUS |
| Default Codes: | |

**Notes:**
**CRITICAL CARE DISCHARGE STATUS is the same as attribute CRITICAL CARE DISCHARGE STATUS.**

#### CRITICAL CARE DISCHARGE TIME

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an8 HH:MM:SS |
| National Codes: | |
| Default Codes: | |

**Notes:**
**CRITICAL CARE DISCHARGE TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*End Time*' for the CRITICAL CARE PERIOD.**

#### CRITICAL CARE LEVEL

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See CRITICAL CARE LEVEL |
| Default Codes: | |

**Notes:**
**CRITICAL CARE LEVEL is the same as attribute CRITICAL CARE LEVEL.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | CRITICAL CARE LEVELS |

#### CRITICAL CARE LEVEL

**Change to Data Element: New Data Element**

## CRITICAL CARE LEVEL

**Attribute:**

| CRITICAL CARE LEVEL |
|---|

#### CRITICAL CARE LEVEL 2 DAYS

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an3 |
| National Codes: | |
| Default Codes: | 998 - 998 or more level 2 days |
| | 999 - Level 2 days occurred but day count not known |

**Notes:**
**CRITICAL CARE LEVEL 2 DAYS is the same as attribute ACTIVITY DURATION.**

**CRITICAL CARE LEVEL 2 DAYS is the total number of days a PATIENT received level 2 care during a CRITICAL CARE PERIOD, ranging from 0 to 997 days.**

CRITICAL CARE LEVEL 2 DAYS 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 *'Level 2'* within the CRITICAL CARE PERIOD.

CRITICAL CARE LEVEL 2 DAYS is used by the Secondary Uses Service to derive the **Healthcare Resource Group** 4. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

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### CRITICAL CARE LEVEL 3 DAYS

---

Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | max an3 |
| National Codes: | |
| Default Codes: | 998 - 998 or more level 3 days |
| | 999 - Level 3 days occurred but day count not known |

**Notes:**
CRITICAL CARE LEVEL 3 DAYS is the same as attribute ACTIVITY DURATION.

CRITICAL CARE LEVEL 3 DAYS is the total number of days a PATIENT received level 3 care during a CRITICAL CARE PERIOD, ranging from 0 to 997 days.

CRITICAL CARE LEVEL 3 DAYS 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 *'Level 3'* within the CRITICAL CARE PERIOD.

CRITICAL CARE LEVEL 3 DAYS is used by the Secondary Uses Service to derive the **Healthcare Resource Group** 4. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

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### CRITICAL CARE LOCAL IDENTIFIER

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Change to Data Element: Changed Dataset

| | |
|---|---|
| Format/Length: | max an8 |
| National Codes: | |
| Default Codes: | |

**Notes:**
CRITICAL CARE LOCAL IDENTIFIER is the same as attribute ACTIVITY IDENTIFIER.

CRITICAL CARE LOCAL IDENTIFIER is a unique local ACTIVITY IDENTIFIER used to identify the start of CARE ACTIVITY within a CRITICAL CARE PERIOD.

**CRITICAL CARE LOCAL IDENTIFIER 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.**

**Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.**

### CRITICAL CARE SOURCE LOCATION

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See CRITICAL CARE SOURCE LOCATION |
| Default Codes: | |

**Notes:**
**CRITICAL CARE SOURCE LOCATION is the same as attribute CRITICAL CARE SOURCE LOCATION .**

### CRITICAL CARE START DATE

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
**CRITICAL CARE START DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the CRITICAL CARE PERIOD.**

**CRITICAL CARE START DATE is used by the Secondary Uses Service to derive the Healthcare Resource Group 4. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.**

**For further information, please refer to the NHS Digital website at: Payment by Results Guidance.**

### CRITICAL CARE START TIME

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an8 HH:MM:SS |
| National Codes: | |
| Default Codes: | |

**Notes:**
**CRITICAL CARE START TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Start Time*' for the CRITICAL CARE PERIOD.**

### CRITICAL CARE UNIT BED CONFIGURATION

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See UNIT BED CONFIGURATION |
| Default Codes: | |

**Notes:**
**CRITICAL CARE UNIT BED CONFIGURATION is the same as attribute UNIT BED CONFIGURATION.**

#### CRITICAL CARE UNIT FUNCTION

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See CRITICAL CARE UNIT FUNCTION |
| Default Codes: | |

**Notes:**
**CRITICAL CARE UNIT FUNCTION is the same as attribute CRITICAL CARE UNIT FUNCTION.**

**The National Codes for non standard locations may be recorded where the delivery of care is CRITICAL CARE LEVEL National Code 02 *'Level 2'* or 03 '*level 3'* and the duration of care is greater than four hours.**

**CRITICAL CARE UNIT FUNCTION is used by the Secondary Uses Service to derive the Healthcare Resource Group 4. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.**

**For further information, please refer to the NHS Digital website at: Payment by Results Guidance.**

#### DATA ABSENT REASON (FHIR R4)

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | max an20 |
| National Codes: | |
| Default Codes: | |

**Notes:**
**DATA ABSENT REASON (FHIR R4) is the same as attribute DATA ABSENT REASON.**

**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.**

**The FHIR Release 4 Value Set codes can be accessed from the HL7 FHIR website at: data-absent-reason.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | DATA ABSENT REASONS (FHIR R4) |

#### DATA ABSENT REASON (FHIR R4)

**Change to Data Element: New Data Element**

## DATA ABSENT REASON (FHIR R4)

**Attribute:**

| DATA ABSENT REASON |
|---|

#### DECIDED TO ADMIT DATE

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |

| Default Codes: | |
|---|---|

**Notes:**
**DECIDED TO ADMIT DATE is the same as attribute DECIDED TO ADMIT DATE.**

**DECIDED TO ADMIT DATE may be the same as the date of admission (e.g. most emergency admissions). Alternatively, a decision can be made to admit at a future date. This decision denotes that the PATIENT is intended to be admitted to a Hospital Bed, either immediately or subsequently in the future. It records the event that a clinical DECISION TO ADMIT a PATIENT to a Hospital Bed has been made by or on behalf of someone, who has the right of admission to a Hospital Provider.**

**The date will be different from the ORIGINAL DECIDED TO ADMIT DATE when the PATIENT has been transferred from another provider's list, or when the PATIENT has been admitted to hospital, discharged but not treated and is again placed on an ELECTIVE ADMISSION LIST with a new DECISION TO ADMIT.**

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#### DELIVERY METHOD CODE

---

**Change to Data Element: Changed Dataset**

| Format/Length: | an1 |
|---|---|
| National Codes: | See DELIVERY METHOD |
| Default Codes: | |

**Notes:**
**DELIVERY METHOD CODE is the same as attribute DELIVERY METHOD.**

**Additional National Code guidance not contained in the attribute definition is given below. It is shown in *italics*.**

- 0 Spontaneous vertex *(normal vaginal Delivery, occipitoanterior)*
- 1 Spontaneous other cephalic *(cephalic vaginal Delivery with abnormal presentation of head at Delivery, without instruments, with or without manipulation)*
- 2 Low forceps, not breech *(e.g. forceps, low application, without manipulation. Includes forceps Delivery not otherwise specified)*
- 3 Other forceps, not breech *(e.g. forceps with manipulation. Includes high forceps and mid forceps)*
- 4 Ventouse, vacuum extraction
- 5 Breech *(spontaneous Delivery assisted or unspecified. Includes partial breech extraction)*
- 6 Breech extraction (*not otherwise specified. Includes total breech extraction and version with breech extraction*)
- 7 Elective caesarean section (*caesarean section before, or at onset of, Labour*)
- 8 Emergency caesarean section
- 9 Other than those specified above *(e.g. application of weight to leg in breech Delivery. Includes destructive operation to facilitate Delivery and other surgical or instrumental Delivery)*

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#### DELIVERY PLACE CHANGE REASON CODE

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**Change to Data Element: Changed Dataset**

| Format/Length: | an1 |
|---|---|
| National Codes: | See DELIVERY PLACE CHANGE REASON |
| Default Codes: | 8 - Not applicable (i.e. no change)<br>9 - DELIVERY PLACE CHANGE REASON not known |

**Notes:**
**DELIVERY PLACE CHANGE REASON CODE is the same as attribute DELIVERY PLACE CHANGE REASON.**

Note: the Default Code description for 9 - Not known has been updated. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

#### DELIVERY PLACE TYPE CODE (ACTUAL)

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See ACTUAL DELIVERY PLACE |
| Default Codes: | |

**Notes:**
**DELIVERY PLACE TYPE CODE (ACTUAL) is the same as attribute ACTUAL DELIVERY PLACE.**

#### DELIVERY PLACE TYPE CODE (INTENDED)

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See INTENDED DELIVERY PLACE |
| Default Codes: | |

**Notes:**
**DELIVERY PLACE TYPE CODE (INTENDED) is the same as attribute INTENDED DELIVERY PLACE.**

#### DELIVERY TIMESTAMP

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an25 |
| National Codes: | |
| Default Codes: | |

**Notes:**
**DELIVERY TIMESTAMP is the same as attribute PERSON BIRTH DATE and PERSON BIRTH TIME.**

**~~This item is being used for development purposes and has not yet been approved.~~DELIVERY TIMESTAMP is the date, time and time zone of delivery for each REGISTRABLE BIRTH.**

**A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time.**

**In most cases offset time is restricted to:**

- **+01:00**
- **+00:00**
- **-00:00**

**Examples of valid formats are:**

- **2020-08-21T10:15:20+01:00 British Summer Time (GMT + 1 Hour)**
- **2020-08-21T10:15:20+00:00 Greenwich Mean Time**
- **2020-08-21T10:15:20-00:00 Greenwich Mean Time**
- **2020-08-21T09:18:00Z Greenwich Mean Time.**

#### DERMATOLOGICAL SUPPORT DAYS

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an3 |
| National Codes: | |
| Default Codes: | 998 - 998 or more days of dermatological support<br>999 - Occurred but day count not known |

**Notes:**
**DERMATOLOGICAL SUPPORT DAYS is the same as attribute ACTIVITY DURATION.**

**DERMATOLOGICAL SUPPORT DAYS is the total number of days that the PATIENT received dermatological system support during a CRITICAL CARE PERIOD, ranging from 0 to 997 days.**

**DERMATOLOGICAL SUPPORT DAYS 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 '*Dermatological Support'* within the CRITICAL CARE PERIOD.**

**DERMATOLOGICAL SUPPORT DAYS is used by the Secondary Uses Service to derive the Healthcare Resource Group 4. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.**

**For further information, please refer to the NHS Digital website at: Payment by Results Guidance.**

**Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.**

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#### DESTINATION OF DISCHARGE (HOSPITAL PROVIDER SPELL)

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See DESTINATION OF DISCHARGE |
| Default Codes: | 98 - Not applicable - Hospital Provider Spell not finished at episode end (i.e. not discharged) or current episode unfinished<br>99 - DESTINATION OF DISCHARGE not known |

**Notes:**
**DESTINATION OF DISCHARGE (HOSPITAL PROVIDER SPELL) is the same as attribute DESTINATION OF DISCHARGE.**

**~~This item is being used for development purposes and has not yet been approved.~~DESTINATION OF DISCHARGE (HOSPITAL PROVIDER SPELL) is used by the Secondary Uses Service to derive the Healthcare Resource Group 4. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.**

**For further information, please refer to the NHS Digital website at: Payment by Results Guidance.**

**DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL) will be replaced with DESTINATION OF DISCHARGE (HOSPITAL PROVIDER SPELL), which is the most recent approved national information standard to describe the required definition.**

---

#### DIAGNOSIS (SNOMED CT EXPRESSION)

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | See SNOMED CT EXPRESSION |

| | |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
**DIAGNOSIS (SNOMED CT EXPRESSION) is the same as attribute CLINICAL TERMINOLOGY CODE.**

**~~This item is being used for development purposes and has not yet been approved.~~DIAGNOSIS (SNOMED CT EXPRESSION) is a structured combination of one or more SNOMED CT® concept identifiers which are used to describe a PATIENT DIAGNOSIS.**

**For further information on SNOMED CT EXPRESSIONS, see the SNOMED CT® Glossary at: Expression.**

---

#### DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET)

---

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See DIAGNOSIS SCHEME IN USE |
| Default Codes: | |

**Notes:**
**DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET) is the same as attribute DIAGNOSIS SCHEME IN USE for the Commissioning Data Sets.**

***Permitted National Codes:***

| | |
|---|---|
| 02 | ICD-10 |

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | DIAGNOSIS SCHEMES IN USE (COMMISSIONING DATA SET) |

---

#### DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET)

---

**Change to Data Element: New Data Element**

## DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET)

**Attribute:**

| DIAGNOSIS SCHEME IN USE |
|---|

---

#### DIRECT ACCESS REFERRAL INDICATOR

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See DIRECT ACCESS REFERRAL INDICATOR |
| Default Codes: | 9 - Not known whether the PATIENT was referred to a Direct Access Service |

**Notes:**
**DIRECT ACCESS REFERRAL INDICATOR is the same as attribute DIRECT ACCESS REFERRAL INDICATOR.**

---

#### DISCHARGE DATE (HOSPITAL PROVIDER SPELL)

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
**DISCHARGE DATE (HOSPITAL PROVIDER SPELL) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Discharge Date'*.**

**DISCHARGE DATE (HOSPITAL PROVIDER SPELL) is the date a PATIENT was discharged from a Hospital Provider Spell.**

---

#### DISCHARGED TO NHS AT HOME SERVICE INDICATOR

---

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See DISCHARGED TO NHS AT HOME SERVICE INDICATOR |
| Default Codes: | 9 - Not known whether the PATIENT was discharged to an NHS At Home Service |

**Notes:**
**DISCHARGED TO NHS AT HOME SERVICE INDICATOR is the same as attribute DISCHARGED TO NHS AT HOME SERVICE INDICATOR.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | DISCHARGED TO NHS AT HOME SERVICE INDICATORS |

---

#### DISCHARGED TO NHS AT HOME SERVICE INDICATOR

---

**Change to Data Element: New Data Element**

## DISCHARGED TO NHS AT HOME SERVICE INDICATOR

**Attribute:**

| |
|---|
| DISCHARGED TO NHS AT HOME SERVICE INDICATOR |

---

#### DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL)

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
**DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Discharge Ready Date'* of the Hospital Provider Spell.**

---

#### DISCHARGE TIME (HOSPITAL PROVIDER SPELL)

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an8 HH:MM:SS |
| National Codes: | |
| Default Codes: | |

**Notes:**

DISCHARGE TIME (HOSPITAL PROVIDER SPELL) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Discharge Time*'.

DISCHARGE TIME (HOSPITAL PROVIDER SPELL) is the time a PATIENT was discharged from a Hospital Provider Spell.

#### DISCHARGE TIME (HOSPITAL PROVIDER SPELL)

**Change to Data Element: Changed Dataset**

- null

#### DURATION OF ELECTIVE WAIT

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an4 |
| National Codes: | |
| Default Codes: | 9998 - Not applicable<br>9999 - Not known (no date known for DECISION TO ADMIT) |

**Notes:**
DURATION OF ELECTIVE WAIT is the same as attribute ACTIVITY DURATION.

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.

Please note that the PATIENT's WAITING PERIOD EXCLUSIONS (their aggregate suspended and/or self-deferred periods) should be subtracted from the DURATION OF ELECTIVE WAIT.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

#### EARLIEST CLINICALLY APPROPRIATE DATE

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
EARLIEST CLINICALLY APPROPRIATE DATE is the same as attribute ACTIVITY DATE.

EARLIEST CLINICALLY APPROPRIATE DATE is the earliest date that it was clinically appropriate for an ACTIVITY to take place.

For the Radiotherapy Data Set, EARLIEST CLINICALLY APPROPRIATE DATE is the:

- first date that the PATIENT would have been clinically fit to start Radiotherapy and
- same as the DECISION TO TREAT DATE unless there was an elective delay, i.e. a clinical reason, such as the PATIENT was not fit.

For the Community Services Data Set, Mental Health Services Data Set and Commissioning Data Sets (version 6-2 onwards), the EARLIEST CLINICALLY APPROPRIATE DATE may be used locally to inform waiting time calculations. It can be used to account for periods of time where it is not appropriate to treat the PATIENT for clinical reasons, for example:

- where the PATIENT has been admitted to hospital for an unrelated condition and the SERVICE cannot commence planned treatment until the PATIENT has been discharged
- where the PATIENT is frail and cannot be treated until their condition improves, but it is not appropriate to discharge the PATIENT from the SERVICE.

---

**EARLIEST REASONABLE OFFER DATE**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
EARLIEST REASONABLE OFFER DATE 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.

- For an APPOINTMENT this is the earliest of the APPOINTMENT DATES OFFERED where the APPOINTMENT OFFER is a '*Reasonable Offer*'.
- For an OFFER OF ADMISSION this is the earliest of the OFFERED FOR ADMISSION DATES where the OFFER OF ADMISSION is a '*Reasonable Offer*'.

**Patient Cancellations**
Where, for any reason, a PATIENT cancels or does not attend an APPOINTMENT or an OFFER OF ADMISSION the EARLIEST REASONABLE OFFER DATE for the rearranged APPOINTMENT or OFFER OF ADMISSION will be the EARLIEST REASONABLE OFFER DATE of the cancelled APPOINTMENT or OFFER OF ADMISSION.

**Provider Cancellations**
Where, for any reason, any Health Care Provider cancels and re-arranges an APPOINTMENT or an OFFER OF ADMISSION, the EARLIEST REASONABLE OFFER DATE for the re-arranged APPOINTMENT or OFFER OF ADMISSION will be the date of the earliest Reasonable Offer made following the cancellation.

**Patients who are unavailable**
Where a PATIENT makes themself unavailable for a longer period of time, for example a PATIENT who is a teacher who wishes to delay their admission until the summer holidays, making a Reasonable Offer may be inappropriate.

In these circumstances, so long as the Health Care Provider could have made at least two Reasonable Offers, the EARLIEST REASONABLE OFFER DATE will be the date of the earliest Reasonable Offer that the provider could have offered the PATIENT. This must be communicated to the PATIENT.

**Use in Commissioning Data Set version 6-0 onwards for Referral To Treatment Consultant-Led Waiting Times:**

If the Commissioning Data Set record:

- relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement

  **and**

- includes the REFERRAL TO TREATMENT PERIOD END DATE of the REFERRAL TO TREATMENT PERIOD

  and

- is of the following Commissioning Data Set Types:
  - CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode CDS
  - CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode CDS

then EARLIEST REASONABLE OFFER DATE must be populated in the Commissioning Data Set record if a Patient Pause (the PATIENT is paused on the ELECTIVE ADMISSION LIST because they have made themselves unavailable for treatment for a specified period (for non-clinical reasons)) is to be applied to a REFERRAL TO TREATMENT PERIOD by the Secondary Uses Service.

Failure to include EARLIEST REASONABLE OFFER DATE in the Admitted Patient Care General Episode Commissioning Data Set record carrying the REFERRAL TO TREATMENT PERIOD END DATE, will mean no Patient Pause is applied to the duration of wait calculation for the REFERRAL TO TREATMENT PERIOD performed by the Secondary Uses Service.

**Use in the Community Services Data Set, Mental Health Services Data Set, Commissioning Data Sets (version 6-2 onwards) for Allied Health Professional Referral To Treatment:**

For the Community Services Data Set, Mental Health Services Data Set and the Commissioning Data Sets (version 6-2 onwards) the EARLIEST REASONABLE OFFER DATE may be used locally to inform waiting time calculations for Allied Health Professional Referral To Treatment Measurement. It can be used to account for periods of time where the PATIENT has not accepted the first available APPOINTMENT OFFER and this has extended the Allied Health Professional Referral To Treatment Measurement waiting time, for example:

- where a PATIENT who is a child has been offered an APPOINTMENT but their parent/Carer states that they wish to wait until the school holidays commence. The SERVICE cannot commence planned treatment until the PATIENT is available.
- where the PATIENT works away and cannot attend for a period of time, but it is not appropriate to discharge the PATIENT from the SERVICE.

---

**EMED3 FIT NOTE ASSESSMENT DATE**

---

Change to Data Element: New Data Element

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
EMED3 FIT NOTE ASSESSMENT DATE is the same as the attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*eMED3 Fit Note Assessment Date*'.

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | EMED3 FIT NOTE ASSESSMENT DATES |

---

**EMED3 FIT NOTE ASSESSMENT DATE**

---

Change to Data Element: New Data Element

## EMED3 FIT NOTE ASSESSMENT DATE

**Attribute:**

| ACTIVITY DATE |
|---|

##### EMED3 FIT NOTE CONDITION (SNOMED CT EXPRESSION)

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | See SNOMED CT EXPRESSION |
| National Codes: | |
| Default Codes: | |

**Notes:**
**EMED3 FIT NOTE CONDITION (SNOMED CT EXPRESSION) is the same as attribute CLINICAL TERMINOLOGY CODE.**

**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.**

**For further information on SNOMED CT EXPRESSIONS, see the SNOMED CT® Glossary at: Expression.**

##### EMED3 FIT NOTE CONDITION (SNOMED CT EXPRESSION)

**Change to Data Element: New Data Element**

## EMED3 FIT NOTE CONDITION (SNOMED CT EXPRESSION)

**Attribute:**

| CLINICAL TERMINOLOGY CODE |
|---|

##### EMED3 FIT NOTE DIAGNOSIS (ICD)

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | See ICD-10 CODE |
| National Codes: | |
| Default Codes: | |

**Notes:**
**EMED3 FIT NOTE DIAGNOSIS (ICD) is the same as attribute CLINICAL CLASSIFICATION CODE.**

**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.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | EMED3 FIT NOTE DIAGNOSES (ICD) |

##### EMED3 FIT NOTE DIAGNOSIS (ICD)

**Change to Data Element: New Data Element**

## EMED3 FIT NOTE DIAGNOSIS (ICD)

**Attribute:**

| CLINICAL CLASSIFICATION CODE |
|---|

#### EMED3 FIT NOTE DURATION

**Change to Data Element: New Data Element**

| Format/Length: | max an3 |
|---|---|
| National Codes: | |
| Default Codes: | 999 - eMED3 Fit Note is for an indefinite period |

**Notes:**
**EMED3 FIT NOTE DURATION is the same as attribute PERSON PROPERTY ASSIGNMENT PERIOD DURATION.**

**EMED3 FIT NOTE DURATION is the number of days duration of an eMED3 Fit Note Applicable Period.**

#### EMED3 FIT NOTE DURATION

**Change to Data Element: New Data Element**

## EMED3 FIT NOTE DURATION

**Attribute:**

| PERSON PROPERTY ASSIGNMENT PERIOD DURATION |
|---|

#### EMED3 FIT NOTE END DATE

**Change to Data Element: New Data Element**

| Format/Length: | an10 CCYY-MM-DD |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
**EMED3 FIT NOTE END DATE is the same as attribute PERSON PROPERTY EFFECTIVE END DATE.**

**EMED3 FIT NOTE END DATE is the date that the eMED3 Fit Note Applicable Period ended.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | EMED3 FIT NOTE END DATES |

#### EMED3 FIT NOTE END DATE

**Change to Data Element: New Data Element**

## EMED3 FIT NOTE END DATE

**Attribute:**

| PERSON PROPERTY EFFECTIVE END DATE |
|---|

#### EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR |
| Default Codes: | |

**Notes:**
**EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR is the same as attribute EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATORS |

---

**EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR**

---

**Change to Data Element: New Data Element**

# EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR

**Attribute:**

| EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR |
|---|

---

**EMED3 FIT NOTE RECORDED DATE**

---

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
**EMED3 FIT NOTE RECORDED DATE is the same as the attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*eMED3 Fit Note Recorded Date*'.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | EMED3 FIT NOTE RECORDED DATES |

---

**EMED3 FIT NOTE RECORDED DATE**

---

**Change to Data Element: New Data Element**

# EMED3 FIT NOTE RECORDED DATE

**Attribute:**

| ACTIVITY DATE |
|---|

---

**EMED3 FIT NOTE START DATE**

---

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
**EMED3 FIT NOTE START DATE is the same as attribute PERSON PROPERTY EFFECTIVE START DATE.**

**EMED3 FIT NOTE START DATE is the date that the eMED3 Fit Note Applicable Period commenced.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | EMED3 FIT NOTE START DATES |

---

**EMED3 FIT NOTE START DATE**

---

**Change to Data Element: New Data Element**

## EMED3 FIT NOTE START DATE

**Attribute:**

| PERSON PROPERTY EFFECTIVE START DATE |
|---|

---

**END DATE (COMMISSIONER ASSIGNMENT PERIOD)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
**END DATE (COMMISSIONER ASSIGNMENT PERIOD) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*End Date*' of the Commissioner Assignment Period.**

---

**END DATE (EPISODE)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
**END DATE (EPISODE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*End Date*' of an Episode.**

**END DATE (EPISODE) is used by the Secondary Uses Service to derive the Healthcare Resource Group 4. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.**

**For further information, please refer to the NHS Digital website at: Payment by Results Guidance.**

---

**END DATE (HOME LEAVE)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
**END DATE (HOME LEAVE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'End Date'* of the Home Leave.**

---

**END DATE (WARD STAY)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
**END DATE (WARD STAY) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code is National Code *'End Date'* of the Ward Stay.**

---

**END TIME (EPISODE)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an8 HH:MM:SS |
| National Codes: | |
| Default Codes: | |

**Notes:**
**END TIME (EPISODE) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code *'End Time'* of the episode.**

---

**END TIME (HOME LEAVE)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an8 HH:MM:SS |
| National Codes: | |
| Default Codes: | |

**Notes:**
**END TIME (HOME LEAVE) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code *'End Time'* of the Home Leave.**

---

**END TIME (WARD STAY)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an8 HH:MM:SS |
| National Codes: | |
| Default Codes: | |

**Notes:**
**END TIME (WARD STAY) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code *'End Time'* of the Ward Stay.**

---

**EPISODE NUMBER**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an2 |
| National Codes: | |
| Default Codes: | 98 - Not applicable |
| | 99 - EPISODE NUMBER not known |

**Notes:**
**EPISODE NUMBER is the same as attribute ACTIVITY IDENTIFIER.**

EPISODE NUMBER is used to uniquely identify episodes, and is a sequence number for each Consultant Episode (Hospital Provider) in a Hospital Provider Spell.

The first episode of each new Hospital Provider Spell (including re-admitted PATIENTS) commences at 1.

A known EPISODE NUMBER can be between 1 to 87.

For other Health Care Provider episodes, it is a sequence number for a CONSULTANT/PATIENT combination; or it is a sequence number for each Sexual Health and HIV Episode.

EPISODE NUMBER is used by the Secondary Uses Service to derive the **Healthcare Resource Group** 4. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

Notes:

- The Default Code description for 99 - Not known has been updated. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.
- Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

### ETHNIC CATEGORY

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an2 |
| NWDS ID: | PETH |
| NWDS Field Name: | Ethnic Category |
| ESR Field Name: | Ethnic Origin |
| National Codes: | See ETHNIC CATEGORY CODE 2001 |
| Default Codes: | 99 - Not known |

**Notes:**
ETHNIC CATEGORY is the same as attribute ETHNIC CATEGORY CODE 2001.

The 16+1 ethnic data categories defined in the 2001 census is the national mandatory standard for the collection and analysis of ethnicity.

The national code must be transmitted as the first character in the 2 character field. The second character is optional for use locally. It must, however, be able to be grouped consistently with the 16 main categories.

National code Z should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to. Default code 99 should be used where the PERSON's ETHNIC CATEGORY is not known.

Note: for the Stop Smoking Services Quarterly Data Set default code 99 *'Not Known'* is **not** valid.

---

### ETHNIC CATEGORY 2021

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an3 |
| National Codes: | |
| Default Codes: | |

**Notes:**
**ETHNIC CATEGORY 2021 is the same as attribute ETHNIC CATEGORY 2021.**

**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.**

---

#### EXPECTED DURATION OF APPOINTMENT

---

**Change to Data Element: Changed Dataset**

| Format/Length: | max n3 |
| --- | --- |
| National Codes: | |
| Default Codes: | |

**Notes:**
**EXPECTED DURATION OF APPOINTMENT is the same as attribute ACTIVITY DURATION.**

**EXPECTED DURATION OF APPOINTMENT is the expected duration in minutes of an APPOINTMENT when booked, prior to the attendance of the PATIENT.**

---

#### FINDING (SNOMED CT EXPRESSION)

---

**Change to Data Element: Changed Dataset**

| Format/Length: | See SNOMED CT EXPRESSION |
| --- | --- |
| National Codes: | |
| Default Codes: | |

**Notes:**
**FINDING (SNOMED CT EXPRESSION) is the same as attribute CLINICAL TERMINOLOGY CODE.**

**~~This item is being used for development purposes and has not yet been approved.~~FINDING (SNOMED CT EXPRESSION) is a structured combination of one or more SNOMED CT® concept identifiers which are used to describe a Finding.**

**For further information on Findings, see the see the: SNOMED CT Fact Sheet.**

**For further information on SNOMED CT EXPRESSIONS, see the SNOMED CT® Glossary at: Expression.**

---

#### FIRST ANTENATAL ASSESSMENT DATE

---

**Change to Data Element: Changed Dataset**

| Format/Length: | an10 CCYY-MM-DD |
| --- | --- |
| National Codes: | |
| Default Codes: | |

**Notes:**
**FIRST ANTENATAL ASSESSMENT DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National code '*First Antenatal Assessment Date*'.**

---

#### FIRST ATTENDANCE CODE

---

**Change to Data Element: Changed Dataset**

| Format/Length: | an1 |
| --- | --- |

| | |
|---|---|
| National Codes: | See FIRST ATTENDANCE |
| Default Codes: | |

**Notes:**
**FIRST ATTENDANCE CODE is the same as attribute FIRST ATTENDANCE.**

**FIRST ATTENDANCE CODE is used by the Secondary Uses Service to derive the Healthcare Resource Group 4. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.**

**For further information, please refer to the NHS Digital website at: Payment by Results Guidance.**

**For specific National Code usage, see FIRST ATTENDANCE.**

---

#### FIRST REGULAR DAY OR NIGHT ADMISSION CODE

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See FIRST REGULAR DAY OR NIGHT ADMISSION |
| Default Codes: | |

**Notes:**
**FIRST REGULAR DAY OR NIGHT ADMISSION CODE is the same as attribute FIRST REGULAR DAY OR NIGHT ADMISSION.**

---

#### GASTRO-INTESTINAL SUPPORT DAYS

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an3 |
| National Codes: | |
| Default Codes: | 998 - 998 or more days of gastro-intestinal support |
| | 999 - Occurred but day count not known |

**Notes:**
**GASTRO-INTESTINAL SUPPORT DAYS is the same as attribute ACTIVITY DURATION.**

**GASTRO-INTESTINAL SUPPORT DAYS is the total number of days that the PATIENT received gastro-intestinal system support during a CRITICAL CARE PERIOD, ranging from 0 to 997 days.**

**GASTRO-INTESTINAL SUPPORT DAYS 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 '*Gastrointestinal Support*' within the CRITICAL CARE PERIOD.**

**Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.**

---

#### GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION)

---

**Change to Data Element: Changed Dataset**

**This item is being used for development purposes and has not yet been approved.**

---

#### GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE)

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an8 |
| National Codes: | |
| Default Codes: | G9999998 - GENERAL MEDICAL PRACTITIONER PPD CODE not known<br>G9999981 - GENERAL MEDICAL PRACTITIONER PPD CODE not applicable |

**Notes:**
**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 (SPECIFIED)

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an8 |
| National Codes: | |
| Default Codes: | G9999998 - GENERAL MEDICAL PRACTITIONER PPD CODE not known<br>G9999981 - GENERAL MEDICAL PRACTITIONER PPD CODE not applicable |

**Notes:**
**GENERAL MEDICAL PRACTITIONER (SPECIFIED) is the GENERAL MEDICAL PRACTITIONER PPD CODE of the GENERAL MEDICAL PRACTITIONER specified by the PATIENT.**

**This GENERAL MEDICAL PRACTITIONER works within the General Medical Practitioner Practice with which the PATIENT is registered.**

**A GENERAL MEDICAL PRACTITIONER will have at least one of the following:**

- **GENERAL MEDICAL COUNCIL REFERENCE NUMBER**
- **DOCTOR INDEX NUMBER**
- **GENERAL MEDICAL PRACTITIONER PPD CODE.**

**Ministry of Defence Doctors:**

- **If a Ministry of Defence Doctor has a GENERAL MEDICAL PRACTITIONER PPD CODE, the GENERAL MEDICAL PRACTITIONER PPD CODE should be used**
- **If a Ministry of Defence Doctor does not have a GENERAL MEDICAL PRACTITIONER PPD CODE, Organisation Data Service Default Code G9999981 *'GENERAL MEDICAL PRACTITIONER PPD CODE not applicable'* should be used.**

---

#### GENERAL MEDICAL PRACTITIONER PRACTICE (PATIENT ANTENATAL CARE)

---

**Change to Data Element: Changed Dataset**

**This item is being used for development purposes and has not yet been approved.**

---

#### GESTATION LENGTH (ASSESSMENT)

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | |
| Default Codes: | 99 - Not known |

**Notes:**
**GESTATION LENGTH (ASSESSMENT) is the same as attribute GESTATION LENGTH IN WEEKS.**

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.

#### GESTATION LENGTH (AT DELIVERY)

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | |
| Default Codes: | 99 - Not known |

**Notes:**
GESTATION LENGTH (AT DELIVERY) is the same as attribute GESTATION LENGTH IN WEEKS and records a period of between 10 to 49 weeks in completed weeks at delivery.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

#### GESTATION LENGTH (LABOUR ONSET)

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | |
| Default Codes: | 99 - Not known |

**Notes:**
GESTATION LENGTH (LABOUR ONSET) is the same as attribute GESTATION LENGTH IN WEEKS.

GESTATION LENGTH (LABOUR ONSET) records a period of between 10 to 49 weeks in completed weeks at the onset of labour.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

#### HIGH COST DRUGS (OPCS)

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | See OPCS-4 CODE |
| National Codes: | |
| Default Codes: | |

**Notes:**
HIGH COST DRUGS (OPCS) is the same as attribute CLINICAL CLASSIFICATION CODE.

HIGH COST DRUGS (OPCS) is the use of high cost drugs as per the OPCS-4 definitions provided as a CARE ACTIVITY.

#### HOSPITAL PROVIDER SPELL IDENTIFIER

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an20 |

| | |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
HOSPITAL PROVIDER SPELL IDENTIFIER is the same as attribute ACTIVITY IDENTIFIER.

~~This item is being used for development purposes and has not yet been approved.~~HOSPITAL PROVIDER SPELL IDENTIFIER is a unique identifier for each Hospital Provider Spell for a Health Care Provider.

Note that the HOSPITAL PROVIDER SPELL IDENTIFIER must be constructed without the use of PATIENT Confidential Information. This includes PATIENT Identifiers such as NHS NUMBER or LOCAL PATIENT IDENTIFIER, as well as any text which may identify the PATIENT DIAGNOSIS of the PATIENT or any PATIENT procedures being undertaken.

HOSPITAL PROVIDER SPELL IDENTIFIER is used by the Secondary Uses Service to derive the **Healthcare Resource Group** 4. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

**HOSPITAL PROVIDER SPELL NUMBER will be replaced with HOSPITAL PROVIDER SPELL IDENTIFIER, which is the most recent approved national information standard to describe the required definition.**

---

### INTENDED MANAGEMENT CODE

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See INTENDED MANAGEMENT |
| Default Codes: | 8 - Not applicable |
| | 9 - INTENDED MANAGEMENT not known |

**Notes:**
INTENDED MANAGEMENT CODE is the same as attribute INTENDED MANAGEMENT.

INTENDED MANAGEMENT CODE describes what is intended to happen to the PATIENT.

Occasionally the PATIENT's treatment does not go exactly to plan. For example, a PATIENT admitted as a day case may develop complications and have to be kept in overnight. Therefore another data item, PATIENT CLASSIFICATION, is used to describe what actually happens to the PATIENT. In this example, the PATIENT CLASSIFICATION would be 'Ordinary admission' and not 'Day case admission'.

Note: the Default Code description for 9 - Not known has been updated. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

### LABOUR OR DELIVERY ONSET METHOD CODE

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See LABOUR OR DELIVERY ONSET METHOD |
| Default Codes: | 9 - LABOUR OR DELIVERY ONSET METHOD not known |

**Notes:**

LABOUR OR DELIVERY ONSET METHOD CODE is the same as attribute LABOUR OR DELIVERY ONSET METHOD.

Only those methods that are used to induce Labour, such as surgical induction, medical induction or a combination of the two, should be recorded. Methods that are used to accelerate Labour should not be recorded.

For specific National Code usage, see LABOUR OR DELIVERY ONSET METHOD.

Note: the Default Code description for 9 - Not known has been updated. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

#### LAST EPISODE IN SPELL INDICATOR CODE

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See LAST EPISODE IN SPELL INDICATOR CODE |
| Default Codes: | 9 - Not known |

**Notes:**
LAST EPISODE IN SPELL INDICATOR CODE is the same as attribute LAST EPISODE IN SPELL INDICATOR CODE.

---

#### LAST PATIENT CANCELLED DATE

---

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
LAST PATIENT CANCELLED DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is '*Last Patient Cancelled Date*'.

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.

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | LAST PATIENT DID NOT ATTEND DATES |

---

#### LAST PATIENT CANCELLED DATE

---

**Change to Data Element: New Data Element**

## LAST PATIENT CANCELLED DATE

**Attribute:**

| ACTIVITY DATE |
|---|

---

#### LAST PATIENT DID NOT ATTEND DATE

---

**Change to Data Element: New Data Element**

| Format/Length: | an10 CCYY-MM-DD |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
**LAST PATIENT DID NOT ATTEND DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is '*Last Patient Did Not Attend Date*'.**

**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.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | LAST PATIENT DID NOT ATTEND DATES |

---

**LAST PATIENT DID NOT ATTEND DATE**

---

**Change to Data Element: New Data Element**

## LAST PATIENT DID NOT ATTEND DATE

**Attribute:**

| ACTIVITY DATE |
|---|

---

**LATEST CLINICALLY APPROPRIATE DATE**

---

**Change to Data Element: New Data Element**

| Format/Length: | an10 CCYY-MM-DD |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
**LATEST CLINICALLY APPROPRIATE DATE is the same as attribute ACTIVITY DATE.**

**LATEST CLINICALLY APPROPRIATE DATE is the latest date that it was clinically appropriate for an ACTIVITY to take place.**

**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.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | LATEST CLINICALLY APPROPRIATE DATES |

---

**LATEST CLINICALLY APPROPRIATE DATE**

---

**Change to Data Element: New Data Element**

## LATEST CLINICALLY APPROPRIATE DATE

**Attribute:**

| ACTIVITY DATE |
|---|

---

#### LENGTH OF STAY ADJUSTMENT (REHABILITATION)

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max n3 |
| National Codes: | |
| Default Codes: | |

**Notes:**

**LENGTH OF STAY ADJUSTMENT (REHABILITATION) is the same as attribute LENGTH OF STAY ADJUSTMENT where the LENGTH OF STAY ADJUSTMENT REASON is National Code *'Rehabilitation'*.**

---

#### LENGTH OF STAY ADJUSTMENT (SPECIALIST PALLIATIVE CARE)

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max n3 |
| National Codes: | |
| Default Codes: | |

**Notes:**

**LENGTH OF STAY ADJUSTMENT (SPECIALIST PALLIATIVE CARE) is the same as attribute LENGTH OF STAY ADJUSTMENT where the LENGTH OF STAY ADJUSTMENT REASON is National Code *'Specialist Palliative Care'*.**

---

#### LIVE OR STILL BIRTH CODE

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See LIVE OR STILL BIRTH |
| Default Codes: | |

**Notes:**

**LIVE OR STILL BIRTH CODE is the same as attribute LIVE OR STILL BIRTH.**

**If born dead before 24 weeks, it would be a spontaneous abortion.**

---

#### LIVER SUPPORT DAYS

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an3 |
| National Codes: | |
| Default Codes: | 998 - 998 or more days of liver support |
| | 999 - Occurred but day count not known |

**Notes:**

**LIVER SUPPORT DAYS is the same as attribute ACTIVITY DURATION.**

**LIVER SUPPORT DAYS is the total number of days that the PATIENT received liver support during a CRITICAL CARE PERIOD, ranging from 0 to 997 days.**

LIVER SUPPORT DAYS 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 '*Liver Support*' within the CRITICAL CARE PERIOD.

LIVER SUPPORT DAYS is used by the Secondary Uses Service to derive the **Healthcare Resource Group** 4. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

**LOCAL PATIENT IDENTIFIER (EXTENDED (BABY))**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an20 |
| National Codes: | |
| Default Codes: | |

**Notes:**
LOCAL PATIENT IDENTIFIER (EXTENDED (BABY)) is the same as data element LOCAL PATIENT IDENTIFIER (EXTENDED) for the baby.

---

**LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER))**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an20 |
| National Codes: | |
| Default Codes: | |

**Notes:**
LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER)) is the same as data element LOCAL PATIENT IDENTIFIER (EXTENDED) for the mother.

---

**LOCAL PATIENT IDENTIFIER (EXTENDED)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an20 |
| National Codes: | |
| Default Codes: | |

**Notes:**
LOCAL PATIENT IDENTIFIER (EXTENDED) is the same as attribute LOCAL PATIENT IDENTIFIER.

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.

---

**LOCAL SUB-SPECIALTY CODE**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an8 |
| National Codes: | |
| Default Codes: | |

**Notes:**
**LOCAL SUB-SPECIALTY CODE is the same as the attribute LOCAL SUB-SPECIALTY CODE.**

**LOCAL SUB-SPECIALTY CODE is an optional item in the Commissioning Data Set version 6-2, and is for local use only. However it must NOT contain any text which may identify the PATIENT DIAGNOSIS of the PATIENT to which the ACTIVITY relates (for example, it must not include the acronym 'HIV') or the Patient Procedure being undertaken (for example using the acronym 'TOP' for terminations of pregnancy). Use of such identifiers contravenes the legal requirements for withholding identifiable information about PATIENTS with identified conditions. See Security Issues and Patient Confidentiality for further details.**

---

**MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE |
| Default Codes: | |

**Notes:**
**MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION) is the same as attribute MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE on admission.**

---

**METHOD OF ADMISSION (HOSPITAL PROVIDER SPELL)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See METHOD OF ADMISSION |
| Default Codes: | 98 - Not applicable |
| | 99 - METHOD OF ADMISSION not known |

**Notes:**
**METHOD OF ADMISSION (HOSPITAL PROVIDER SPELL) is the same as attribute METHOD OF ADMISSION.**

**~~This item is being used for development purposes and has not yet been approved.~~METHOD OF ADMISSION (HOSPITAL PROVIDER SPELL) is used by the Secondary Uses Service to derive the Healthcare Resource Group 4. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.**

**For further information, please refer to the NHS Digital website at: Payment by Results Guidance.**

**ADMISSION METHOD CODE (HOSPITAL PROVIDER SPELL) will be replaced with METHOD OF ADMISSION (HOSPITAL PROVIDER SPELL), which is the most recent approved national information standard to describe the required definition.**

---

**METHOD OF DISCHARGE (HOSPITAL PROVIDER SPELL)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See METHOD OF DISCHARGE |
| Default Codes: | 8 - Not applicable (Hospital Provider Spell not finished at episode end (i.e. not discharged) or current episode unfinished) |
| | 9 - METHOD OF DISCHARGE not known |

**Notes:**
METHOD OF DISCHARGE (HOSPITAL PROVIDER SPELL) is the same as attribute METHOD OF DISCHARGE.

~~This item is being used for development purposes and has not yet been approved.~~METHOD OF DISCHARGE (HOSPITAL PROVIDER SPELL) is used by the Secondary Uses Service to derive the **Healthcare Resource Group** 4. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

**DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL) will be replaced with METHOD OF DISCHARGE (HOSPITAL PROVIDER SPELL), which is the most recent approved national information standard to describe the required definition.**

---

**MULTI-PROFESSIONAL OR MULTI-DISCIPLINARY INDICATION CODE (NATIONAL TARIFF PAYMENT SYSTEM)**

---

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See MULTI-PROFESSIONAL OR MULTI-DISCIPLINARY INDICATION CODE |
| Default Codes: | 9 - Not known whether attendance was uni-professional, multi-professional or multi-disciplinary |

**Notes:**
MULTI-PROFESSIONAL OR MULTI-DISCIPLINARY INDICATION CODE (NATIONAL TARIFF PAYMENT SYSTEM) is the same as attribute MULTI-PROFESSIONAL OR MULTI-DISCIPLINARY INDICATION CODE.

**This data item is included in Commissioning Data Set version 6-3, but should not be submitted until further development by the Department of Health and Social Care has been undertaken.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | MULTI-PROFESSIONAL OR MULTI-DISCIPLINARY CONSULTATION INDICATION CODES (NATIONAL TARIFF PAYMENT SYSTEM) |

---

**MULTI-PROFESSIONAL OR MULTI-DISCIPLINARY INDICATION CODE (NATIONAL TARIFF PAYMENT SYSTEM)**

---

**Change to Data Element: New Data Element**

# MULTI-PROFESSIONAL OR MULTI-DISCIPLINARY INDICATION CODE (NATIONAL TARIFF PAYMENT SYSTEM)

**Attribute:**

| |
|---|
| MULTI-PROFESSIONAL OR MULTI-DISCIPLINARY INDICATION CODE |

---

**NEONATAL LEVEL OF CARE CODE**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See NEONATAL LEVEL OF CARE |
| Default Codes: | 8 - Not applicable |
| | 9 - Not known |

**Notes:**
NEONATAL LEVEL OF CARE CODE is the same as attribute NEONATAL LEVEL OF CARE.

The value recorded must be the highest level of care given during a Hospital Provider Spell with Neonatal Level Of Care Periods.

NEONATAL LEVEL OF CARE CODE is used by the Secondary Uses Service to derive the **Healthcare Resource Group** 4. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

For the Commissioning Data Sets:

- Not applicable means "stillbirth or the episode of care does not involve a Neonate during all, or part, of the duration of the episode"
- Not known means "the episode of care involves a Neonate and is finished but no data has been entered, or the episode involves a Neonate and is unfinished therefore no data needs to be present. This would constitute a validation error only for a finished episode".

---

**NEUROLOGICAL SUPPORT DAYS**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an3 |
| National Codes: | |
| Default Codes: | 998 - 998 or more days of neurological support |
| | 999 - Occurred but day count not known |

**Notes:**
NEUROLOGICAL SUPPORT DAYS is the same as attribute ACTIVITY DURATION.

NEUROLOGICAL SUPPORT DAYS is total number of days that the PATIENT received neurological system support during a CRITICAL CARE PERIOD, ranging from 0 to 997 days.

NEUROLOGICAL SUPPORT DAYS 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 '*Neurological Support*' within the CRITICAL CARE PERIOD.

NEUROLOGICAL SUPPORT DAYS is used by the Secondary Uses Service to derive the **Healthcare Resource Group** 4. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

**NHS NUMBER**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | n10 |
| National Codes: | |
| Default Codes: | |

**Notes:**
NHS NUMBER is the same as attribute NHS NUMBER.

For the AIDC for Patient Identification Data Set further guidance can be found on the NHS Digital website at: DCB1077: AIDC for Patient Identification.

---

#### NHS NUMBER (BABY)

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | n10 |
| National Codes: | |
| Default Codes: | |

**Notes:**
NHS NUMBER (BABY) is the same as attribute NHS NUMBER for the baby.

---

#### NHS NUMBER (MOTHER)

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | n10 |
| National Codes: | |
| Default Codes: | |

**Notes:**
NHS NUMBER (MOTHER) is the same as attribute NHS NUMBER for the mother.

---

#### NHS NUMBER STATUS INDICATOR CODE

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See NHS NUMBER STATUS INDICATOR CODE |
| Default Codes: | |

**Notes:**
NHS NUMBER STATUS INDICATOR CODE is the same as attribute NHS NUMBER STATUS INDICATOR CODE.

For specific National Code usage in different data sets, see NHS NUMBER STATUS INDICATOR CODE.

---

#### NHS NUMBER STATUS INDICATOR CODE (BABY)

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | See NHS NUMBER STATUS INDICATOR CODE |
| National Codes: | See NHS NUMBER STATUS INDICATOR CODE |
| Default Codes: | |

**Notes:**
NHS NUMBER STATUS INDICATOR CODE (BABY) is the is the same as attribute NHS NUMBER STATUS INDICATOR CODE of the NHS NUMBER (BABY).

For specific National Code usage in different data sets, see NHS NUMBER STATUS INDICATOR CODE.

---

#### NHS NUMBER STATUS INDICATOR CODE (MOTHER)

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | See NHS NUMBER STATUS INDICATOR CODE |
| National Codes: | See NHS NUMBER STATUS INDICATOR CODE |
| Default Codes: | |

**Notes:**
**NHS NUMBER STATUS INDICATOR CODE (MOTHER) is the same as attribute NHS NUMBER STATUS INDICATOR CODE of the NHS NUMBER (MOTHER).**

**For specific National Code usage in different data sets, see NHS NUMBER STATUS INDICATOR CODE.**

---

**NHS SERVICE AGREEMENT IDENTIFIER**

---

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | max an20 |
| National Codes: | |
| Default Codes: | |

**Notes:**
**NHS SERVICE AGREEMENT IDENTIFIER is the same as attribute NHS SERVICE AGREEMENT IDENTIFIER.**

**Where a PATIENT is receiving Non-Contract Activity treatment, Health Care Providers submitting the Commissioning Data Sets should populate the first 3 characters of the NHS SERVICE AGREEMENT IDENTIFIER with the letters 'OAT' (in capital letters). The remaining characters continue to be locally-populated as required.**

**Where the ACTIVITY in the Commissioning Data Set record should be excluded from the National Tariff Payment System tariff, an '=' (equals sign) should be entered as the last character in the NHS SERVICE AGREEMENT IDENTIFIER. The position of the last character depends on any preceding characters; for example where the field is otherwise blank, the '=' sign would be the first character. Where the first three characters are 'OAT' as above, the '=' sign is entered as the 4th character. The '=' sign provides a general exclusion from National Tariff Payment System processing by the Secondary Uses Service which should be used for unusual circumstances, or where more specific rules regarding population of other data fields used in the Healthcare Resource Group Payment Grouper cannot be implemented due to local system restrictions.**

**COMMISSIONING SERIAL NUMBER will be replaced with NHS SERVICE AGREEMENT IDENTIFIER, which is the most recent approved national information standard to describe the required definition.**

---

**NHS SERVICE AGREEMENT IDENTIFIER**

---

**Change to Data Element: New Data Element**

## NHS SERVICE AGREEMENT IDENTIFIER

**Attribute:**

| |
|---|
| NHS SERVICE AGREEMENT IDENTIFIER |

---

**NHS SERVICE AGREEMENT LINE IDENTIFIER**

---

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | max an20 |
| National Codes: | |
| Default Codes: | |

**Notes:**
NHS SERVICE AGREEMENT LINE IDENTIFIER is the same as attribute NHS SERVICE AGREEMENT LINE IDENTIFIER.

**NHS SERVICE AGREEMENT LINE NUMBER will be replaced with NHS SERVICE AGREEMENT LINE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | NHS SERVICE AGREEMENT LINE IDENTIFIERS |

**NHS SERVICE AGREEMENT LINE IDENTIFIER**

**Change to Data Element: New Data Element**

## NHS SERVICE AGREEMENT LINE IDENTIFIER

**Attribute:**

| NHS SERVICE AGREEMENT LINE IDENTIFIER |
|---|

**NHS SERVICE AGREEMENT LINE NUMBER**

**Change to Data Element: Changed Description**

| | |
|---|---|
| Format/Length: | max an10 |
| National Codes: | |
| Default Codes: | |

**Notes:**
NHS SERVICE AGREEMENT LINE NUMBER is the same as attribute NHS SERVICE AGREEMENT LINE NUMBER.

NHS SERVICE AGREEMENT LINE NUMBER may be used to identify a specific NHS SERVICE AGREEMENT reference where the main identifier refers to a general omnibus agreement.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

**NHS SERVICE AGREEMENT LINE NUMBER will be replaced with NHS SERVICE AGREEMENT LINE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.**

**NUMBER OF BABIES INDICATION CODE**

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See NUMBER OF BABIES INDICATION CODE |
| Default Codes: | 9 - Number of REGISTRABLE BIRTHS not known |

**Notes:**
NUMBER OF BABIES INDICATION CODE is the same as attribute NUMBER OF BABIES INDICATION CODE.

**Note: the Default Code description for 9 - Not known has been updated. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.**

---

#### NUMBER OF PREVIOUS PREGNANCIES RESULTING IN REGISTRABLE BIRTH

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an2 |
| National Codes: | |
| Default Codes: | 99 - Number of previous pregnancies resulting in a REGISTRABLE BIRTH not known |

**Notes:**
NUMBER OF PREVIOUS PREGNANCIES RESULTING IN REGISTRABLE BIRTH is the same as attribute ACTIVITY COUNT.

~~This item is being used for development purposes and has not yet been approved.~~NUMBER OF PREVIOUS PREGNANCIES RESULTING IN REGISTRABLE BIRTH is the number of previous pregnancies resulting in one or more REGISTRABLE BIRTHS.

**PREGNANCY TOTAL PREVIOUS PREGNANCIES will be replaced with NUMBER OF PREVIOUS PREGNANCIES RESULTING IN REGISTRABLE BIRTH, which is the most recent approved national information standard to describe the required definition.**

---

#### OBSERVATION (SNOMED CT EXPRESSION)

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | See SNOMED CT EXPRESSION |
| National Codes: | |
| Default Codes: | |

**Notes:**
OBSERVATION (SNOMED CT EXPRESSION) is the same as attribute CLINICAL TERMINOLOGY CODE.

~~This item is being used for development purposes and has not yet been approved.~~OBSERVATION (SNOMED CT EXPRESSION) is a structured combination of one or more SNOMED CT® concept identifiers which are used to describe an Observable Entity.

For further information on Observable Entities, see the see the: SNOMED CT Fact Sheet.

For further information on SNOMED CT EXPRESSIONS, see the SNOMED CT® Glossary at: Expression.

---

#### OBSERVATION VALUE

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an10 |
| National Codes: | |
| Default Codes: | |

**Notes:**
OBSERVATION VALUE is the same as attribute OBSERVATION VALUE.

---

#### ORGANISATION IDENTIFIER (CDS RECIPIENT)

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | min an3 max an5 |
| National Codes: | |
| Default Codes: | TDH00 - Overseas Visitor exempt from charges |
| | VPP00 - Private PATIENTS / Overseas Visitor liable for charges |

**Notes:**
ORGANISATION IDENTIFIER (CDS RECIPIENT) is the same as attribute ORGANISATION IDENTIFIER.

ORGANISATION IDENTIFIER (CDS RECIPIENT) is the NHS ORGANISATION IDENTIFIER (or valid Organisation Data Service Default Code) for an ORGANISATION identified as a recipient of the commissioning data set data.

**Usage:**
A maximum of 7 ORGANISATION IDENTIFIERS (CDS RECIPIENT) may be submitted. The submission order does not infer the primacy of one recipient over another.

A Recipient may be an agency or SERVICE provider that carries out the receiving (and perhaps other) processes on behalf of the NHS ORGANISATION that ultimately uses the data.

Where NHS England and NHS Improvement is the responsible Commissioner for a specialised SERVICE, based on the NHS England and NHS Improvement Commissioner Assignment Method (CAM), one of the Specialised Commissioning Hub ORGANISATION IDENTIFIERS should be used depending on which Health Care Provider delivered the SERVICE, e.g. NHS Trust, Independent Sector Healthcare Provider.

The NHS Digital website provides a mapping list of which Health Care Providers map to which Specialised Commissioning Hub. The mapping can be found on the Organisation Data Service web pages at: Provider to Commissioning Hub Mapping.

Please note that the following Organisation Data Service Default Codes must not be used in the Commissioning Data Set (CDS) header because they are not default Commissioner codes:

- Q99 - High Level Health Geography/Primary Care Organisation of Residence Not Known
  - a valid ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) must be reported where a recipient of commissioning data is specified
- X98 - Primary Care Organisation Not Applicable (Overseas Visitors).

**CDS PRIME RECIPIENT IDENTITY and CDS COPY RECIPIENT IDENTITY will be replaced with ORGANISATION IDENTIFIER (CDS RECIPIENT), which is the most recent approved national information standard to describe the required definition.**

---

#### ORGANISATION IDENTIFIER (CDS SENDER)

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | min an3 max an5 |
| National Codes: | |
| Default Codes: | |

**Notes:**
ORGANISATION IDENTIFIER (CDS SENDER) is the same as attribute ORGANISATION IDENTIFIER.

**ORGANISATION IDENTIFIER (CDS SENDER) is the mandatory ORGANISATION IDENTIFIER of the ORGANISATION acting as the physical Sender of Commissioning Data Set submissions.**

**Usage:**
**The Commissioning Data Set sender must make sure that the Commissioning Data Set extraction and submission facilities and processes differentiate correctly between:**

- **ORGANISATION IDENTIFIER (CDS SENDER) as carried in the Commissioning Data Set Transaction Header Group for every Commissioning Data Set,**
  **and**
- **ORGANISATION IDENTIFIER (CODE OF PROVIDER) as carried in the Service Agreement details which are part of the Episode/Attendance details.**

**For further guidance see the Commissioning Data Set Submission Protocol.**

**CDS SENDER IDENTITY will be replaced with ORGANISATION IDENTIFIER (CDS SENDER), which is the most recent approved national information standard to describe the required definition.**

---

**ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | min an3 max an5 |
| National Codes: | |
| Default Codes: | VPP00 - Private PATIENTS / Overseas Visitor liable for charge |
| | XMD00 - Commissioner Code for Ministry of Defence (MoD) Healthcare |
| | YDD82 - Episodes funded directly by the National Commissioning Group for England (Retired September 2018) |

**Notes:**
**ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) is the same as attribute ORGANISATION IDENTIFIER.**

**ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) is the ORGANISATION IDENTIFIER of the ORGANISATION commissioning health care.**

**For Commissioning Data Sets, the ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) should always be the ORGANISATION IDENTIFIER of the original commissioner to support the National Tariff Payment System.**

**The NHS England and NHS Improvement document "Who pays? Determining responsibility for payments to providers" sets out a framework for establishing responsibility for commissioning an individual's care within the NHS, (i.e. determining who pays for a PATIENT's care.)**

**The document includes information on the following:**

- **General Rules**
- **Applying the rules to Clinical Commissioning Group and NHS England and NHS Improvement commissioned services**
- **Exceptions to the general rules**
- **Examples to help clarify the boundaries of responsibility between commissioning ORGANISATIONS.**

**For further information on this document contact NHS England and NHS Improvement at "Contact us".**

**Where NHS England and NHS Improvement is the responsible commissioner for a specialised SERVICE, based on the NHS England and NHS Improvement Commissioner Assignment Method (CAM), one of the Specialised Commissioning Hub ORGANISATION IDENTIFIERS should be used depending on which Health Care Provider delivered the SERVICE, e.g. NHS Trust, Independent Sector Healthcare Provider.**

**The NHS Digital website provides a mapping list of which Health Care Providers map to which Specialised Commissioning Hub. The mapping can be found on the Organisation Data Service web pages at: Provider to Commissioning Hub Mapping.**

**ORGANISATION CODE (CODE OF COMMISSIONER) will be replaced with ORGANISATION IDENTIFIER (CODE OF COMMISSIONER), which is the most recent approved national information standard to describe the required definition.**

---

**ORGANISATION IDENTIFIER (CODE OF PROVIDER)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | min an3 max an6 |
| National Codes: | |
| Default Codes: | 89997 - Non-UK provider where no ORGANISATION IDENTIFIER has been issued<br>89999 - Non-NHS UK provider where no ORGANISATION IDENTIFIER has been issued |

**Notes:**
**ORGANISATION IDENTIFIER (CODE OF PROVIDER) is the same as the attribute ORGANISATION IDENTIFIER.**

**ORGANISATION IDENTIFIER (CODE OF PROVIDER) is the ORGANISATION IDENTIFIER of the ORGANISATION acting as a Health Care Provider.**

**For Commissioning Data Sets, the ORGANISATION IDENTIFIER (CODE OF PROVIDER) should always be the ORGANISATION IDENTIFIER of the Health Care Provider receiving the National Tariff Payment System income.**

**ORGANISATION CODE (CODE OF PROVIDER) is used by the Secondary Uses Service to derive the Healthcare Resource Group 4. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.**

**For further information, please refer to the NHS Digital website at: Payment by Results Guidance.**

**ORGANISATION CODE (CODE OF PROVIDER) will be replaced with ORGANISATION IDENTIFIER (CODE OF PROVIDER), which is the most recent approved national information standard to describe the required definition.**

---

**ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | min an3 max an5 |
| National Codes: | |
| Default Codes: | |

**Notes:**
**ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST) is the same as attribute ORGANISATION IDENTIFIER.**

**ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST) is the ORGANISATION IDENTIFIER of an Ambulance Service which conveys a PATIENT.**

**ORGANISATION CODE (CONVEYING AMBULANCE TRUST) will be replaced with ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST), which is the most recent approved national information standard to describe the required definition.**

### ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (BABY))

**Change to Data Element: Changed Dataset**

| Format/Length: | min an3 max an5 |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (BABY)) is the same as attribute ORGANISATION IDENTIFIER.

ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (BABY)) is the ORGANISATION IDENTIFIER of the ORGANISATION that assigned the LOCAL PATIENT IDENTIFIER for the baby.

**ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (BABY)) will be replaced with ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (BABY)), which is the most recent approved national information standard to describe the required definition.**

### ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER))

**Change to Data Element: Changed Dataset**

| Format/Length: | min an3 max an5 |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER)) is the same as attribute ORGANISATION IDENTIFIER.

ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER)) is the ORGANISATION IDENTIFIER of the ORGANISATION that assigned the LOCAL PATIENT IDENTIFIER for the mother.

**ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (MOTHER)) will be replaced with ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER)), which is the most recent approved national information standard to describe the required definition.**

### ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)

**Change to Data Element: Changed Dataset**

| Format/Length: | min an3 max an5 |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) is the same as attribute ORGANISATION IDENTIFIER.

ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) is the ORGANISATION IDENTIFIER of the ORGANISATION that assigned the LOCAL PATIENT IDENTIFIER.

**ORGANISATION CODE (LOCAL PATIENT IDENTIFIER) will be replaced with ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER), which is the most recent approved national information standard to describe the required definition.**

## ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)

**Change to Data Element: Changed Dataset, Description**

| Format/Length: | min an3 max an5 |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
**ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER) is the same as attribute ORGANISATION IDENTIFIER.**

**ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER) 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.**

**Use in Commissioning Data Set version 6-0 onwards**

**If the Commissioning Data Set record relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, and is of the following Commissioning Data Set Types:**

- ~~CDS V6-2 Type 020 - Outpatient Commissioning Data Set~~
- ~~CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set~~
- ~~CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set~~
- ~~CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set~~
- ~~CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) Commissioning Data Set~~
- ~~CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) Commissioning Data Set~~
- ~~CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) Commissioning Data Set~~
- CDS V6-2 Type 020 - Outpatient Commissioning Data Set / CDS V6-3 Type 020 - Outpatient Commissioning Data Set
- CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set / CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set
- CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set / CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set
- CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set
- CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) Commissioning Data Set
- CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) Commissioning Data Set
- CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) Commissioning Data Set

**then ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.**

**ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) will be replaced with ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER), which is the most recent approved national information standard to describe the required definition.**

## ORGANISATION IDENTIFIER (REFERRING ORGANISATION)

**Change to Data Element: Changed Dataset**

| Format/Length: | min an3 max an8 |
|---|---|
| National Codes: | |

| | |
|---|---|
| Default Codes: | X99998 - Referring ORGANISATION IDENTIFIER not applicable<br>X99999 - Referring ORGANISATION IDENTIFIER not known |

**Notes:**
**ORGANISATION IDENTIFIER (REFERRING ORGANISATION) is the same as attribute ORGANISATION IDENTIFIER.**

**~~This item is being used for development purposes and has not yet been approved.~~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.**

**This information is essential for managing service agreements which are based on patterns of referral.**

**REFERRING ORGANISATION CODE and ORGANISATION IDENTIFIER (REFERRING) will be replaced with ORGANISATION IDENTIFIER (REFERRING ORGANISATION), which is the most recent approved national information standard to describe the required definition.**

---

**ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | min an3 max an5 |
| National Codes: | |
| Default Codes: | Q99 - High Level Health Geography/Primary Care ORGANISATION of Residence Not Known<br>Note: This code must not be used in the Commissioning Data Set header. It is not a default commissioner code.<br>X98 - Primary Care ORGANISATION Not Applicable (Overseas Visitors)<br>Note: this code must not be used in the Commissioning Data Set (CDS) header. It is not a default Commissioner code. |

**Notes:**
**ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) is the same as attribute ORGANISATION IDENTIFIER.**

**ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) is the ORGANISATION IDENTIFIER derived from the PATIENT's POSTCODE OF USUAL ADDRESS, where they reside within the boundary of a:**

- **Clinical Commissioning Group**
- **Care Trust**
- **Local Health Board (Wales)**
- **Scottish Health Board**
- **Northern Ireland Local Commissioning Group**
- **Primary Healthcare Directorate (Isle of Man)**
- **Local Authority.**

**For PATIENTS who are Overseas Visitors: Organisation Data Service Default Code X98 '*Primary Care Organisation Not Applicable (Overseas Visitors)*' should be reported.**
***Note: A review of Organisation Data Service Default Codes is planned to be carried out and this default code will be updated as part of that.***

**For the purposes of sending Commissioning Data Set messages to the Secondary Uses Service (regardless of how local systems hold the data), it is essential at present to continue using a 3 character field, using the first 3 characters of the ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) and following the same update rules relating to Prime Recipient as are currently in place. This is necessary, primarily to preserve the integrity of the current Commissioning Data Set message and the CDS PRIME RECIPIENT IDENTITY which is derived from the ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY).**

**ORGANISATION CODE (RESIDENCE RESPONSIBILITY) will be replaced with ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY),which is the most recent approved national information standard to describe the required definition.**

---

**ORGANISATION SITE IDENTIFIER (OF TREATMENT)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | min an5 max an9 |
| National Codes: | |
| Default Codes: | R9998 - Not a hospital site<br>89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued<br>89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued |

**Notes:**
**ORGANISATION SITE IDENTIFIER (OF TREATMENT) is the same as attribute ORGANISATION SITE IDENTIFIER.**

**ORGANISATION SITE IDENTIFIER (OF TREATMENT) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE where the PATIENT was treated, i.e. it should enable the treating ORGANISATION to be identified.**

**ORGANISATION SITE IDENTIFIER (OF TREATMENT) identifies the ORGANISATION SITE within the ORGANISATION on which the PATIENT was treated, since facilities may vary on different hospital sites.**

**The code recorded should always be the national code; if the treatment is sub-commissioned to another NHS Health Care Provider or an independent UK provider, the ORGANISATION SITE IDENTIFIER (OF TREATMENT) used should be the ORGANISATION SITE IDENTIFIER of the Health Care Provider actually carrying out the work.**

**Where treatment is sub-commissioned to an overseas provider the Organisation Data Service Default Code 89997 *'Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued'* is applicable.**

**Each ORGANISATION has a unique ORGANISATION SITE IDENTIFIER. However, where an ORGANISATION has more than one site from which it provides SERVICES, then each site is uniquely identified. These sites are ORGANISATION SITES and are uniquely identified by an ORGANISATION SITE IDENTIFIER.**

**For out-patients, ACTIVITY may take place outside the hospital, such as in the PATIENT'S home; in such cases, raising a site code is impractical. Therefore, code R9998 *'Not a hospital site'* would be used in these circumstances.**
***Note: LOCATION CLASS is used in the Commissioning Data Set (CDS) message to indicate the physical LOCATION within which the ACTIVITY occurred.***

**Use in the Future Outpatient CDS:**
**If the INTENDED SITE CODE (OF TREATMENT) is not known, this data element should be omitted.**

**SITE CODE (OF TREATMENT) will be replaced with ORGANISATION SITE IDENTIFIER (OF TREATMENT), which is the most recent approved national information standard to describe the required definition.**

---

**ORGAN SUPPORT MAXIMUM**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | |

| Default Codes: | |
|---|---|

**Notes:**
**ORGAN SUPPORT MAXIMUM is the same as attribute ORGAN SUPPORT MAXIMUM.**

**Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.**

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**ORGAN SYSTEM SUPPORTED**

---

**Change to Data Element: New Data Element**

| Format/Length: | an2 |
|---|---|
| National Codes: | See ORGAN SYSTEM SUPPORTED |
| Default Codes: | |

**Notes:**
**ORGAN SYSTEM SUPPORTED is the same as attribute ORGAN SYSTEM SUPPORTED.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | ORGAN SYSTEMS SUPPORTED |

---

**ORGAN SYSTEM SUPPORTED**

---

**Change to Data Element: New Data Element**

## ORGAN SYSTEM SUPPORTED

**Attribute:**

| ORGAN SYSTEM SUPPORTED |
|---|

---

**OUTPATIENT ATTENDANCE IDENTIFIER**

---

**Change to Data Element: Changed Dataset, Description**

| Format/Length: | max an20 |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
**OUTPATIENT ATTENDANCE IDENTIFIER is the same as attribute ACTIVITY IDENTIFIER.**

**~~This item is being used for development purposes and has not yet been approved.~~OUTPATIENT ATTENDANCE IDENTIFIER is a unique identifier for each Care Professional Out-Patient Attendance.**

**Note that the OUTPATIENT ATTENDANCE IDENTIFIER must be constructed without the use of PATIENT Confidential Information. This includes PATIENT Identifiers such as NHS NUMBER or LOCAL PATIENT IDENTIFIER, as well as any text which may identify the PATIENT DIAGNOSIS of the PATIENT or any PATIENT procedures being undertaken.**

**ATTENDANCE IDENTIFIER will be replaced with OUTPATIENT ATTENDANCE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.**

#### OUT-PATIENT ATTENDANCE OUTCOME

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See OUT-PATIENT ATTENDANCE OUTCOME |
| Default Codes: | |

**Notes:**
**OUT-PATIENT ATTENDANCE OUTCOME is the same as attribute OUT-PATIENT ATTENDANCE OUTCOME.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | OUT-PATIENT ATTENDANCE OUTCOMES |

#### OUT-PATIENT ATTENDANCE OUTCOME

**Change to Data Element: New Data Element**

## OUT-PATIENT ATTENDANCE OUTCOME

**Attribute:**

| OUT-PATIENT ATTENDANCE OUTCOME |
|---|

#### OVERSEAS VISITOR CHARGING CATEGORY

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See OVERSEAS VISITOR CHARGING CATEGORY |
| Default Codes: | 9 - OVERSEAS VISITOR CHARGING CATEGORY Not Known (Not Recorded) |

**Notes:**
**OVERSEAS VISITOR CHARGING CATEGORY is the same as attribute OVERSEAS VISITOR CHARGING CATEGORY.**

**OVERSEAS VISITOR STATUS information must be collected in accordance with the Overseas Visitor Charging Category Information Standard: DCB3017.**

#### OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE END DATE

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
**OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE END DATE is the same as attribute PERSON PROPERTY EFFECTIVE END DATE.**

**~~This item is being used for development purposes and has not yet been approved.~~OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE END DATE is the date the OVERSEAS VISITOR CHARGING CATEGORY was applicable until.**

OVERSEAS VISITOR STATUS information must be collected in accordance with the Overseas Visitor Charging Category Information Standard: DCB3017: NHS Trusts and NHS Foundation Trusts are required to record on a PATIENT's NHS Record the date on which the assessment of their OVERSEAS VISITOR CHARGING CATEGORY took place.

---

**OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE FROM DATE**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
**OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE FROM DATE is the same as attribute PERSON PROPERTY EFFECTIVE START DATE.**

**~~This item is being used for development purposes and has not yet been approved.~~OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE FROM DATE is the date when the OVERSEAS VISITOR CHARGING CATEGORY was applicable from.**

**OVERSEAS VISITOR STATUS information must be collected in accordance with the Overseas Visitor Charging Category Information Standard: DCB3017: NHS Trusts and NHS Foundation Trusts are required to record on a PATIENT's NHS Record the date on which the assessment of their OVERSEAS VISITOR CHARGING CATEGORY took place.**

**OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE DATE will be replaced with OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE FROM DATE, which is the most recent approved national information standard to describe the required definition.**

---

**OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See OVERSEAS VISITOR CHARGING CATEGORY |
| Default Codes: | 9 - OVERSEAS VISITOR CHARGING CATEGORY Not Known (Not Recorded) |
| | X - Not Known (Decision pending on OVERSEAS VISITOR CHARGING CATEGORY): only valid for CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set |

**Notes:**
**OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE is the same as attribute OVERSEAS VISITOR CHARGING CATEGORY, recorded at the CDS ACTIVITY DATE.**

**OVERSEAS VISITOR STATUS information must be collected in accordance with the Overseas Visitor Charging Category Information Standard: DCB3017.**

---

**PATIENT CLASSIFICATION CODE**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See PATIENT CLASSIFICATION |
| Default Codes: | 8 - Not applicable |

**Notes:**
PATIENT CLASSIFICATION CODE is the same as attribute PATIENT CLASSIFICATION.

PATIENT CLASSIFICATION CODE is derived from the ADMISSION METHOD, INTENDED MANAGEMENT and the duration of stay of the PATIENT.

The duration of stay is derived by subtracting the date of admission from the date of discharge.

In the case of maternity PATIENTS, the use being made of the Delivery facilities is also used in this derivation.

PATIENT CLASSIFICATION CODE is used by the Secondary Uses Service to derive the **Healthcare Resource Group** 4. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

---

**PATIENT FAMILY NAME**

---

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | max an35 |
| National Codes: | |
| Default Codes: | |

**Notes:**
PATIENT FAMILY NAME is the same as attribute PERSON NAME WORD TEXT where the PERSON NAME WORD TYPE is National Code *'Person Family Name'*.

PATIENT FAMILY NAME is the PERSON FAMILY NAME of the PATIENT.

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | PATIENT FAMILY NAMES |

---

**PATIENT FAMILY NAME**

---

**Change to Data Element: New Data Element**

## PATIENT FAMILY NAME

**Attribute:**

| PERSON NAME WORD TEXT |
|---|

---

**PATIENT FULL NAME**

---

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | max an70 |
| National Codes: | |
| Default Codes: | |

**Notes:**
PATIENT FULL NAME is the same as attribute PERSON NAME WORD TEXT.

PATIENT FULL NAME is the preferred PERSON FULL NAME of the PATIENT.

The PATIENT's name and ADDRESS should be withheld from any Commissioning Data Set that contains a valid NHS NUMBER. For further information, see the Security Issues and Patient Confidentiality.

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | PATIENT FULL NAMES |

**PATIENT FULL NAME**

**Change to Data Element: New Data Element**

## PATIENT FULL NAME

**Attribute:**

| PERSON NAME WORD TEXT |
|---|

**PATIENT GIVEN NAME**

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | max an35 |
| National Codes: | |
| Default Codes: | |

**Notes:**
PATIENT GIVEN NAME is the same as attribute PERSON NAME WORD TEXT where the PERSON NAME WORD TYPE is National Code *'Person Given Name'*.

PATIENT GIVEN NAME is the PERSON GIVEN NAME of the PATIENT.

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | PATIENT GIVEN NAMES |

**PATIENT GIVEN NAME**

**Change to Data Element: New Data Element**

## PATIENT GIVEN NAME

**Attribute:**

| PERSON NAME WORD TEXT |
|---|

**PATIENT INITIALS**

**Change to Data Element: New Data Element**

| Format/Length: | max an35 |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
PATIENT INITIALS is the same as attribute PERSON NAME WORD TEXT where the PERSON NAME WORD TYPE is National Code *'Person Initials'*.

PATIENT INITIALS is the PERSON INITIALS of the PATIENT.

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | PATIENT INITIALS |

**PATIENT INITIALS**

**Change to Data Element: New Data Element**

# PATIENT INITIALS

**Attribute:**

| PERSON NAME WORD TEXT |
|---|

**PATIENT NAME SUFFIX**

**Change to Data Element: New Data Element**

| Format/Length: | max an35 |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
PATIENT NAME SUFFIX is the same as attribute PERSON NAME WORD TEXT where the PERSON NAME WORD TYPE is National Code *'Person Name Suffix'.*

PATIENT NAME SUFFIX is the PERSON NAME SUFFIX of the PATIENT.

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | PATIENT NAME SUFFIXES |

**PATIENT NAME SUFFIX**

**Change to Data Element: New Data Element**

# PATIENT NAME SUFFIX

**Attribute:**

| PERSON NAME WORD TEXT |
|---|

**PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR AT CDS ACTIVITY DATE**

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR |
| Default Codes: | |

**Notes:**
**PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR AT CDS ACTIVITY DATE is the same as attribute PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR.**

**PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR AT CDS ACTIVITY DATE indicates whether the PATIENT is on a Patient Initiated Out-Patient Follow-Up Pathway at the CDS ACTIVITY DATE.**

---

**PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR AT CDS ACTIVITY DATE**

---

**Change to Data Element: New Data Element**

# PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR AT CDS ACTIVITY DATE

**Attribute:**

| PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR |
|---|

---

**PATIENT PATHWAY IDENTIFIER**

---

**Change to Data Element: Changed Dataset, Description**

| | |
|---|---|
| Format/Length: | an20 |
| National Codes: | |
| Default Codes: | |

**Notes:**
**PATIENT PATHWAY IDENTIFIER is the same as PATIENT PATHWAY IDENTIFIER.**

**Use in Commissioning Data Set version 6-0 onwards**

**If the Commissioning Data Set record relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, and is of the following Commissioning Data Set Types:**

- ~~CDS V6-2 Type 020 - Outpatient Commissioning Data Set~~
- ~~CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set~~
- ~~CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set~~
- **CDS V6-2 Type 020 - Outpatient Commissioning Data Set / CDS V6-3 Type 020 - Outpatient Commissioning Data Set**
- **CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set / CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set**
- **CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set / CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set**
- **CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set**
- **CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) Commissioning Data Set**
- **CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) Commissioning Data Set**

- CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) Commissioning Data Set

**then either UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) or PATIENT PATHWAY IDENTIFIER must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.**

---

**PATIENT SUBJECT TO REMOTE MONITORING INDICATOR AT CDS ACTIVITY DATE**

---

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See PATIENT SUBJECT TO REMOTE MONITORING INDICATOR |
| Default Codes: | |

**Notes:**
**PATIENT SUBJECT TO REMOTE MONITORING INDICATOR AT CDS ACTIVITY DATE is the same as attribute PATIENT SUBJECT TO REMOTE MONITORING INDICATOR.**

**PATIENT SUBJECT TO REMOTE MONITORING INDICATOR AT CDS ACTIVITY DATE indicates whether the PATIENT is subject to Remote Monitoring at the CDS ACTIVITY DATE.**

---

**PATIENT SUBJECT TO REMOTE MONITORING INDICATOR AT CDS ACTIVITY DATE**

---

**Change to Data Element: New Data Element**

# PATIENT SUBJECT TO REMOTE MONITORING INDICATOR AT CDS ACTIVITY DATE

**Attribute:**

| PATIENT SUBJECT TO REMOTE MONITORING INDICATOR |
|---|

---

**PATIENT TITLE**

---

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | max an35 |
| National Codes: | |
| Default Codes: | |

**Notes:**
**PATIENT TITLE is the same as attribute PERSON NAME WORD TEXT where the PERSON NAME WORD TYPE is National Code *'Person Title'.***

**PATIENT TITLE is the PERSON TITLE of the PATIENT.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | PATIENT TITLES |

---

**PATIENT TITLE**

---

Change to Data Element: New Data Element

## PATIENT TITLE

**Attribute:**

| PERSON NAME WORD TEXT |
|---|

---

**PATIENT USUAL ADDRESS (STRUCTURED (BABY))**

---

Change to Data Element: New Data Element

| | |
|---|---|
| Format/Length: | max an35 |
| National Codes: | |
| Default Codes: | |

**Notes:**

PATIENT USUAL ADDRESS (STRUCTURED (BABY)) is the same as attribute ADDRESS, for a baby.

PATIENT USUAL ADDRESS (STRUCTURED (BABY)) is the usual ADDRESS STRUCTURED nominated by the PATIENT, where the ADDRESS ASSOCIATION TYPE is National Code *'Main Permanent Residence'* or *'Other Permanent Residence'*.

For the baby in a birth episode, the PATIENT USUAL ADDRESS (STRUCTURED (BABY)) should usually refer to the mother's usual permanent place of residence, unless different circumstances apply (for example the baby is to be taken into care after birth).

PATIENT USUAL ADDRESS (STRUCTURED (BABY)) requires submission of at least the first two lines of the ADDRESS of the PATIENT. 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. For example:

Flat 1, 21 Arbuthnott Avenue, Pollo (35 characters)
k Estate, Lesser Hinkley, Staffords (35 characters)
hire (4 chars)

If PATIENTS usually resident elsewhere are staying in hotels, hostels or other residential establishments for a short period of time, they should be recorded as staying at their usual permanent place of residence. However if the PATIENTs stay is long term, for example if they are resident at a boarding school, the School ADDRESS must be recorded. University students may nominate either their home ADDRESS or the ADDRESS of their University ACCOMMODATION.

PATIENTS not able to provide a current permanent ADDRESS should be asked for their most recent ADDRESS. If this cannot be established, record the ADDRESS as *'No fixed abode'* or *'Address unknown'*. These PATIENTS are regarded as resident in the local geographical district for commissioning purposes.

The PATIENT's name and ADDRESS should be withheld from any Commissioning Data Set record which contains a valid NHS NUMBER.

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | PATIENT USUAL ADDRESSES (STRUCTURED (BABY)) |

---

**PATIENT USUAL ADDRESS (STRUCTURED (BABY))**

---

Change to Data Element: New Data Element

## PATIENT USUAL ADDRESS (STRUCTURED (BABY))

**Attribute:**

| ADDRESS |
|---|

**PATIENT USUAL ADDRESS (STRUCTURED (MOTHER))**

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | max an35 |
| National Codes: | |
| Default Codes: | |

**Notes:**

**PATIENT USUAL ADDRESS (STRUCTURED (MOTHER)) is the same as attribute ADDRESS, for the Mother of a baby.**

**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'*.**

**PATIENT USUAL ADDRESS (STRUCTURED (MOTHER)) requires submission of at least the first two lines of the ADDRESS of the PATIENT (mother). 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. For example:**

Flat 1, 21 Arbuthnott Avenue, Pollo (35 characters)
k Estate, Lesser Hinkley, Staffords (35 characters)
hire (4 chars)

**If PATIENTS usually resident elsewhere are staying in hotels, hostels or other residential establishments for a short period of time, they should be recorded as staying at their usual permanent place of residence. However if the PATIENTs stay is long term, for example if they are resident at a boarding school, the School ADDRESS must be recorded. University students may nominate either their home ADDRESS or the ADDRESS of their University ACCOMMODATION.**

**Where PATIENTS do not have the capacity to supply this information, because of mental illness, for example, then the PERSON responsible for the PATIENT such as a parent, guardian or other representative should nominate the PATIENT USUAL ADDRESS (STRUCTURED (MOTHER)).**

**PATIENTS not able to provide a current permanent ADDRESS should be asked for their most recent ADDRESS. If this cannot be established, record the ADDRESS as *'No fixed abode'* or *'Address unknown'*. These PATIENTS are regarded as resident in the local geographical district for commissioning purposes.**

**The PATIENT's name and ADDRESS should be withheld from any Commissioning Data Set record which contains a valid NHS NUMBER.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | PATIENT USUAL ADDRESSES (STRUCTURED (MOTHER)) |

**PATIENT USUAL ADDRESS (STRUCTURED (MOTHER))**

**Change to Data Element: New Data Element**

## PATIENT USUAL ADDRESS (STRUCTURED (MOTHER))

**Attribute:**

| ADDRESS |
|---|

---

**PATIENT USUAL ADDRESS (STRUCTURED)**

---

**Change to Data Element: New Data Element**

| Format/Length: | max an35 |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
**PATIENT USUAL ADDRESS (STRUCTURED) is the same as attribute ADDRESS.**

**PATIENT USUAL ADDRESS (STRUCTURED) is the usual ADDRESS STRUCTURED nominated by the PATIENT, where the ADDRESS ASSOCIATION TYPE is National Code *'Main Permanent Residence'* or *'Other Permanent Residence'*.**

**PATIENT USUAL ADDRESS (STRUCTURED) requires submission of at least the first two lines of the ADDRESS of the PATIENT. 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. For example:**

> Flat 1, 21 Arbuthnott Avenue, Pollo (35 characters)
> k Estate, Lesser Hinkley, Staffords (35 characters)
> hire (4 chars)

**If PATIENTS usually resident elsewhere are staying in hotels, hostels or other residential establishments for a short period of time, they should be recorded as staying at their usual permanent place of residence. However if the PATIENTs stay is long term, for example if they are resident at a boarding school, the School ADDRESS must be recorded. University students may nominate either their home ADDRESS or the ADDRESS of their University ACCOMMODATION.**

**Where PATIENTS do not have the capacity to supply this information, because of mental illness, for example, then the PERSON responsible for the PATIENT such as a parent, guardian or other representative should nominate the PATIENT USUAL ADDRESS (UNSTRUCTURED).**

**PATIENTS not able to provide a current permanent ADDRESS should be asked for their most recent ADDRESS. If this cannot be established, record the ADDRESS as *'No fixed abode'* or *'Address unknown'*. These PATIENTS are regarded as resident in the local geographical district for commissioning purposes.**

**For the baby in a birth episode, the PATIENT USUAL ADDRESS (UNSTRUCTURED) should usually refer to the mother's usual permanent place of residence, unless different circumstances apply (for example the baby is to be taken into care after birth).**

**The PATIENT's name and ADDRESS should be withheld from any Commissioning Data Set record which contains a valid NHS NUMBER.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | PATIENT USUAL ADDRESSES (STRUCTURED) |

---

**PATIENT USUAL ADDRESS (STRUCTURED)**

---

**Change to Data Element: New Data Element**

---

## PATIENT USUAL ADDRESS (STRUCTURED)

**Attribute:**

| ADDRESS |
|---|

---

**PATIENT USUAL ADDRESS (UNSTRUCTURED (BABY))**

---

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | max an175 |
| National Codes: | |
| Default Codes: | |

**Notes:**
**PATIENT USUAL ADDRESS (UNSTRUCTURED (BABY)) is the same as attribute ADDRESS for a baby.**

**PATIENT USUAL ADDRESS (UNSTRUCTURED (BABY)) is the usual ADDRESS UNSTRUCTURED nominated by the PATIENT, where the ADDRESS ASSOCIATION TYPE is National Code *'Main Permanent Residence'* or *'Other Permanent Residence'*.**

**For the baby in a birth episode, the PATIENT USUAL ADDRESS (UNSTRUCTURED (BABY)) should usually refer to the mother's usual permanent place of residence, unless different circumstances apply (for example the baby is to be taken into care after birth).**

**If PATIENTS usually resident elsewhere are staying in hotels, hostels or other residential establishments for a short period of time, they should be recorded as staying at their usual permanent place of residence. However if the PATIENTs stay is long term, for example if they are resident at a boarding school, the School ADDRESS must be recorded. University students may nominate either their home ADDRESS or the ADDRESS of their University ACCOMMODATION.**

**PATIENTS not able to provide a current permanent ADDRESS should be asked for their most recent ADDRESS. If this cannot be established, record the ADDRESS as *'No fixed abode'* or *'Address unknown'*. These PATIENTS are regarded as resident in the local geographical district for commissioning purposes.**

**The PATIENT's name and ADDRESS should be withheld from any Commissioning Data Set record which contains a valid NHS NUMBER.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | PATIENT USUAL ADDRESSES (UNSTRUCTURED (BABY)) |

---

**PATIENT USUAL ADDRESS (UNSTRUCTURED (BABY))**

---

**Change to Data Element: New Data Element**

## PATIENT USUAL ADDRESS (UNSTRUCTURED (BABY))

**Attribute:**

| ADDRESS |
|---|

---

**PATIENT USUAL ADDRESS (UNSTRUCTURED (MOTHER))**

---

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | max an175 |

National Codes:
Default Codes:

**Notes:**
PATIENT USUAL ADDRESS (UNSTRUCTURED (MOTHER)) is the same as attribute ADDRESS for the mother of a baby.

PATIENT USUAL ADDRESS (UNSTRUCTURED (MOTHER)) is the usual ADDRESS UNSTRUCTURED nominated by the PATIENT, where the ADDRESS ASSOCIATION TYPE is National Code *'Main Permanent Residence'* or *'Other Permanent Residence'*.

If PATIENTS usually resident elsewhere are staying in hotels, hostels or other residential establishments for a short period of time, they should be recorded as staying at their usual permanent place of residence. However if the PATIENTs stay is long term, for example if they are resident at a boarding school, the School ADDRESS must be recorded. University students may nominate either their home ADDRESS or the ADDRESS of their University ACCOMMODATION.

Where PATIENTS do not have the capacity to supply this information, because of mental illness, for example, then the PERSON responsible for the PATIENT such as a parent, guardian or other representative should nominate the PATIENT USUAL ADDRESS (UNSTRUCTURED (MOTHER)).

PATIENTS not able to provide a current permanent ADDRESS should be asked for their most recent ADDRESS. If this cannot be established, record the ADDRESS as *'No fixed abode'* or *'Address unknown'*. These PATIENTS are regarded as resident in the local geographical district for commissioning purposes.

The PATIENT's name and ADDRESS should be withheld from any Commissioning Data Set record which contains a valid NHS NUMBER.

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | PATIENT USUAL ADDRESSES (UNSTRUCTURED (MOTHER)) |

**PATIENT USUAL ADDRESS (UNSTRUCTURED (MOTHER))**

**Change to Data Element: New Data Element**

## PATIENT USUAL ADDRESS (UNSTRUCTURED (MOTHER))

**Attribute:**

ADDRESS

**PATIENT USUAL ADDRESS (UNSTRUCTURED)**

**Change to Data Element: New Data Element**

Format/Length: max an175
National Codes:
Default Codes:

**Notes:**
PATIENT USUAL ADDRESS (UNSTRUCTURED) is the same as attribute ADDRESS.

PATIENT USUAL ADDRESS (UNSTRUCTURED) is the usual ADDRESS UNSTRUCTURED nominated by the PATIENT, where the ADDRESS ASSOCIATION TYPE is National Code *'Main Permanent Residence'* or *'Other Permanent Residence'*.

If PATIENTS usually resident elsewhere are staying in hotels, hostels or other residential establishments for a short period of time, they should be recorded as staying at their usual permanent place of residence. However if the PATIENTs stay is long term, for example if they are resident at a boarding school, the School ADDRESS must be recorded. University students may nominate either their home ADDRESS or the ADDRESS of their University ACCOMMODATION.

Where PATIENTS do not have the capacity to supply this information, because of mental illness, for example, then the PERSON responsible for the PATIENT such as a parent, guardian or other representative should nominate the PATIENT USUAL ADDRESS (UNSTRUCTURED).

PATIENTS not able to provide a current permanent ADDRESS should be asked for their most recent ADDRESS. If this cannot be established, record the ADDRESS as *'No fixed abode'* or *'Address unknown'*. These PATIENTS are regarded as resident in the local geographical district for commissioning purposes.

For the baby in a birth episode, the PATIENT USUAL ADDRESS (UNSTRUCTURED) should usually refer to the mother's usual permanent place of residence, unless different circumstances apply (for example the baby is to be taken into care after birth).

The PATIENT's name and ADDRESS should be withheld from any Commissioning Data Set record which contains a valid NHS NUMBER.

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | PATIENT USUAL ADDRESSES (UNSTRUCTURED) |

---

**PATIENT USUAL ADDRESS (UNSTRUCTURED)**

---

**Change to Data Element: New Data Element**

## PATIENT USUAL ADDRESS (UNSTRUCTURED)

**Attribute:**

| ADDRESS |
|---|

---

**PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE**

---

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE is the same as attribute PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE.

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATES |

---

**PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE**

---

**Change to Data Element: New Data Element**

# PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE

**Attribute:**

| PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE |
|---|

---

**PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY REVIEW DATE**

---

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
**PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY REVIEW DATE is the same as attribute PLANNED ACTIVITY DATE where the PLANNED ACTIVITY DATE TYPE is National Code '*Personalised Out-Patient Follow Up Pathway Review Date*'.**

**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.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY REVIEW DATES |

---

**PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY REVIEW DATE**

---

**Change to Data Element: New Data Element**

# PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY REVIEW DATE

**Attribute:**

| PLANNED ACTIVITY DATE |
|---|

---

**PERSON BIRTH DATE**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| NWDS ID: | PEBD |
| NWDS Field Name: | Date of Birth |
| National Codes: | |
| Default Codes: | |

**Notes:**
**PERSON BIRTH DATE is the same as attribute PERSON BIRTH DATE.**

---

**PERSON BIRTH DATE (BABY)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
**PERSON BIRTH DATE (BABY) is the same as attribute PERSON BIRTH DATE for the baby.**

---

**PERSON BIRTH DATE (MOTHER)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
**PERSON BIRTH DATE (MOTHER) is the same as attribute PERSON BIRTH DATE for the mother.**

---

**PERSON MARITAL STATUS**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See PERSON MARITAL STATUS |
| Default Codes: | 8 - Not applicable |
| | 9 - Not known |

**Notes:**
**PERSON MARITAL STATUS is the same as attribute PERSON MARITAL STATUS.**

---

**PERSON PHENOTYPIC SEX**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See PERSON PHENOTYPIC SEX CLASSIFICATION |
| Default Codes: | X - Not Known (PERSON PHENOTYPIC SEX CLASSIFICATION not recorded) |

**Notes:**
**PERSON PHENOTYPIC SEX is the same as attribute PERSON PHENOTYPIC SEX CLASSIFICATION.**

**PERSON GENDER CODE CURRENT will be replaced with PERSON STATED GENDER CODE or PERSON PHENOTYPIC SEX, which are the most recent approved national information standards to describe the required definition.**

---

**PERSON SCORE**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an5 |
| National Codes: | |
| Default Codes: | |

**Notes:**
**PERSON SCORE is the same as attribute PERSON SCORE.**

---

**PERSON STATED GENDER CODE**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See PERSON STATED GENDER CODE |
| Default Codes: | X - Not Known (PERSON STATED GENDER CODE not recorded) |

**Notes:**
**PERSON STATED GENDER CODE is the same as attribute PERSON STATED GENDER CODE.**

**PERSON GENDER CODE CURRENT will be replaced with PERSON STATED GENDER CODE or PERSON PHENOTYPIC SEX, which are the most recent approved national information standards to describe the required definition.**

---

**PERSON WEIGHT**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max n3.max n3 |
| National Codes: | |
| Default Codes: | |

**Notes:**
**PERSON WEIGHT is the same as attribute CLINICAL INVESTIGATION RESULT VALUE.**

**PERSON WEIGHT is the result of the Clinical Investigation which measures the PATIENT's Weight, where the UCUM UNIT OF MEASUREMENT is '*Kilograms (kg)*'.**

**Notes:**

- **For the Commissioning Data Sets, PERSON WEIGHT must be padded to match the Format/Length pattern of n3.n3, for example 001.100 is a valid entry (1.1 is invalid)**
- **For Neonatal Critical Care Minimum Data Set, PERSON WEIGHT will be the last recorded Weight on a particular ACTIVITY DATE (CRITICAL CARE)**
- **For the Systemic Anti-Cancer Therapy Data Set, PERSON WEIGHT is the Weight at the start of the:**
    - **Systemic Anti-Cancer Therapy Drug Regimen and**
    - **Systemic Anti-Cancer Therapy Drug Cycle.**

---

**POSTCODE OF USUAL ADDRESS**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | See POSTCODE |
| National Codes: | |
| Default Codes: | |

**Notes:**
**POSTCODE OF USUAL ADDRESS is the same as attribute POSTCODE.**

**POSTCODE OF USUAL ADDRESS is the POSTCODE of the ADDRESS nominated by the PATIENT where the ADDRESS ASSOCIATION TYPE is National Code *'Main Permanent Residence'* or *'Other Permanent Residence'*.**

**For further information on POSTCODES, see POSTCODE.**

---

**POSTCODE OF USUAL ADDRESS (MOTHER)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | See POSTCODE OF USUAL ADDRESS |
| National Codes: | |
| Default Codes: | |

**Notes:**
POSTCODE OF USUAL ADDRESS (MOTHER) is the same as attribute POSTCODE.

POSTCODE OF USUAL ADDRESS (MOTHER) is the POSTCODE OF USUAL ADDRESS where it relates to the mother of the PATIENT.

---

**PRESENT ON ADMISSION INDICATOR**

---

**Change to Data Element: Changed Dataset, Description**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See PRESENT ON ADMISSION INDICATOR |
| Default Codes: | 8 - Not applicable (indication of this PATIENT DIAGNOSIS on admission not required nationally)<br>9 - Not known whether the PATIENT DIAGNOSIS was present on admission |

**Notes:**
PRESENT ON ADMISSION INDICATOR is the same as attribute PRESENT ON ADMISSION INDICATOR.

~~**Note:**~~
~~**This data item is included in Commissioning Data Set version 6-2, but should not be submitted until further development by NHS Digital has been undertaken.**~~Note: **PRESENT ON ADMISSION INDICATOR is only required for PATIENTS with a PATIENT 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 SNOMED CT-coded Comorbidity data structure to submit this data in CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set / CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set, which is the preferred mechanism of data submission.**

---

**PRIMARY DIAGNOSIS (ICD)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | See ICD-10 CODE |
| National Codes: | |
| Default Codes: | |

**Notes:**
PRIMARY DIAGNOSIS (ICD) is the same as attribute CLINICAL CLASSIFICATION CODE.

PRIMARY DIAGNOSIS (ICD) is the International Classification of Diseases (ICD) code used to identify the PRIMARY DIAGNOSIS.

PRIMARY DIAGNOSIS (ICD) is used by the Secondary Uses Service to derive the **Healthcare Resource Group** 4. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

Note:

- The format/length of this Data Element has been corrected as a result of the work undertaken for the development of the Coding Strategy.
- The data set specifications of the data sets that contain this Data Element will be updated in the next version of the information standard where it is not already correct.

### PRIMARY PROCEDURE (OPCS)

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | See OPCS-4 CODE |
| National Codes: | |
| Default Codes: | |

**Notes:**
**PRIMARY PROCEDURE (OPCS) is the same as attribute CLINICAL CLASSIFICATION CODE.**

**PRIMARY PROCEDURE (OPCS) is the OPCS Classification of Interventions and Procedures code which is used to identify the primary Patient Procedure carried out.**

### PRIORITY TYPE CODE

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See PRIORITY TYPE |
| Default Codes: | |

**Notes:**
**PRIORITY TYPE CODE is the same as attribute PRIORITY TYPE.**

**PRIORITY TYPE CODES can be defined more precisely if this is needed for local purposes, as long as the classifications can be mapped back to the National Codes.**

### PROCEDURE (OPCS)

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | See OPCS-4 CODE |
| National Codes: | |
| Default Codes: | |

**Notes:**
**PROCEDURE (OPCS) is the same as attribute CLINICAL CLASSIFICATION CODE.**

**PROCEDURE (OPCS) is a Patient Procedure other than the PRIMARY PROCEDURE (OPCS).**

**For Commissioning Data Sets purposes it is recommended that multiple Patient Procedures are recorded and the CDS XML Schema (CDS Version 6 onwards) has been designed to carry as many Patient Procedures as required.**

### PROCEDURE (SNOMED CT EXPRESSION)

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | See SNOMED CT EXPRESSION |
| National Codes: | |
| Default Codes: | |

**Notes:**
**PROCEDURE (SNOMED CT EXPRESSION) is the same as attribute CLINICAL TERMINOLOGY CODE.**

~~This item is being used for development purposes and has not yet been approved.~~**PROCEDURE (SNOMED CT EXPRESSION) is a structured combination of one or more SNOMED CT® concept identifiers which are used to describe a Patient Procedure.**

**For further information on SNOMED CT EXPRESSIONS, see the SNOMED CT® Glossary at: Expression.**

---

**PROCEDURE DATE**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
**PROCEDURE DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Procedure Date'*.**

---

**PROCEDURE SCHEME IN USE (COMMISSIONING DATA SET)**

---

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See PROCEDURE SCHEME IN USE |
| Default Codes: | |

**Notes:**
**PROCEDURE SCHEME IN USE (COMMISSIONING DATA SET) is the same as attribute PROCEDURE SCHEME IN USE for the Commissioning Data Sets.**

***Permitted National Codes:***

| | |
|---|---|
| 02 | OPCS-4 |

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | PROCEDURE SCHEMES IN USE (COMMISSIONING DATA SET) |

---

**PROCEDURE SCHEME IN USE (COMMISSIONING DATA SET)**

---

**Change to Data Element: New Data Element**

## PROCEDURE SCHEME IN USE (COMMISSIONING DATA SET)

**Attribute:**

| |
|---|
| PROCEDURE SCHEME IN USE |

---

**PROFESSIONAL REGISTRATION ENTRY IDENTIFIER**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an32 |
| NWDS ID: | EPRN |
| NWDS Field Name: | Professional Registration Number |
| National Codes: | |
| Default Codes: | |

**Notes:**

PROFESSIONAL REGISTRATION ENTRY IDENTIFIER is the same as attribute PROFESSIONAL REGISTRATION ENTRY IDENTIFIER.

**PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)**

**Change to Data Element: Changed Dataset, Description**

| Format/Length: | max an32 |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) is the same as attribute PROFESSIONAL REGISTRATION ENTRY IDENTIFIER.

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.~~In Commissioning Data Set versions 6-2 and 6-3, PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) must be accompanied by the PROFESSIONAL REGISTRATION ISSUER CODE, which indicates the body which issued the PROFESSIONAL REGISTRATION of the main/lead CARE PROFESSIONAL.

~~In Commissioning Data Set version 6-2, PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) must be accompanied by the PROFESSIONAL REGISTRATION ISSUER CODE, which indicates the body which issued the PROFESSIONAL REGISTRATION of the main/lead CARE PROFESSIONAL, where it is one of the following:~~

- ~~General Dental Council~~
- ~~General Medical Council~~
- ~~Health and Care Professions Council~~
- ~~Nursing and Midwifery Council.~~

Note: the Format/Length has been updated. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

**PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)**

**Change to Data Element: Changed Dataset, Description**

| Format/Length: | max an32 |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) is the same as attribute PROFESSIONAL REGISTRATION ENTRY IDENTIFIER.

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.~~In Commissioning Data Set versions 6-2 and 6-3, PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) must be accompanied by the PROFESSIONAL REGISTRATION

ISSUER CODE, which indicates the body which issued the PROFESSIONAL REGISTRATION of the main/lead anaesthetist.

~~In Commissioning Data Set version 6-2, PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) must be accompanied by the PROFESSIONAL REGISTRATION ISSUER CODE, which indicates the body which issued the PROFESSIONAL REGISTRATION of the main/lead anaesthetist, where it is one of the following:~~

- ~~General Dental Council~~
- ~~General Medical Council~~
- ~~Health and Care Professions Council~~
- ~~Nursing and Midwifery Council.~~

Note: the Format/Length has been updated. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

**PROFESSIONAL REGISTRATION ISSUER CODE**

---

**Change to Data Element: Changed Dataset, Description**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | |
| Default Codes: | |

**Notes:**
PROFESSIONAL REGISTRATION ISSUER CODE is the same as attribute PROFESSIONAL REGISTRATION BODY CODE

Notes:

- ~~National Code 04 '*General Optical Council*' is only valid for CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set/ CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set and must not be submitted in other Commissioning Data Set versions~~
- ~~National Code 16 '*General Pharmaceutical Council*' is only valid for CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set and must not be submitted in other Commissioning Data Set versions.~~
- National Code 04 '*General Optical Council*' is only valid for CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set / CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set / Commissioning Data Sets version 6-3, and must not be submitted in other Commissioning Data Set versions
- National Code 16 '*General Pharmaceutical Council*' is only valid for CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set / Commissioning Data Sets version 6-3, and must not be submitted in other Commissioning Data Set versions.

***Permitted National Codes:***

| | |
|---|---|
| 02 | General Dental Council |
| 03 | General Medical Council |
| 04 | General Optical Council |
| 08 | Health and Care Professions Council |
| 09 | Nursing and Midwifery Council |
| 16 | General Pharmaceutical Council |

---

**PROVIDER REFERENCE IDENTIFIER**

---

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | max an20 |
| National Codes: | |
| Default Codes: | |

**Notes:**
**PROVIDER REFERENCE IDENTIFIER is the same as attribute PROVIDER REFERENCE IDENTIFIER.**

**PROVIDER REFERENCE NUMBER will be replaced with PROVIDER REFERENCE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | PROVIDER REFERENCE IDENTIFIERS |

**PROVIDER REFERENCE IDENTIFIER**

**Change to Data Element: New Data Element**

## PROVIDER REFERENCE IDENTIFIER

**Attribute:**

| PROVIDER REFERENCE IDENTIFIER |
|---|

**PROVIDER REFERENCE NUMBER**

**Change to Data Element: Changed Description**

| | |
|---|---|
| Format/Length: | max an17 |
| National Codes: | |
| Default Codes: | |

**Notes:**
**PROVIDER REFERENCE NUMBER is the same as attribute PROVIDER REFERENCE NUMBER**

**Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.**

**PROVIDER REFERENCE NUMBER will be replaced with PROVIDER REFERENCE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.**

**PSYCHIATRIC PATIENT STATUS CODE**

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See PSYCHIATRIC PATIENT STATUS |
| Default Codes: | 8 - Not applicable: the PATIENT is not receiving admitted patient care under a CONSULTANT in a psychiatric specialty |
| | 9 - Not known: the PATIENT is receiving admitted patient care under a CONSULTANT in a psychiatric specialty, but the information is not available. |

**Notes:**

**PSYCHIATRIC PATIENT STATUS CODE is the same as attribute PSYCHIATRIC PATIENT STATUS.**

---

**REFERRAL REQUEST RECEIVED DATE**

---

**Change to Data Element: Changed Dataset**

| Format/Length: | an10 CCYY-MM-DD |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
**REFERRAL REQUEST RECEIVED DATE is the same as attribute REFERRAL REQUEST RECEIVED DATE.**

**For the purposes of the National Cancer Waiting Times Monitoring Data Set, REFERRAL REQUEST RECEIVED DATE is used to derive the CANCER REFERRAL TO TREATMENT PERIOD START DATE.**

---

**REFERRAL TO TREATMENT PERIOD END DATE**

---

**Change to Data Element: Changed Dataset, Description**

| Format/Length: | an10 CCYY-MM-DD |
|---|---|
| National Codes: | |
| Default Codes: | |

**Notes:**
**REFERRAL TO TREATMENT PERIOD END DATE is the same as attribute REFERRAL TO TREATMENT PERIOD END DATE.**

**Use in Commissioning Data Set version 6-0 onwards**

**If the Commissioning Data Set record relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, and is of the following Commissioning Data Set Types:**

- ~~**CDS V6-2 Type 020 - Outpatient Commissioning Data Set**~~
- ~~**CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set**~~
- ~~**CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set**~~
- **CDS V6-2 Type 020 - Outpatient Commissioning Data Set / CDS V6-3 Type 020 - Outpatient Commissioning Data Set**
- **CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set / CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set**
- **CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set / CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set**
- **CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set**
- **CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) Commissioning Data Set**
- **CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) Commissioning Data Set**
- **CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) Commissioning Data Set**

**then REFERRAL TO TREATMENT PERIOD END DATE must be present in the Commissioning Data Set PATIENT PATHWAY Data Group, where the REFERRAL TO TREATMENT PERIOD has ended.**

---

**REFERRAL TO TREATMENT PERIOD START DATE**

---

**Change to Data Element: Changed Dataset, Description**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
**REFERRAL TO TREATMENT PERIOD START DATE is the same as attribute REFERRAL TO TREATMENT PERIOD START DATE.**

**Use in Commissioning Data Set version 6-0 onwards**

**If the Commissioning Data Set record relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, and is of the following Commissioning Data Set Types:**

- ~~**CDS V6-2 Type 020 - Outpatient Commissioning Data Set**~~
- ~~**CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set**~~
- ~~**CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set**~~
- **CDS V6-2 Type 020 - Outpatient Commissioning Data Set / CDS V6-3 Type 020 - Outpatient Commissioning Data Set**
- **CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set / CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set**
- **CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set / CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set**
- **CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set**
- **CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) Commissioning Data Set**
- **CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) Commissioning Data Set**
- **CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) Commissioning Data Set**

**then REFERRAL TO TREATMENT PERIOD START DATE must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.**

---

**REFERRAL TO TREATMENT PERIOD STATUS**

---

**Change to Data Element: Changed Dataset, Description**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See REFERRAL TO TREATMENT PERIOD STATUS |
| Default Codes: | |

**Notes:**
**REFERRAL TO TREATMENT PERIOD STATUS is the same as attribute REFERRAL TO TREATMENT PERIOD STATUS.**

**Use in Commissioning Data Set version 6-0 onwards**

**If the Commissioning Data Set record relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, and is of the following Commissioning Data Set Types:**

- ~~CDS V6-2 Type 020 - Outpatient Commissioning Data Set~~
- ~~CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set~~
- ~~CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set~~
- **CDS V6-2 Type 020 - Outpatient Commissioning Data Set / CDS V6-3 Type 020 - Outpatient Commissioning Data Set**
- **CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set / CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set**
- **CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set / CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set**
- **CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set**
- **CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) Commissioning Data Set**
- **CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) Commissioning Data Set**
- **CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) Commissioning Data Set**

**then REFERRAL TO TREATMENT PERIOD STATUS must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.**

**For specific National Code usage, see REFERRAL TO TREATMENT PERIOD STATUS.**

---

**REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR**

---

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR |
| Default Codes: | 9 - Not Known whether PATIENT referred by a First Contact Practitioner |

**Notes:**
**REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR is the same as attribute REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | REFERRED BY FIRST CONTACT PRACTITIONER INDICATORS |

---

**REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR**

---

**Change to Data Element: New Data Element**

## REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR

**Attribute:**

| REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR |
|---|

---

**REFERRER CODE**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an8 |
| National Codes: | |
| Default Codes: | A9999998 - Ministry of Defence Doctor<br>C9999998 - CONSULTANT GENERAL MEDICAL COUNCIL REFERENCE NUMBER not known<br>CD999998 - Dental CONSULTANT: GENERAL MEDICAL COUNCIL REFERENCE NUMBER / GENERAL DENTAL COUNCIL REGISTRATION NUMBER not known<br>D9999998 - Dentist, GENERAL DENTAL PRACTITIONER CODE not known<br>R9999981 - Referrer other than GENERAL MEDICAL PRACTITIONER, GENERAL DENTAL PRACTITIONER or CONSULTANT<br>X9999998 - Not applicable, e.g. PATIENT has self-presented or not known |

**Notes:**
**REFERRER CODE is the same as attribute CARE PROFESSIONAL IDENTIFIER.**

**REFERRER CODE is the code of the PERSON making the REFERRAL REQUEST. This will normally be a CARE PROFESSIONAL, GENERAL MEDICAL PRACTITIONER or CONSULTANT.**

**The intention is for this item to reflect the actual (true) referrer. For example, following a GENERAL MEDICAL PRACTITIONER referral, a CONSULTANT may subsequently refer the PATIENT to another CONSULTANT within the Hospital Provider Spell. The code of the CONSULTANT making the referral and the CONSULTANTS ORGANISATION should be recorded in the Commissioning Data Set (CDS) rather than the code of the GENERAL MEDICAL PRACTITIONER referrer. This also applies where a CONSULTANT refers an NHS PATIENT to another doctor for NHS-commissioned treatment at another NHS / non-NHS provider, or an overseas provider. Where the CONSULTANT CODE is not known, the Organisation Data Service Default Code C9999998 should be used.**

**In all other cases, the code of the referring GENERAL MEDICAL PRACTITIONER should be recorded, if applicable. When a locum refers, use the GENERAL MEDICAL PRACTITIONER PPD CODE of the GENERAL PRACTITIONER for whom the locum is acting.**

**See CONSULTANT CODE and GENERAL MEDICAL PRACTITIONER (SPECIFIED) for the codes available for CONSULTANTS and GENERAL MEDICAL PRACTITIONERS and GENERAL DENTAL PRACTITIONERS.**

**If the REFERRER CODE is not known or not applicable e.g. the PATIENT has self-presented, the Organisation Data Service Default Code (X9999998) should be used.**

---

**REHABILITATION ASSESSMENT TEAM TYPE**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See REHABILITATION ASSESSMENT TEAM TYPE |
| Default Codes: | 8 - Not applicable - ACTIVITY is not Rehabilitation Assessment<br>9 - REHABILITATION ASSESSMENT TEAM TYPE not known |

**Notes:**
**REHABILITATION ASSESSMENT TEAM TYPE is the same as attribute REHABILITATION ASSESSMENT TEAM TYPE.**

**This data item is included in Commissioning Data Set versions 6-2 and 6-3, but should not be submitted until further development by the Department of Health and Social Care has been undertaken.**

---

**RENAL SUPPORT DAYS**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an3 |
| National Codes: | |
| Default Codes: | 998 - 998 or more days of renal support |
| | 999 - Occurred but day count not known |

**Notes:**
**RENAL SUPPORT DAYS is the same as attribute ACTIVITY DURATION.**

**RENAL SUPPORT DAYS is the total number of days that the PATIENT received renal system support during a CRITICAL CARE PERIOD, ranging from 0 to 997 days.**

**RENAL SUPPORT DAYS 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 '*Renal Support*' within the CRITICAL CARE PERIOD.**

**RENAL SUPPORT DAYS is used by the Secondary Uses Service to derive the Healthcare Resource Group 4. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.**

**For further information, please refer to the NHS Digital website at: Payment by Results Guidance.**

**Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.**

---

**RESPONSIBLE CARE PROFESSIONAL INDICATOR**

---

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See RESPONSIBLE CARE PROFESSIONAL INDICATOR |
| Default Codes: | |

**Notes:**
**RESPONSIBLE CARE PROFESSIONAL INDICATOR is the same as attribute RESPONSIBLE CARE PROFESSIONAL INDICATOR.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | RESPONSIBLE CARE PROFESSIONAL INDICATORS |

**RESPONSIBLE CARE PROFESSIONAL INDICATOR**

**Change to Data Element: New Data Element**

## RESPONSIBLE CARE PROFESSIONAL INDICATOR

**Attribute:**

| RESPONSIBLE CARE PROFESSIONAL INDICATOR |
|---|

**RESUSCITATION METHOD CODE**

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See RESUSCITATION METHOD CODE |
| Default Codes: | 8 - Not applicable (e.g. stillborn, where no method of resuscitation was attempted)<br>9 - RESUSCITATION METHOD CODE not known |

**Notes:**
**RESUSCITATION METHOD CODE is the same as attribute RESUSCITATION METHOD CODE.**

**Note: the Default Code description for 9 - Not known has been updated. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.**

**SECONDARY DIAGNOSIS (ICD)**

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | See ICD-10 CODE |
| National Codes: | |
| Default Codes: | |

**Notes:**
**SECONDARY DIAGNOSIS (ICD) is the same as attribute CLINICAL CLASSIFICATION CODE.**

**SECONDARY DIAGNOSIS (ICD) is the International Classification of Diseases (ICD) code used to identify the secondary PATIENT DIAGNOSIS.**

**For Commissioning Data Sets (CDS) purposes it is recommended that multiple Diagnoses are recorded and the CDS XML Schema (CDS Version 6 onwards) has been designed to carry as many Diagnoses as required.**

**SECONDARY DIAGNOSIS (ICD) is used by the Secondary Uses Service to derive the Healthcare Resource Group 4. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually resulting in lower levels of healthcare resource.**

**For further information, please refer to the NHS Digital website at: Payment by Results Guidance.**

**Note:**

- **The format/length of this Data Element has been corrected as a result of the work undertaken for the development of the Coding Strategy.**
- **The data set specifications of the data sets that contain this Data Element will be updated in the next version of the information standard where it is not already correct.**

#### SERVICE REQUEST IDENTIFIER

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an20 |
| National Codes: | |
| Default Codes: | |

**Notes:**
**SERVICE REQUEST IDENTIFIER is the same as attribute SERVICE REQUEST IDENTIFIER.**

#### SERVICE TYPE REQUESTED CODE

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See SERVICE TYPE REQUESTED |
| Default Codes: | |

**Notes:**
**SERVICE TYPE REQUESTED CODE is the same as attribute SERVICE TYPE REQUESTED.**

#### SEX OF PATIENTS CODE

**Change to Data Element: Changed Description**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See SEX OF PATIENTS |
| Default Codes: | |

**Notes:**
**SEX OF PATIENTS CODE is the same as attribute SEX OF PATIENTS.**

**For specific National Code usage in different data sets, see SEX OF PATIENTS.**

**SEX OF PATIENTS CODE will be replaced with WARD INTENDED SEX OF PATIENTS, which is the most recent approved national information standard to describe the required definition.**

#### SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION)

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | See SNOMED CT EXPRESSION |
| National Codes: | |
| Default Codes: | |

**Notes:**
**SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION) is the same as attribute CLINICAL TERMINOLOGY CODE.**

**~~This item is being used for development purposes and has not yet been approved.~~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.**

**For further information on SNOMED CT EXPRESSIONS, see the SNOMED CT® Glossary at: Expression.**

#### SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an25 |
| National Codes: | |
| Default Codes: | |

**Notes:**
**SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP is the same as attribute PERSON PROPERTY RECORDED DATE and PERSON PROPERTY RECORDED TIME.**

**~~This item is being used for development purposes and has not yet been approved.~~SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP is the date, time and time zone when the SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT) was recorded.**

**A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time.**

**In most cases offset time is restricted to:**

- **+01:00**
- **+00:00**
- **-00:00**

**Examples of valid formats are:**

- **2020-08-21T10:15:20+01:00 British Summer Time (GMT + 1 Hour)**
- **2020-08-21T10:15:20+00:00 Greenwich Mean Time**
- **2020-08-21T10:15:20-00:00 Greenwich Mean Time**
- **2020-08-21T09:18:00Z Greenwich Mean Time.**

---

#### SOURCE OF REFERRAL FOR OUT-PATIENTS

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See SOURCE OF REFERRAL FOR OUT-PATIENTS |
| Default Codes: | |

**Notes:**
**SOURCE OF REFERRAL FOR OUT-PATIENTS is the same as attribute SOURCE OF REFERRAL FOR OUT-PATIENTS.**

**For specific National Code usage, see SOURCE OF REFERRAL FOR OUT-PATIENTS.**

---

#### SPECIALISED SERVICE CODE

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an12 |
| National Codes: | |
| Default Codes: | |

**Notes:**
**SPECIALISED SERVICE CODE is the same as attribute SPECIALISED SERVICE CODE.**

#### START DATE (COMMISSIONER ASSIGNMENT PERIOD)

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
**START DATE (COMMISSIONER ASSIGNMENT PERIOD) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Commissioner Assignment Period.**

#### START DATE (EPISODE)

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
**START DATE (EPISODE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the episode.**

**START DATE (EPISODE) is used by the Secondary Uses Service to derive the Healthcare Resource Group 4. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.**

**For further information, please refer to the NHS Digital website at: Payment by Results Guidance.**

#### START DATE (HOME LEAVE)

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
**START DATE (HOME LEAVE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Home Leave.**

#### START DATE (HOSPITAL PROVIDER SPELL)

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
**START DATE (HOSPITAL PROVIDER SPELL) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Hospital Provider Spell.**

**The Start Date of the Hospital Provider Spell is the date of admission: the CONSULTANT or MIDWIFE has assumed responsibility for care following the DECISION TO ADMIT the PATIENT.**

**START DATE (HOSPITAL PROVIDER SPELL) is used by the Secondary Uses Service to derive the Healthcare Resource Group 4. Failure to correctly populate this data element is likely to**

**result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.**

**For further information, please refer to the NHS Digital website at: Payment by Results Guidance.**

---

**START DATE (WARD STAY)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an10 CCYY-MM-DD |
| National Codes: | |
| Default Codes: | |

**Notes:**
**START DATE (WARD STAY) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Ward Stay.**

---

**START TIME (EPISODE)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an8 HH:MM:SS |
| National Codes: | |
| Default Codes: | |

**Notes:**
**START TIME (EPISODE) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Start Time*' of the episode.**

---

**START TIME (HOME LEAVE)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an8 HH:MM:SS |
| National Codes: | |
| Default Codes: | |

**Notes:**
**START TIME (HOME LEAVE) is the same as the attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Start Time*' of the Home Leave.**

---

**START TIME (HOSPITAL PROVIDER SPELL)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an8 HH:MM:SS |
| National Codes: | |
| Default Codes: | |

**Notes:**
**START TIME (HOSPITAL PROVIDER SPELL) is the same as the attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Start Time*' of the Hospital Provider Spell.**

---

**START TIME (WARD STAY)**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an8 HH:MM:SS |
| National Codes: | |
| Default Codes: | |

**Notes:**

**START TIME (WARD STAY) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Start Time*' of the Ward Stay.**

---

**STATUS OF PERSON CONDUCTING DELIVERY CODE**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See STATUS OF PERSON CONDUCTING DELIVERY |
| Default Codes: | 9 - STATUS OF PERSON CONDUCTING DELIVERY not known |

**Notes:**
**STATUS OF PERSON CONDUCTING DELIVERY CODE is the same as attribute STATUS OF PERSON CONDUCTING DELIVERY.**

**Note: the Default Code description for 9 - Not known has been updated. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.**

---

**UCUM UNIT OF MEASUREMENT**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an10 |
| National Codes: | |
| Default Codes: | |

**Notes:**
**UCUM UNIT OF MEASUREMENT is the same as attribute UCUM UNIT OF MEASUREMENT.**

---

**UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)**

---

**Change to Data Element: Changed Dataset, Description**

| | |
|---|---|
| Format/Length: | n12 |
| National Codes: | |
| Default Codes: | |

**Notes:**
**UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) is the same as attribute UNIQUE BOOKING REFERENCE NUMBER (CONVERTED).**

**Use in Commissioning Data Set version 6-0 onwards**

**If the Commissioning Data Set record relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, and is of the following Commissioning Data Set Types:**

- ~~**CDS V6-2 Type 020 - Outpatient Commissioning Data Set**~~
- ~~**CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set**~~
- ~~**CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set**~~
- **CDS V6-2 Type 020 - Outpatient Commissioning Data Set / CDS V6-3 Type 020 - Outpatient Commissioning Data Set**
- **CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set / CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set**
- **CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set / CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set**

- **CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set**
- **CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) Commissioning Data Set**
- **CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) Commissioning Data Set**
- **CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) Commissioning Data Set**

**then either UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) or PATIENT PATHWAY IDENTIFIER must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.**

---

**WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)**

---

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | |
| Default Codes: | |

**Notes:**
**WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET) is the same as attribute WAITING TIME MEASUREMENT TYPE for the Commissioning Data Sets.**

***Permitted National Codes:***

| | |
|---|---|
| 01 | Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement |
| 02 | Allied Health Professional Referral To Treatment Measurement |
| 09 | Other Referral To Treatment Measurement Type (not listed) |

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | WAITING TIME MEASUREMENT TYPES (COMMISSIONING DATA SET) |

---

**WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)**

---

**Change to Data Element: New Data Element**

## WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)

**Attribute:**

| |
|---|
| WAITING TIME MEASUREMENT TYPE |

---

**WARD CODE**

---

**Change to Data Element: Changed Dataset**

| | |
|---|---|
| Format/Length: | max an12 |
| National Codes: | |
| Default Codes: | |

**Notes:**
**WARD CODE is the same as attribute WARD CODE.**

**For Commissioning Data Set version 6-2, WARD CODE identifies the WARD where ACTIVITY during a Hospital Provider Spell took place.**

**WARD CODE is an optional item in the Commissioning Data Set version 6-2, and is for local use only. However it must NOT contain any text which may identify the PATIENT DIAGNOSIS of the PATIENTS using the WARD (for example, it must not include the acronym 'HIV') or the Patient Procedure being undertaken (for example using the acronym 'TOP' for terminations of pregnancy). Use of such identifiers contravenes the legal requirements for withholding identifiable information about PATIENTS with identified conditions. See Security Issues and Patient Confidentiality for further details.**

---

**WARD INTENDED AGE GROUP**

---

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See WARD INTENDED AGE GROUP |
| Default Codes: | |

**Notes:**
**WARD INTENDED AGE GROUP is the same as attribute WARD INTENDED AGE GROUP.**

**INTENDED AGE GROUP will be replaced with WARD INTENDED AGE GROUP, which is the most recent approved national information standard to describe the required definition.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | WARD INTENDED AGE GROUPS |

---

**WARD INTENDED AGE GROUP**

---

**Change to Data Element: New Data Element**

## WARD INTENDED AGE GROUP

**Attribute:**

| WARD INTENDED AGE GROUP |
|---|

---

**WARD INTENDED CLINICAL CARE INTENSITY**

---

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | an2 |
| National Codes: | See WARD INTENDED CLINICAL CARE INTENSITY |
| Default Codes: | |

**Notes:**
**WARD INTENDED CLINICAL CARE INTENSITY is the same as attribute WARD INTENDED CLINICAL CARE INTENSITY.**

**INTENDED CLINICAL CARE INTENSITY CODE will be replaced with WARD INTENDED CLINICAL CARE INTENSITY, which is the most recent approved national information standard to describe the required definition.**

#### WARD INTENDED CLINICAL CARE INTENSITY

**Change to Data Element: New Data Element**

## WARD INTENDED CLINICAL CARE INTENSITY

**Attribute:**

| WARD INTENDED CLINICAL CARE INTENSITY |
|---|

#### WARD INTENDED DAY PERIOD AVAILABILITY

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See WARD INTENDED DAY PERIOD AVAILABILITY |
| Default Codes: | |

**Notes:**
**WARD INTENDED DAY PERIOD AVAILABILITY is the same as attribute WARD INTENDED DAY PERIOD AVAILABILITY.**

**WARD DAY PERIOD AVAILABILITY CODE will be replaced with WARD INTENDED DAY PERIOD AVAILABILITY, which is the most recent approved national information standard to describe the required definition.**

**This data element is also known by these names:**

| Context | Alias |
|---|---|
| plural | WARD INTENDED DAY PERIOD AVAILABILITIES |

#### WARD INTENDED DAY PERIOD AVAILABILITY

**Change to Data Element: New Data Element**

## WARD INTENDED DAY PERIOD AVAILABILITY

**Attribute:**

| WARD INTENDED DAY PERIOD AVAILABILITY |
|---|

#### WARD INTENDED NIGHT PERIOD AVAILABILITY

**Change to Data Element: New Data Element**

| | |
|---|---|
| Format/Length: | an1 |
| National Codes: | See WARD INTENDED NIGHT PERIOD AVAILABILITY |
| Default Codes: | |

**Notes:**
**WARD INTENDED NIGHT PERIOD AVAILABILITY is the same as attribute WARD INTENDED NIGHT PERIOD AVAILABILITY.**

**WARD NIGHT PERIOD AVAILABILITY CODE will be replaced with WARD INTENDED NIGHT PERIOD AVAILABILITY, which is the most recent approved national information standard to describe the required definition.**

**This data element is also known by these names:**

| Context | Alias |
| --- | --- |
| plural | WARD INTENDED NIGHT PERIOD AVAILABILITIES |

---

**WARD INTENDED NIGHT PERIOD AVAILABILITY**

---

**Change to Data Element: New Data Element**

## WARD INTENDED NIGHT PERIOD AVAILABILITY

**Attribute:**

| WARD INTENDED NIGHT PERIOD AVAILABILITY |
| --- |

---

**WARD INTENDED SEX OF PATIENTS**

---

**Change to Data Element: New Data Element**

| | |
| --- | --- |
| Format/Length: | an1 |
| National Codes: | See WARD INTENDED SEX OF PATIENTS |
| Default Codes: | |

**Notes:**
**WARD INTENDED SEX OF PATIENTS is the same as attribute WARD INTENDED SEX OF PATIENTS.**

**SEX OF PATIENTS CODE will be replaced with WARD INTENDED SEX OF PATIENTS, which is the most recent approved national information standard to describe the required definition.**

---

**WARD INTENDED SEX OF PATIENTS**

---

**Change to Data Element: New Data Element**

## WARD INTENDED SEX OF PATIENTS

**Attribute:**

| WARD INTENDED SEX OF PATIENTS |
| --- |

---

**WARD SECURITY LEVEL**

---

**Change to Data Element: Changed Dataset**

| | |
| --- | --- |
| Format/Length: | an1 |
| National Codes: | See WARD SECURITY LEVEL |
| Default Codes: | |

**Notes:**
**WARD SECURITY LEVEL is the same as attribute WARD SECURITY LEVEL.**

---

**WITHHELD IDENTITY REASON**

---

**Change to Data Element: Changed Dataset**

| | |
| --- | --- |
| Format/Length: | an2 |
| National Codes: | See WITHHELD IDENTITY REASON |
| Default Codes: | 99 - Identity withheld but reason not known |

**Notes:**
**WITHHELD IDENTITY REASON is the same as attribute WITHHELD IDENTITY REASON.**

---

**COMMISSIONING DATA SET VERSION 6-3 XML SCHEMA CONSTRAINTS**

---

**Change to XML Schema Constraint: New XML Schema Constraint**

**XML Schema constraints applied to the Commissioning Data Sets V6-3.**

**The "Allowed Values" column indicates the NHS Data Model and Dictionary National Codes and Default Codes present in the XML Schema:**

- **None = The National Codes and Default Codes are included in the XML Schema**
- **Removed = The National Codes and Default Codes are not included in the XML Schema.**

| Data Element | XML Schema Format/Length | Allowed Values | Range | Pattern Match | Reason / Comment / XML Choice |
|---|---|---|---|---|---|
| ACTIVITY LOCATION TYPE CODE | None | Removed | None | None | National Codes not enumerated in XML schema |
| ACTIVITY TREATMENT FUNCTION CODE | None | Removed | None | None | National Codes not enumerated in XML schema |
| ASSESSMENT TOOL (SNOMED CT EXPRESSION) | min an6 max an4000 | None | None | None | SNOMED CT EXPRESSION data item constrained to recommended length |
| CARE PROFESSIONAL MAIN SPECIALTY CODE | None | Removed | None | None | National Codes not enumerated in XML schema |
| CDS BULK REPLACEMENT GROUP CODE | None | 010,020,030,040,060 | None | None | Commissioning Data Set version 6-3 only allows these CDS BULK REPLACEMENT GROUP CODES |
| CDS MESSAGE VERSION NUMBER | None | CDS063 | None | None | Message version is hard coded in the XML schema |
| CDS TYPE CODE | None | 020,120,130,140,150,160,180,190,200 | None | None | Commissioning Data Set version 6-3 only allows these CDS Types |
| COMORBIDITY (SNOMED CT EXPRESSION) | min an6 max an4000 | None | None | None | SNOMED CT EXPRESSION data item constrained to recommended length |
| CRITICAL CARE ACTIVITY CODE | None | Removed | None | None | National Codes not enumerated in XML schema |
| DIAGNOSIS (SNOMED CT EXPRESSION) | min an6 max an4000 | None | None | None | SNOMED CT EXPRESSION data item constrained to recommended length |
| EMED3 FIT NOTE CONDITION (SNOMED CT EXPRESSION) | min an6 max an4000 | None | None | None | SNOMED CT EXPRESSION data item constrained to recommended length |
| ETHNIC CATEGORY | max an2 | None | None | None | Existing Format/Length means |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | fixed length which is incorrect. Unable to change this as it is used in other data sets. Second character can be for local use. Format/Length amended to max an2 |
| FINDING (SNOMED CT EXPRESSION) | min an6 max an4000 | None | None | None | SNOMED CT EXPRESSION data item constrained to recommended length |
| GENERAL MEDICAL PRACTITIONER (SPECIFIED) | None | Removed | None | None | National Codes and default codes not enumerated in the XML Schema |
| MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION) | None | Removed | None | None | National Codes not enumerated in XML schema |
| OBSERVATION (SNOMED CT EXPRESSION) | min an6 max an4000 | None | None | None | SNOMED CT EXPRESSION data item constrained to recommended length |
| ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) | None | Removed | None | None | Default codes not enumerated in the XML Schema |
| ORGANISATION IDENTIFIER (CODE OF PROVIDER) | None | Removed | None | None | Default codes not enumerated in the XML Schema |
| ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) | None | Removed | None | None | Default codes not enumerated in the XML Schema |
| ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (BABY)) | None | Removed | None | None | Default codes not enumerated in the XML Schema |
| ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER)) | None | Removed | None | None | Default codes not enumerated in the XML Schema |
| ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER) | None | Removed | None | None | Default codes not enumerated in the XML Schema |
| ORGANISATION IDENTIFIER (REFERRING ORGANISATION) | None | Removed | None | None | Default codes not enumerated in the XML Schema |
| ORGANISATION IDENTIFIER | None | Removed | None | None | |

| | | | | | |
|---|---|---|---|---|---|
| (RESIDENCE RESPONSIBILITY) | | | | | Default codes not enumerated in the XML Schema |
| ORGANISATION SITE IDENTIFIER (OF TREATMENT) | None | Removed | None | None | Default Codes not enumerated in the XML schema |
| OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE | None | A,B,C,D,E,F,P,9 | None | None | National Code X is not valid in Commissioning Data Set version 6-3 |
| REFERRER CODE | None | Removed | None | None | Default Codes not enumerated in the XML schema |
| PROCEDURE (SNOMED CT EXPRESSION) | min an6 max an4000 | None | None | None | Default Codes not enumerated in the XML schema |
| SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION) | min an6 max an4000 | None | None | None | SNOMED CT EXPRESSION data item constrained to recommended length |

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**For enquiries about this Change Request, please email information.standards@nhs.net**

ISO
9001
CERTIFICATION
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