

# NHS Data Model and Dictionary



**Type:** Change Request  
**Reference:** 1864  
**Version No:** 1.0  
**Subject:** CDS 6-3 Corrigendum  
**Effective Date:** Immediate  
**Reason for Change:** Change to Information Standards  
**Publication Date:** 6 July 2022

## Background:

Commissioning Data Sets version 6-3 was published as [DAPB0092: Commissioning Data Sets](#) on 15th June 2021.

Since publication a number of amendments have been requested, which required changes to the existing NHS Data Model and Dictionary content. In addition, technical problems with the CDS-XML schema version 6-3 were identified, resulting in the release of two new CDS-XML Schemas, version 6-3-0 and version 6-3-1, on the [TRUD](#) platform. The CDS-XML Schemas also include changes required by this Corrigendum where applicable.

The changes included in the Corrigendum to the DAPB0092: Commissioning Data Sets standard are as follows:

- Updated definition for DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL) which has been requested by NHS England. Note that this change also impacts Commissioning Data Sets version 6-2, which remains a live version for data submission until providers transition to CDS v6-3.
- Relaxation of mandation for CARE PROFESSIONAL MAIN SPECIALTY CODE to R (Required) to facilitate the submission of Out-Patient Attendances delivered by Pharmacists, as no suitable pseudo-MAIN SPECIALTY CODE yet exists.
- Clarification of the definitions for LAST PATIENT CANCELLED DATE and LAST PATIENT DID NOT ATTEND DATE in Commissioning Data Set type 020 Out-Patients
- Update to the PRESENT ON ADMISSION INDICATOR to include patients with an existing Venous Thromboembolism (VTE)
- Replacement of SPECIALISED SERVICE CODE with SERVICE CODE in the SERVICE AGREEMENT DETAILS data group in all applicable CDS types (020, 120, 130, 140, 150, 160, 180, 190, 200)
- Addition of Pilot Item EMED3 FIT NOTE ISSUER in the EMED3 FIT NOTE data group in all applicable CDS types (020, 130, 190). This is in expectation of its approval as part of the EMED3 Fit Notes in Secondary Care Information Standard.

- A Commissioning Data Set Business Rule, I1 (This is a known schema anomaly and has been registered for future resolution), has been noted against data item OUTPATIENT ATTENDANCE IDENTIFIER in CDS type 020. Since the release of the CDS 6-3-0 XML schema, it has been noted that this data item was not updated to be XML-mandatory to reflect the data item mandation shown in the NHS Data Model and Dictionary and the Technical Output Specification. This has been noted for change at the next CDS-XML schema release. Providers of data should note the Mandatory status of this data item in the approved Information Standard and submit it for each CDS type 020 record.

This Change Request updates the Commissioning Data Sets v6-3 and supporting definitions within the NHS Data Model and Dictionary to support the Corrigendum to 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](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**

<a href="#">CDS V6-3 TYPE 020 - OUTPATIENT CDS</a>	Changed Description
<a href="#">CDS V6-3 TYPE 120 - ADMITTED PATIENT CARE - FINISHED BIRTH EPISODE CDS</a>	Changed Description
<a href="#">CDS V6-3 TYPE 130 - ADMITTED PATIENT CARE - FINISHED GENERAL EPISODE CDS</a>	Changed Description
<a href="#">CDS V6-3 TYPE 140 - ADMITTED PATIENT CARE - FINISHED DELIVERY EPISODE CDS</a>	Changed Description
<a href="#">CDS V6-3 TYPE 150 - ADMITTED PATIENT CARE - OTHER BIRTH EVENT CDS</a>	Changed Description
<a href="#">CDS V6-3 TYPE 160 - ADMITTED PATIENT CARE - OTHER DELIVERY EVENT CDS</a>	Changed Description
<a href="#">CDS V6-3 TYPE 180 - ADMITTED PATIENT CARE - UNFINISHED BIRTH EPISODE CDS</a>	Changed Description
<a href="#">CDS V6-3 TYPE 190 - ADMITTED PATIENT CARE - UNFINISHED GENERAL EPISODE CDS</a>	Changed Description
<a href="#">CDS V6-3 TYPE 200 - ADMITTED PATIENT CARE - UNFINISHED DELIVERY EPISODE CDS</a>	Changed Description

### **Supporting Information**

<a href="#">DISCHARGE READY DATE</a>	Changed Description
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## Attribute Definitions

[PRESENT ON ADMISSION INDICATOR](#)

Changed Description

## Data Elements

[LAST PATIENT CANCELLED DATE](#)

Changed Description

[LAST PATIENT DID NOT ATTEND DATE](#)

Changed Description

[PRESENT ON ADMISSION INDICATOR](#)

Changed Description

**Date:** 6 June 2022

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

**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 020 - OUTPATIENT CDS

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Change to Data Set: Changed Description

#### CDS V6-3 TYPE 020 - OUTPATIENT COMMISSIONING DATA SET

**FUNCTION:** To support the details of an Care Professional Outpatient Attendance.

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

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

<u>Notation</u>		<b>DATA GROUP: CDS V6-3 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>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.</b>
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: <a href="#">CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol</a></b> One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

**OR**

<u>Notation</u>		<b>DATA GROUP: CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>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.</b>
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: <a href="#">CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol</a></b> One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

<u>Notation</u>		<b>DATA GROUP: PATIENT PATHWAY</b>	
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Patient Pathway. This Group must be present if the record relates to a Referral To Treatment Period Included In 18 Weeks Target or is subject to Allied Health Professional Referral To Treatment Measurement.</b>	
<b>R</b>	<b>0..1</b>		
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: PATIENT PATHWAY IDENTITY</b>	<u>Rules</u>
<b>M</b>	<b>1..1</b>	<a href="#">UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)</a>	F
<b>Or</b>		<b>Or</b>	
<b>M</b>	<b>1..1</b>	<a href="#">PATIENT PATHWAY IDENTIFIER</a>	F I2
<b>M</b>	<b>1..1</b>	<a href="#">ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)</a>	F I2
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS</b>	<u>Rules</u>
<b>M</b>	<b>1..1</b>	<a href="#">REFERRAL TO TREATMENT PERIOD STATUS</a>	V

M	1..1	<a href="#">WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)</a>	V
O	0..1	<a href="#">REFERRAL TO TREATMENT PERIOD START DATE</a>	F S13
O	0..1	<a href="#">REFERRAL TO TREATMENT PERIOD END DATE</a>	F S13

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

One of the following DATA GROUPS must be used:

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

OR

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

OR

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

<a href="#">Notation</a>		<b>DATA GROUP: PATIENT CHARACTERISTICS</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the characteristics of the Patient.</b>			
R	0..1				
M	1..1	Data Element Components		<a href="#">Rules</a>	
		R	0..1	<a href="#">PERSON STATED GENDER CODE</a>	V H4
		O	0..1	<a href="#">CARER SUPPORT INDICATOR</a>	V
		R	0..1	<a href="#">ETHNIC CATEGORY</a>	V
		X	0..1	<a href="#">ETHNIC CATEGORY 2021</a>	N2

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

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT SOCIAL AND PERSONAL CIRCUMSTANCES</b>		<a href="#">Rules</a>	
		M	1..1	<a href="#">SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>	<a href="#">Rules</a>	
	O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

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

<u>Notation</u>		<b>DATA GROUP: CARE EPISODE - CLINICAL DIAGNOSIS GROUP (ICD)</b>		
<b>FUNCTION: To carry the details of the ICD coded Clinical Diagnoses for the Patient.</b>				

Group Status	Group Repeats		
O	0..1		
M	1..1	<b>Data Element Components</b>	<a href="#">Rules</a>
M	1..1	<a href="#">DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET)</a>	V
M	1..1	<b>DATA GROUP: PRIMARY DIAGNOSIS</b>	<a href="#">Rules</a>
M	1..1	<a href="#">PRIMARY DIAGNOSIS (ICD)</a>	F
O	0..*	<b>DATA GROUP: SECONDARY DIAGNOSES</b>	<a href="#">Rules</a>
M	1..1	<a href="#">SECONDARY DIAGNOSIS (ICD)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: CARE EPISODE - CLINICAL DIAGNOSIS GROUP (SNOMED CT)</b>
Group Status	Group Repeats	<b>FUNCTION: To carry the details of the SNOMED CT coded Clinical Diagnoses for the Patient.</b>
R	0..*	

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT DIAGNOSIS</b>	<a href="#">Rules</a>
M	1..1	<a href="#">DIAGNOSIS (SNOMED CT EXPRESSION)</a>	F
M	1..1	<a href="#">CODED CLINICAL ENTRY SEQUENCE NUMBER</a>	F
M	1..1	<a href="#">CODED DIAGNOSIS TIMESTAMP</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>	<a href="#">Rules</a>
O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: CARE EPISODE - COMORBIDITY (SNOMED CT)</b>
Group Status	Group Repeats	<b>FUNCTION: To carry the details of the SNOMED CT coded Comorbidities for the Patient.</b>
R	0..*	

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT COMORBIDITY</b>	<a href="#">Rules</a>
M	1..1	<a href="#">COMORBIDITY (SNOMED CT EXPRESSION)</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>	<a href="#">Rules</a>
O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: CARE EPISODE - EMED3 FIT NOTE</b>	
Group Status	Group Repeats	<b>FUNCTION: To carry the details of EMED3 Fit Note issued.</b>	
R	0..1		
M	1..1	<b>Data Element Components</b>	<a href="#">Rules</a>

		<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>	<b>Rules</b>
		R	0..1	<a href="#">EMED3 FIT NOTE ASSESSMENT DATE</a>	F S13
		R	0..1	<a href="#">EMED3 FIT NOTE CONDITION (SNOMED CT EXPRESSION)</a>	F
		R	0..1	<a href="#">EMED3 FIT NOTE DIAGNOSIS (ICD)</a>	F
		R	0..1	<a href="#">EMED3 FIT NOTE START DATE</a>	F S13
		R	0..1	<a href="#">EMED3 FIT NOTE END DATE</a>	F S13
		R	0..1	<a href="#">EMED3 FIT NOTE DURATION</a>	F
		R	0..1	<a href="#">EMED3 FIT NOTE RECORDED DATE</a>	F S13
R	0..1			<a href="#">EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR</a>	V
X	0..1			<a href="#">EMED3 FIT NOTE ISSUER</a>	N2

<u>Notation</u>		<b>DATA GROUP: CARE ATTENDANCE - ACTIVITY CHARACTERISTICS</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Attendance or Missed/Cancelled Appointment.</b>			
<b>M</b>	<b>1..1</b>				
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>			<b>Rules</b>
		<b>M</b>	<b>1..1</b>	<a href="#">OUTPATIENT ATTENDANCE IDENTIFIER</a>	F
		<b>M</b>	<b>1..1</b>	<a href="#">OUTPATIENT ATTENDANCE IDENTIFIER</a>	F I1
		R	0..1	<a href="#">ADMINISTRATIVE CATEGORY CODE</a>	V
		R	0..1	<a href="#">ATTENDANCE STATUS</a>	V
		R	0..1	<a href="#">FIRST ATTENDANCE CODE</a>	V H4
		R	0..1	<a href="#">OUT-PATIENT ATTENDANCE OUTCOME</a>	V
		R	0..1	<a href="#">APPOINTMENT BOOKED REASON</a>	V
		<b>M</b>	<b>1..1</b>	<a href="#">APPOINTMENT DATE</a>	F S1 S13
		O	0..1	<a href="#">APPOINTMENT TIME</a>	F S14

		O	0..1	<a href="#">EXPECTED DURATION OF APPOINTMENT</a>	F
		M	1..1	<a href="#">AGE AT CDS ACTIVITY DATE</a>	F H4 S8
		R	0..1	<a href="#">OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE</a>	V
		R	0..1	<a href="#">EARLIEST REASONABLE OFFER DATE</a>	F S13
		R	0..1	<a href="#">EARLIEST CLINICALLY APPROPRIATE DATE</a>	F S13
		R	0..1	<a href="#">LATEST CLINICALLY APPROPRIATE DATE</a>	F S13
		R	0..1	<a href="#">CONSULTATION MECHANISM</a>	V
		R	0..1	<a href="#">CONSULTATION TYPE</a>	V
		O	0..1	<a href="#">MULTI-PROFESSIONAL OR MULTI-DISCIPLINARY INDICATION CODE (NATIONAL TARIFF PAYMENT SYSTEM)</a>	V
		O	0..1	<a href="#">REHABILITATION ASSESSMENT TEAM TYPE</a>	V N3
		R	0..1	<a href="#">PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR AT CDS ACTIVITY DATE</a>	V
		R	0..1	<a href="#">PATIENT SUBJECT TO REMOTE MONITORING INDICATOR AT CDS ACTIVITY DATE</a>	V
		R	0..1	<a href="#">PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY REVIEW DATE</a>	F S13
R	0..1			<a href="#">PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE</a>	F S13

<b>Notation</b>		<b>DATA GROUP: CARE ATTENDANCE - SERVICE AGREEMENT DETAILS</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Provider, Commissioners and Service Agreements.</b>			
M	1..1				
M	1..1	<b>Data Element Components</b>			<a href="#">Rules</a>
M	1..1	<a href="#">ORGANISATION IDENTIFIER (CODE OF PROVIDER)</a>			F
M	1..*	<b>DATA GROUP: COMMISSIONERS</b>			<a href="#">Rules</a>
M	1..1	<a href="#">ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)</a>			F
R	0..1				

			<a href="#">START DATE (COMMISSIONER ASSIGNMENT PERIOD)</a>	F S13
		R	0..1 <a href="#">END DATE (COMMISSIONER ASSIGNMENT PERIOD)</a>	F S13
		R	0..1 <a href="#">NHS SERVICE AGREEMENT IDENTIFIER</a>	F
		O	0..1 <a href="#">NHS SERVICE AGREEMENT LINE IDENTIFIER</a>	F
		O	0..1 <a href="#">PROVIDER REFERENCE IDENTIFIER</a>	F
		R	0..1 <a href="#">COMMISSIONER REFERENCE IDENTIFIER</a>	F
		R	0..1 <a href="#">SPECIALISED SERVICE CODE</a>	F
R	0..1	<a href="#">SERVICE CODE</a>	F	

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

O	0..1	DATA GROUP: RESPONSIBLE ANAESTHETIST		<a href="#">Rules</a>	
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: CARE ATTENDANCE - PROCEDURE GROUP (SNOMED CT)</b>
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the SNOMED CT coded Procedures for the Patient.</b>

One of the following DATA GROUPS may be used:

M	1..1	DATA GROUP: SNOMED CT PROCEDURE		<a href="#">Rules</a>	
		M	1..1	<a href="#">PROCEDURE (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">CODED CLINICAL ENTRY SEQUENCE NUMBER</a>	F
		M	1..1	<a href="#">CODED PROCEDURE TIMESTAMP</a>	F
O	0..1	DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL		<a href="#">Rules</a>	
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)</a>	F
O	0..1	DATA GROUP: RESPONSIBLE ANAESTHETIST		<a href="#">Rules</a>	
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON		<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>

<a href="#">Notation</a>		<b>DATA GROUP: CARE ATTENDANCE - OBSERVATION GROUP (SNOMED CT)</b>
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the SNOMED CT coded Clinical Observations for the Patient.</b>

One of the following DATA GROUPS may be used:

M	1..1	DATA GROUP: SNOMED CT OBSERVATION		<a href="#">Rules</a>	
		M	1..1	<a href="#">OBSERVATION (SNOMED CT EXPRESSION)</a>	F
		R	0..1	<a href="#">OBSERVATION VALUE</a>	F
		R	0..1	<a href="#">UCUM UNIT OF MEASUREMENT</a>	F
		M	1..1	<a href="#">CODED OBSERVATION TIMESTAMP</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON		<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>

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

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT FINDING</b>	<a href="#">Rules</a>
		M 1..1 <a href="#">FINDING (SNOMED CT EXPRESSION)</a>	F
		M 1..1 <a href="#">CODED FINDING TIMESTAMP</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>	<a href="#">Rules</a>
		O 0..1 <a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

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

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT ASSESSMENT TOOL</b>	<a href="#">Rules</a>
		M 1..1 <a href="#">ASSESSMENT TOOL (SNOMED CT EXPRESSION)</a>	F
		M 1..1 <a href="#">PERSON SCORE</a>	F
		M 1..1 <a href="#">ASSESSMENT TOOL COMPLETION TIMESTAMP</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>	<a href="#">Rules</a>
		O 0..1 <a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<u>Notation</u>		<b>DATA GROUP: LOCATION GROUP - ATTENDANCE</b>	
<b>Group Status</b> R	<b>Group Repeats</b> 0..1	<b>FUNCTION: To carry the details of the Location and Site Code Of Treatment.</b>	
M	1..1	<b>Data Element Components</b>	<a href="#">Rules</a>
		R 0..1 <a href="#">ORGANISATION SITE IDENTIFIER (OF TREATMENT)</a>	F
		R 0..1 <a href="#">ACTIVITY LOCATION TYPE CODE</a>	F
		O 0..1 <a href="#">CLINIC CODE</a>	F

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

M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		O	0..1	<a href="#">GENERAL MEDICAL PRACTITIONER (SPECIFIED)</a>	F
		R	0..1	<a href="#">GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: ACTIVITY CHARACTERISTICS - REFERRAL</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Referral.</b>
R	0..1	

M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		R	0..1	<a href="#">PRIORITY TYPE CODE</a>	V
		R	0..1	<a href="#">SERVICE TYPE REQUESTED CODE</a>	V
		R	0..1	<a href="#">SOURCE OF REFERRAL FOR OUT-PATIENTS</a>	V
		R	0..1	<a href="#">REFERRAL REQUEST RECEIVED DATE</a>	F S13
		O	0..1	<a href="#">DIRECT ACCESS REFERRAL INDICATOR</a>	V
		O	0..1	<a href="#">REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR</a>	V
		R	0..1	<a href="#">SERVICE REQUEST IDENTIFIER</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: REFERRER</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Referrer.</b>
R	0..1	

M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		R	0..1	<a href="#">REFERRER CODE</a>	F
		R	0..1	<a href="#">ORGANISATION IDENTIFIER (REFERRING ORGANISATION)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: CARE REFERRAL - MISSED APPOINTMENT OCCURRENCE</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of a Missed Appointment.</b>
R	0..1	

M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		R	0..1	<a href="#">LAST PATIENT DID NOT ATTEND DATE</a>	F S13
		R	0..1	<a href="#">LAST PATIENT CANCELLED DATE</a>	F S13

<a href="#">Notation</a>		<b>DATA GROUP: CDS V6-3 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER</b>

<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.</b>
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: <a href="#">CDS V6-3 Type 004 - Commissioning Data Set Message Trailer</a></b> One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

<b><u>Notation</u></b>		<b>DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.</b>
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: <a href="#">CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer</a></b> One per Interchange submitted to the Secondary Uses Service. 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: Changed Description

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

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

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

		<p><b>DATA GROUP:</b> <a href="#">CDS V6-3 Type 003 - Commissioning Data Set Message Header</a></p> <p>One per Commissioning Data Set Message submitted to the Secondary Uses Service.</p> <p>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.</p>
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**ONE OF THE FOLLOWING TWO OPTIONS MUST BE USED:**

<u>Notation</u>		<b>DATA GROUP: CDS V6-3 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>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.</b>

<b>M</b>	<b>1..1</b>	<p><b>DATA GROUP:</b> <a href="#">CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol</a></p> <p>One per Commissioning Data Set record submitted to the Secondary Uses Service.</p> <p>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.</p>
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**OR**

<u>Notation</u>		<b>DATA GROUP: CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>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.</b>

<b>M</b>	<b>1..1</b>	<p><b>DATA GROUP:</b> <a href="#">CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol</a></p> <p>One per Commissioning Data Set record submitted to the Secondary Uses Service.</p> <p>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.</p>
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<u>Notation</u>		<b>DATA GROUP: PATIENT PATHWAY</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Patient Pathway.</b>
<b>O</b>	<b>0..1</b>	

<b>M</b>	<b>1..1</b>	<b>DATA GROUP: PATIENT PATHWAY IDENTITY</b>	<b>Rules</b>
<b>M</b>	<b>1..1</b>	<a href="#">UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)</a>	F
<i>Or</i>	<i>Or</i>		
<b>M</b>	<b>1..1</b>	<a href="#">PATIENT PATHWAY IDENTIFIER</a>	F I2
<b>M</b>	<b>1..1</b>	<a href="#">ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)</a>	F I2

M	1..1	<b>DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS</b>	<a href="#">Rules</a>	
	M	1..1	<a href="#">REFERRAL TO TREATMENT PERIOD STATUS</a>	V
	M	1..1	<a href="#">WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)</a>	V
	O	0..1	<a href="#">REFERRAL TO TREATMENT PERIOD START DATE</a>	F S13
	O	0..1	<a href="#">REFERRAL TO TREATMENT PERIOD END DATE</a>	F S13

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

One of the following DATA GROUPS must be used:

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

OR

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

OR

1..1	<b>DATA GROUP: UNVERIFIED IDENTITY STRUCTURE</b>		
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		<a href="#">Rules</a>	
		M	1..1	<a href="#">LOCAL PATIENT IDENTIFIER (EXTENDED)</a>	F S3
		M	1..1	<a href="#">ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)</a>	F
M	1..1	Data Element Components		<a href="#">Rules</a>	
		R	0..1	<a href="#">NHS NUMBER</a>	F S3
		M	1..1	<a href="#">NHS NUMBER STATUS INDICATOR CODE</a>	V
R	0..1	Data Element Components		<a href="#">Rules</a>	
		M	1..1	<a href="#">PATIENT FULL NAME</a>	F S3 I4
		OR	OR	OR	
		O	0..1	<a href="#">PATIENT TITLE</a>	
		and	and	and	
		M	1..1	<a href="#">PATIENT GIVEN NAME</a>	
		and	and	and	
M	1..1	<a href="#">PATIENT FAMILY NAME</a>			
and	and	and			
O	0..1	<a href="#">PATIENT NAME SUFFIX</a>			
and	and	and			
O	0..1	<a href="#">PATIENT INITIALS</a>			
M	1..1	Data Element Components		<a href="#">Rules</a>	
		R	0..1	<a href="#">PERSON BIRTH DATE</a>	F S3 S12

<a href="#">Notation</a>		DATA GROUP: PATIENT CHARACTERISTICS			
Group Status	Group Repeats	FUNCTION: To carry the characteristics of the Patient (the Baby).			
R	0..1				
M	1..1	Data Element Components		<a href="#">Rules</a>	
		R	0..1	<a href="#">PERSON PHENOTYPIC SEX</a>	V H4
		R	0..1	<a href="#">ETHNIC CATEGORY</a>	V
		X	0..1	<a href="#">ETHNIC CATEGORY 2021</a>	N2
		R	0..1	<a href="#">LIVE OR STILL BIRTH CODE</a>	V
		R	0..1	<a href="#">BIRTH WEIGHT</a>	F

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

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT SOCIAL AND PERSONAL CIRCUMSTANCES</b>		<a href="#">Rules</a>	
		M	1..1	<a href="#">SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>		<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>

<a href="#">Notation</a>		<b>DATA GROUP: HOSPITAL PROVIDER SPELL - ADMISSION CHARACTERISTICS</b>		
Group Status	Group Repeats	FUNCTION: To carry the admission details of the Hospital Provider Spell containing the Finished Birth Care Professional Admitted Care Episode.		
M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>
R	0..1	<a href="#">HOSPITAL PROVIDER SPELL IDENTIFIER</a>		F H4
R	0..1	<a href="#">ADMINISTRATIVE CATEGORY CODE (ON ADMISSION)</a>		V
R	0..1	<a href="#">PATIENT CLASSIFICATION CODE</a>		V H4
R	0..1	<a href="#">METHOD OF ADMISSION (HOSPITAL PROVIDER SPELL)</a>		V H4
R	0..1	<a href="#">ADMISSION SOURCE (HOSPITAL PROVIDER SPELL)</a>		V H4
M	1..1	<a href="#">START DATE (HOSPITAL PROVIDER SPELL)</a>		F H4 S13
O	0..1	<a href="#">START TIME (HOSPITAL PROVIDER SPELL)</a>		F S14
M	1..1	<a href="#">AGE ON ADMISSION</a>		F H4

<a href="#">Notation</a>		<b>DATA GROUP: HOSPITAL PROVIDER SPELL - DISCHARGE CHARACTERISTICS</b>		
Group Status	Group Repeats	FUNCTION: To carry the discharge details of the Hospital Provider Spell containing the Finished Birth Care Professional Admitted Care Episode.		
R	0..1			
M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>
R	0..1	<a href="#">DESTINATION OF DISCHARGE (HOSPITAL PROVIDER SPELL)</a>		V H4
R	0..1	<a href="#">METHOD OF DISCHARGE (HOSPITAL PROVIDER SPELL)</a>		

			V H4
R	0..1	<a href="#">DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL)</a>	F S13
R	0..1	<a href="#">DISCHARGE DATE (HOSPITAL PROVIDER SPELL)</a>	F S13
O	0..1	<a href="#">DISCHARGE TIME (HOSPITAL PROVIDER SPELL)</a>	F S14
R	0..1	<a href="#">DISCHARGED TO NHS AT HOME SERVICE INDICATOR</a>	V

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

<u>Notation</u>		<b>DATA GROUP: BIRTH EPISODE - OVERSEAS VISITOR CHARGING CATEGORY</b>	
Group Status	Group Repeats	FUNCTION: To carry the details of the Overseas Visitor Charging Categories of the Patient (the Baby) during the Finished Birth Care Professional Admitted Care Episode.	
R	0..5		
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>	<b><a href="#">Rules</a></b>
M	1..1	<a href="#">OVERSEAS VISITOR CHARGING CATEGORY</a>	V
M	1..1		

			<a href="#">OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE FROM DATE</a>	F S13
	R	0..1	<a href="#">OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE END DATE</a>	F S13

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH EPISODE - SERVICE AGREEMENT DETAILS</b>		
Group Status	Group Repeats	FUNCTION: To carry the details of the Provider, Commissioners and Service Agreements.		
M	1..1			
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<a href="#">Rules</a>
	M	1..1	<a href="#">ORGANISATION IDENTIFIER (CODE OF PROVIDER)</a>	F H4
<b>M</b>	<b>1..*</b>	<b>DATA GROUP: COMMISSIONERS</b>		<a href="#">Rules</a>
	M	1..1	<a href="#">ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)</a>	F
	R	0..1	<a href="#">START DATE (COMMISSIONER ASSIGNMENT PERIOD)</a>	F S13
	R	0..1	<a href="#">END DATE (COMMISSIONER ASSIGNMENT PERIOD)</a>	F S13
	R	0..1	<a href="#">NHS SERVICE AGREEMENT IDENTIFIER</a>	F
	O	0..1	<a href="#">NHS SERVICE AGREEMENT LINE IDENTIFIER</a>	F
	O	0..1	<a href="#">PROVIDER REFERENCE IDENTIFIER</a>	F
	R	0..1	<a href="#">COMMISSIONER REFERENCE IDENTIFIER</a>	F
	R	0..1	<a href="#">SPECIALISED SERVICE CODE</a>	F
R	0..1	<a href="#">SERVICE CODE</a>	F	

<a href="#">Notation</a>		<b>DATA GROUP: CARE EPISODE - PERSON GROUP (CARE PROFESSIONAL)</b>		
Group Status	Group Repeats	FUNCTION: To carry the details of the Care Professionals active during the Finished Birth Care Professional Admitted Care Episode.		
R	0..*			
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<a href="#">Rules</a>
	M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
	M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER</a>	F
	M	1..1	<a href="#">CARE PROFESSIONAL MAIN SPECIALTY CODE</a>	F H4
	R	0..1	<a href="#">CARE PROFESSIONAL MAIN SPECIALTY CODE</a>	F H4

		M	1..1	<a href="#">ACTIVITY TREATMENT FUNCTION CODE</a>	F H4
		O	0..1	<a href="#">LOCAL SUB-SPECIALTY CODE</a>	F
M	1..1	<a href="#">RESPONSIBLE CARE PROFESSIONAL INDICATOR</a>		V	

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH EPISODE - CLINICAL DIAGNOSIS GROUP (ICD)</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the ICD coded Clinical Diagnoses for the Patient (the Baby).</b>			
R	0..1				
M	1..1	<b>Data Element Components</b>			<a href="#">Rules</a>
	M	1..1	<a href="#">DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET)</a>		V
M	1..1	<b>DATA GROUP: PRIMARY DIAGNOSIS</b>			<a href="#">Rules</a>
	M	1..1	<a href="#">PRIMARY DIAGNOSIS (ICD)</a>		F H4
R	0..*	<b>DATA GROUP: SECONDARY DIAGNOSES</b>			<a href="#">Rules</a>
	M	1..1	<a href="#">SECONDARY DIAGNOSIS (ICD)</a>		F H4

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH EPISODE - CLINICAL DIAGNOSIS GROUP (SNOMED CT)</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the SNOMED CT coded Clinical Diagnoses for the Patient (the Baby).</b>			
R	0..*				

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT DIAGNOSIS</b>			<a href="#">Rules</a>
	M	1..1	<a href="#">DIAGNOSIS (SNOMED CT EXPRESSION)</a>		F
	M	1..1	<a href="#">CODED CLINICAL ENTRY SEQUENCE NUMBER</a>		F
	M	1..1	<a href="#">CODED DIAGNOSIS TIMESTAMP</a>		F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>			<a href="#">Rules</a>
	O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>		F

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH EPISODE - COMORBIDITY (SNOMED CT)</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the SNOMED CT coded Comorbidities for the Patient (the Baby).</b>			
R	0..*				

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT COMORBIDITY</b>			<a href="#">Rules</a>
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		<b>M</b>	<b>1..1</b>	<a href="#">COMORBIDITY (SNOMED CT EXPRESSION)</a>	F
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OR

<b>O</b>	<b>0..1</b>	DATA GROUP: DATA ABSENT REASON			<a href="#">Rules</a>
	<b>O</b>	<b>0..1</b>	<a href="#">DATA ABSENT REASON (FHIR R4)</a>		F

<a href="#">Notation</a>		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).			
<b>R</b>	<b>0..1</b>				
<b>M</b>	<b>1..1</b>	Data Element Components			<a href="#">Rules</a>
		<b>M</b>	<b>1..1</b>	<a href="#">PROCEDURE SCHEME IN USE (COMMISSIONING DATA SET)</a>	V
<b>M</b>	<b>1..1</b>	DATA GROUP: PRIMARY PROCEDURE			<a href="#">Rules</a>
		<b>M</b>	<b>1..1</b>	<a href="#">PRIMARY PROCEDURE (OPCS)</a>	F H4
		<b>R</b>	<b>0..1</b>	<a href="#">PROCEDURE DATE</a>	F S13
<b>O</b>	<b>0..1</b>	DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL			<a href="#">Rules</a>
		<b>M</b>	<b>1..1</b>	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		<b>M</b>	<b>1..1</b>	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)</a>	F
<b>O</b>	<b>0..1</b>	DATA GROUP: RESPONSIBLE ANAESTHETIST			<a href="#">Rules</a>
		<b>M</b>	<b>1..1</b>	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		<b>M</b>	<b>1..1</b>	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)</a>	F
<b>R</b>	<b>0..*</b>	DATA GROUP: SECONDARY PROCEDURES			<a href="#">Rules</a>
		<b>M</b>	<b>1..1</b>	<a href="#">PROCEDURE (OPCS)</a>	F H4
		<b>R</b>	<b>0..1</b>	<a href="#">PROCEDURE DATE</a>	F S13
<b>O</b>	<b>0..1</b>	DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL			<a href="#">Rules</a>
		<b>M</b>	<b>1..1</b>	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		<b>M</b>	<b>1..1</b>	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)</a>	F
<b>O</b>	<b>0..1</b>	DATA GROUP: RESPONSIBLE ANAESTHETIST			<a href="#">Rules</a>
		<b>M</b>	<b>1..1</b>	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		<b>M</b>	<b>1..1</b>	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)</a>	F

<a href="#">Notation</a>		DATA GROUP: BIRTH EPISODE - PROCEDURE GROUP (SNOMED CT)			

<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the SNOMED CT coded Procedures for the Patient (the Baby).</b>
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One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT PROCEDURE</b>		<a href="#">Rules</a>	
		M	1..1	<a href="#">PROCEDURE (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">CODED CLINICAL ENTRY SEQUENCE NUMBER</a>	F
		M	1..1	<a href="#">CODED PROCEDURE TIMESTAMP</a>	F
O	0..1	<b>DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL</b>		<a href="#">Rules</a>	
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)</a>	F
O	0..1	<b>DATA GROUP: RESPONSIBLE ANAESTHETIST</b>		<a href="#">Rules</a>	
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>	<a href="#">Rules</a>
O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH EPISODE - OBSERVATION GROUP (SNOMED CT)</b>
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the SNOMED CT coded Clinical Observations for the Patient (the baby).</b>

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT OBSERVATION</b>		<a href="#">Rules</a>	
		M	1..1	<a href="#">OBSERVATION (SNOMED CT EXPRESSION)</a>	F
		R	0..1	<a href="#">OBSERVATION VALUE</a>	F
		R	0..1	<a href="#">UCUM UNIT OF MEASUREMENT</a>	F
		M	1..1	<a href="#">CODED OBSERVATION TIMESTAMP</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>	<a href="#">Rules</a>
O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH EPISODE - FINDING GROUP (SNOMED CT)</b>
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the SNOMED CT coded Clinical Findings for the Patient (the Baby).</b>

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT FINDING</b>	<a href="#">Rules</a>
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		M	1..1	<a href="#">FINDING (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">CODED FINDING TIMESTAMP</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON			<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH EPISODE - ASSESSMENT TOOL GROUP (SNOMED CT)</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the SNOMED CT coded Assessment Tools for the Patient (the Baby).</b>			
R	0..*				

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT ASSESSMENT TOOL</b>			<a href="#">Rules</a>
		M	1..1	<a href="#">ASSESSMENT TOOL (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">PERSON SCORE</a>	F
		M	1..1	<a href="#">ASSESSMENT TOOL COMPLETION TIMESTAMP</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON			<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: LOCATION GROUP (AT START OF BIRTH EPISODE)</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Location at the Start of the Finished Birth Care Professional Admitted Care Episode.</b>			
R	0..1				

M	1..1	<b>Data Element Components</b>			<a href="#">Rules</a>
		R	0..1	<a href="#">ORGANISATION SITE IDENTIFIER (OF TREATMENT)</a>	F
		R	0..1	<a href="#">ACTIVITY LOCATION TYPE CODE</a>	F
		O	0..1	<a href="#">WARD INTENDED CLINICAL CARE INTENSITY</a>	V
		O	0..1	<a href="#">WARD INTENDED AGE GROUP</a>	V
		O	0..1	<a href="#">WARD INTENDED SEX OF PATIENTS</a>	V
		O	0..1	<a href="#">WARD INTENDED DAY PERIOD AVAILABILITY</a>	V
		O	0..1	<a href="#">WARD INTENDED NIGHT PERIOD AVAILABILITY</a>	V
		O	0..1	<a href="#">WARD SECURITY LEVEL</a>	V
		O	0..1	<a href="#">WARD CODE</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: LOCATION GROUP (AT WARD STAY)</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of one or more Ward Stays during the Finished Birth Care Professional Admitted Care Episode.</b>			
R	0..97				
M	1..1	<b>Data Element Components</b>			<a href="#">Rules</a>

	R	0..1	<a href="#">ORGANISATION SITE IDENTIFIER (OF TREATMENT)</a>	F
	R	0..1	<a href="#">ACTIVITY LOCATION TYPE CODE</a>	F
	O	0..1	<a href="#">WARD INTENDED CLINICAL CARE INTENSITY</a>	V
	O	0..1	<a href="#">WARD INTENDED AGE GROUP</a>	V
	O	0..1	<a href="#">WARD INTENDED SEX OF PATIENTS</a>	V
	O	0..1	<a href="#">WARD INTENDED DAY PERIOD AVAILABILITY</a>	V
	O	0..1	<a href="#">WARD INTENDED NIGHT PERIOD AVAILABILITY</a>	V
	O	0..1	<a href="#">START DATE (WARD STAY)</a>	F S13
	O	0..1	<a href="#">START TIME (WARD STAY)</a>	F S14
	O	0..1	<a href="#">END DATE (WARD STAY)</a>	F S13
	O	0..1	<a href="#">END TIME (WARD STAY)</a>	F S14
	O	0..1	<a href="#">WARD SECURITY LEVEL</a>	V
	O	0..1	<a href="#">WARD CODE</a>	F

<u>Notation</u>		DATA GROUP: LOCATION GROUP (AT END OF BIRTH EPISODE)
Group Status	Group Repeats	FUNCTION: To carry the details of the Location at the End of the Finished Birth Care Professional Admitted Care Episode.
R	0..1	

<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<a href="#">Rules</a>	
		R	0..1	<a href="#">ORGANISATION SITE IDENTIFIER (OF TREATMENT)</a>	F
		R	0..1	<a href="#">ACTIVITY LOCATION TYPE CODE</a>	F
		O	0..1	<a href="#">WARD INTENDED CLINICAL CARE INTENSITY</a>	V
		O	0..1	<a href="#">WARD INTENDED AGE GROUP</a>	V
		O	0..1	<a href="#">WARD INTENDED SEX OF PATIENTS</a>	V
		O	0..1	<a href="#">WARD INTENDED DAY PERIOD AVAILABILITY</a>	V
		O	0..1	<a href="#">WARD INTENDED NIGHT PERIOD AVAILABILITY</a>	V
		O	0..1	<a href="#">WARD SECURITY LEVEL</a>	V
		O	0..1	<a href="#">WARD CODE</a>	F

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

<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<a href="#">Rules</a>
		<b>M</b>	<b>1..1</b>	<a href="#">START DATE (HOME LEAVE)</a>

	R	0..1	<a href="#">START TIME (HOME LEAVE)</a>	F S14
	R	0..1	<a href="#">END DATE (HOME LEAVE)</a>	F S13
	R	0..1	<a href="#">END TIME (HOME LEAVE)</a>	F S14

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

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH EPISODE - PAEDIATRIC CRITICAL CARE PERIOD</b>		

Group Status	Group Repeats	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	<b>DATA GROUP: PAEDIATRIC CRITICAL CARE - ADMISSION CHARACTERISTICS</b>	
			<a href="#">Rules</a>
M	1..1	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>	F
M	1..1	<a href="#">CRITICAL CARE START DATE</a>	F H4 S13
M	1..1	<a href="#">CRITICAL CARE START TIME</a>	F S14
M	1..1	<a href="#">CRITICAL CARE UNIT FUNCTION</a>	V H4
M	1..999	<b>DATA GROUP: PAEDIATRIC DAILY CARE - ACTIVITY CHARACTERISTICS</b>	
			<a href="#">Rules</a>
M	1..1	<a href="#">ACTIVITY DATE (CRITICAL CARE)</a>	F S13
M	1..20	<a href="#">CRITICAL CARE ACTIVITY CODE</a>	F N4
R	0..20	<a href="#">HIGH COST DRUGS (OPCS)</a>	F N4
R	0..1	<b>DATA GROUP: PAEDIATRIC CRITICAL CARE - DISCHARGE CHARACTERISTICS</b>	
			<a href="#">Rules</a>
M	1..1	<a href="#">CRITICAL CARE DISCHARGE DATE</a>	F H4 S13
M	1..1	<a href="#">CRITICAL CARE DISCHARGE TIME</a>	F S14

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH EPISODE - ADULT CRITICAL CARE PERIOD</b>	
Group Status	Group Repeats	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	<b>DATA GROUP: ADULT CRITICAL CARE - ADMISSION CHARACTERISTICS</b>	
			<a href="#">Rules</a>
M	1..1	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>	F
M	1..1	<a href="#">CRITICAL CARE START DATE</a>	F H4 S13
O	0..1	<a href="#">CRITICAL CARE START TIME</a>	F S14
M	1..1	<a href="#">CRITICAL CARE UNIT FUNCTION</a>	V H4

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

		O	0..1	<a href="#">CRITICAL CARE DISCHARGE READY DATE</a>	F S13
		O	0..1	<a href="#">CRITICAL CARE DISCHARGE READY TIME</a>	F S14
		O	0..1	<a href="#">CRITICAL CARE DISCHARGE STATUS</a>	V
		O	0..1	<a href="#">CRITICAL CARE DISCHARGE DESTINATION</a>	V
		O	0..1	<a href="#">CRITICAL CARE DISCHARGE LOCATION</a>	V

<u>Notation</u>		<b>DATA GROUP: GP REGISTRATION</b>			
<b>Group Status</b> R	<b>Group Repeats</b> 0..1	<b>FUNCTION: To carry the Patient's General Medical Practitioner and the General Practice details.</b>			
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>			<a href="#">Rules</a>
		O	0..1	<a href="#">GENERAL MEDICAL PRACTITIONER (SPECIFIED)</a>	F
		R	0..1	<a href="#">GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION)</a>	F

<u>Notation</u>		<b>DATA GROUP: REFERRER</b>			
<b>Group Status</b> R	<b>Group Repeats</b> 0..1	<b>FUNCTION: To carry the details of the Referrer.</b>			
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>			<a href="#">Rules</a>
		R	0..1	<a href="#">REFERRER CODE</a>	F
		R	0..1	<a href="#">ORGANISATION IDENTIFIER (REFERRING ORGANISATION)</a>	F

<u>Notation</u>		<b>DATA GROUP: PREGNANCY - ACTIVITY CHARACTERISTICS</b>			
<b>Group Status</b> R	<b>Group Repeats</b> 0..1	<b>FUNCTION: To carry the details of the Pregnancy.</b>			
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>			<a href="#">Rules</a>
		R	0..1	<a href="#">NUMBER OF BABIES INDICATION CODE</a>	V

<u>Notation</u>		<b>DATA GROUP: ANTENATAL CARE - ACTIVITY CHARACTERISTICS</b>			
<b>Group Status</b> R	<b>Group Repeats</b> 0..1	<b>FUNCTION: To carry the details of the Antenatal Care.</b>			
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>			<a href="#">Rules</a>
		R	0..1	<a href="#">FIRST ANTENATAL ASSESSMENT DATE</a>	F S13

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

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

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

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

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

One of the following DATA GROUPS must be used:

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

OR

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

OR

1..1	<b>DATA GROUP: UNVERIFIED IDENTITY STRUCTURE</b>			
Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE (MOTHER) NOT included in the above				
O	0..1	<b>DATA GROUP: LOCAL IDENTIFIER STRUCTURE</b>	<a href="#">Rules</a>	
		M 1..1	<a href="#">LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER))</a>	F S3
		M 1..1	<a href="#">ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER))</a>	F

M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		R	0..1	<a href="#">NHS NUMBER (MOTHER)</a>	F S3
		M	1..1	<a href="#">NHS NUMBER STATUS INDICATOR CODE (MOTHER)</a>	V
O	0..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		M OR M	1..1 OR 2..5	<a href="#">PATIENT USUAL ADDRESS (UNSTRUCTURED (MOTHER))</a> OR <a href="#">PATIENT USUAL ADDRESS (STRUCTURED (MOTHER))</a>	F S3 I5
		<b>Data Element Components</b>		<a href="#">Rules</a>	
M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		R	0..1	<a href="#">POSTCODE OF USUAL ADDRESS (MOTHER)</a>	F S3
		R	0..1	<a href="#">ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)</a>	F
R	0..1	<a href="#">PERSON BIRTH DATE (MOTHER)</a>	F S3 S12		

<a href="#">Notation</a>		<b>DATA GROUP: DELIVERY OCCURRENCE - OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE</b>		
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Overseas Visitor Charging Category of the Mother.</b>		
R	0..1			
M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>
		R	0..1	<a href="#">OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE</a>

<a href="#">Notation</a>		<b>DATA GROUP: DELIVERY OCCURRENCE - LOCATION GROUP - DELIVERY PLACE ACTUAL</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Actual Delivery Location.</b>			
R	0..1				
M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		R	0..1	<a href="#">ACTIVITY LOCATION TYPE CODE</a>	F
		R	0..1	<a href="#">DELIVERY PLACE TYPE CODE (ACTUAL)</a>	V

<a href="#">Notation</a>		<b>DATA GROUP: CDS V6-3 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER</b>		
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.</b>		
M	1..*	<b>DATA GROUP: <a href="#">CDS V6-3 Type 004 - Commissioning Data Set Message Trailer</a></b>		
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.
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<u>Notation</u>		<b>DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.</b>
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: <a href="#">CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer</a></b> One per Interchange submitted to the Secondary Uses Service. 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: Changed Description

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

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

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

<u>Notation</u>		<b>DATA GROUP: CDS V6-3 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>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.</b>
<b>M</b>	<b>1..1</b>	<p><b>DATA GROUP: <a href="#">CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol</a></b></p> <p>One per Commissioning Data Set record submitted to the Secondary Uses Service.</p> <p>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.</p>

**OR**

<u>Notation</u>		<b>DATA GROUP: CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>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.</b>
<b>M</b>	<b>1..1</b>	<p><b>DATA GROUP: <a href="#">CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol</a></b></p> <p>One per Commissioning Data Set record submitted to the Secondary Uses Service.</p> <p>Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.</p>

<u>Notation</u>		<b>DATA GROUP: PATIENT PATHWAY</b>	
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: 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.</b>	
<b>R</b>	<b>0..1</b>		
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: PATIENT PATHWAY IDENTITY</b>	<u>Rules</u>
<b>M</b>	<b>1..1</b>	<a href="#">UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)</a>	F
<i>Or</i>		<i>Or</i>	
<b>M</b>	<b>1..1</b>	<a href="#">PATIENT PATHWAY IDENTIFIER</a>	F I2
<b>M</b>	<b>1..1</b>	<a href="#">ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)</a>	F I2
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS</b>	<u>Rules</u>
<b>M</b>	<b>1..1</b>	<a href="#">REFERRAL TO TREATMENT PERIOD STATUS</a>	V
<b>M</b>	<b>1..1</b>	<a href="#">WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)</a>	V
<b>O</b>	<b>0..1</b>	<a href="#">REFERRAL TO TREATMENT PERIOD START DATE</a>	

			F S13
O	0..1	<a href="#">REFERRAL TO TREATMENT PERIOD END DATE</a>	F S13

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

One of the following DATA GROUPS must be used:

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

OR

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

OR

1..1	<b>DATA GROUP: UNVERIFIED IDENTITY STRUCTURE</b> Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE NOT included in the above			
R	0..1	<b>DATA GROUP: LOCAL IDENTIFIER STRUCTURE</b>		<a href="#">Rules</a>
		M	1..1	<a href="#">LOCAL PATIENT IDENTIFIER (EXTENDED)</a>

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

Notation		DATA GROUP: PATIENT CHARACTERISTICS			
Group Status	Group Repeats	FUNCTION: To carry the characteristics of the Patient.			
R	0..1				
M	1..1	<b>Data Element Components</b>	<a href="#">Rules</a>		
		R	0..1	<a href="#">PERSON STATED GENDER CODE</a>	V H4
		O	0..1	<a href="#">CARER SUPPORT INDICATOR</a>	V
		R	0..1	<a href="#">ETHNIC CATEGORY</a>	V
		X	0..1	<a href="#">ETHNIC CATEGORY 2021</a>	N2
		R	0..1	<a href="#">PERSON MARITAL STATUS</a>	V

		R	0..1	<a href="#">MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)</a>	F
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<b>Notation</b>		<b>DATA GROUP: PATIENT CHARACTERISTICS - SOCIAL AND PERSONAL CIRCUMSTANCES (SNOMED CT)</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the SNOMED CT coded Social and Personal Circumstances for the Patient.</b>			
R	0..*				

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT SOCIAL AND PERSONAL CIRCUMSTANCES</b>			<a href="#">Rules</a>
		M	1..1	<a href="#">SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>			<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<b>Notation</b>		<b>DATA GROUP: HOSPITAL PROVIDER SPELL - ADMISSION CHARACTERISTICS</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the admission details of the Hospital Provider Spell containing the Finished General Care Professional Admitted Care Episode.</b>			
M	1..1				
M	1..1	<b>Data Element Components</b>			<a href="#">Rules</a>
		R	0..1	<a href="#">HOSPITAL PROVIDER SPELL IDENTIFIER</a>	F H4
		R	0..1	<a href="#">ADMINISTRATIVE CATEGORY CODE (ON ADMISSION)</a>	V
		R	0..1	<a href="#">PATIENT CLASSIFICATION CODE</a>	V H4
		R	0..1	<a href="#">METHOD OF ADMISSION (HOSPITAL PROVIDER SPELL)</a>	V H4
		R	0..1	<a href="#">ADMISSION SOURCE (HOSPITAL PROVIDER SPELL)</a>	V H4
		M	1..1	<a href="#">START DATE (HOSPITAL PROVIDER SPELL)</a>	F H4 S13
		O	0..1	<a href="#">START TIME (HOSPITAL PROVIDER SPELL)</a>	F S14
		M	1..1	<a href="#">AGE ON ADMISSION</a>	F H4
		R	0..1	<a href="#">AMBULANCE CALL IDENTIFIER</a>	F

	R	0..1	<a href="#">ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST)</a>	F
	R	0..1	<a href="#">CARE CONTACT IDENTIFIER (AMBULANCE SERVICE)</a>	F

<u>Notation</u>		<b>DATA GROUP: HOSPITAL PROVIDER SPELL - DISCHARGE CHARACTERISTICS</b>		
Group Status	Group Repeats	FUNCTION: To carry the discharge details of the Hospital Provider Spell containing the Finished General Care Professional Admitted Care Episode.		
R	0..1			
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<u>Rules</u>
R	0..1	<a href="#">DESTINATION OF DISCHARGE (HOSPITAL PROVIDER SPELL)</a>		V H4
R	0..1	<a href="#">METHOD OF DISCHARGE (HOSPITAL PROVIDER SPELL)</a>		V H4
R	0..1	<a href="#">DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL)</a>		F S13
R	0..1	<a href="#">DISCHARGE DATE (HOSPITAL PROVIDER SPELL)</a>		F S13
O	0..1	<a href="#">DISCHARGE TIME (HOSPITAL PROVIDER SPELL)</a>		F S14
R	0..1	<a href="#">DISCHARGED TO NHS AT HOME SERVICE INDICATOR</a>		V

<u>Notation</u>		<b>DATA GROUP: CARE EPISODE - ACTIVITY CHARACTERISTICS</b>		
Group Status	Group Repeats	FUNCTION: To carry the details of the Patient's Finished General Care Professional Admitted Care Episode.		
M	1..1			
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<u>Rules</u>
R	0..1	<a href="#">EPISODE NUMBER</a>		F H4
R	0..1	<a href="#">LAST EPISODE IN SPELL INDICATOR CODE</a>		V
R	0..1	<a href="#">NEONATAL LEVEL OF CARE CODE</a>		V H4
O	0..1	<a href="#">FIRST REGULAR DAY OR NIGHT ADMISSION CODE</a>		V
R	0..1	<a href="#">PSYCHIATRIC PATIENT STATUS CODE</a>		V
<b>M</b>	<b>1..1</b>	<a href="#">START DATE (EPISODE)</a>		F H4 S13
O	0..1	<a href="#">START TIME (EPISODE)</a>		F S14
<b>M</b>	<b>1..1</b>	<a href="#">END DATE (EPISODE)</a>		F H4

				S1 S13
	O	0..1	<a href="#">END TIME (EPISODE)</a>	F S14
	M	1..1	<a href="#">AGE AT CDS ACTIVITY DATE</a>	F H4 S8
	O	0..1	<a href="#">REHABILITATION ASSESSMENT TEAM TYPE</a>	V N3

<u>Notation</u>		<b>DATA GROUP: CARE EPISODE - LENGTH OF STAY ADJUSTMENT</b>		
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry details of length of stay adjustments to the Finished General Care Professional Admitted Care Episode .</b>		
R	0..1			
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<a href="#">Rules</a>
	R	0..1	<a href="#">LENGTH OF STAY ADJUSTMENT (REHABILITATION)</a>	F H4
	R	0..1	<a href="#">LENGTH OF STAY ADJUSTMENT (SPECIALIST PALLIATIVE CARE)</a>	F H4

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

<u>Notation</u>		<b>DATA GROUP: CARE EPISODE - SERVICE AGREEMENT DETAILS</b>		
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Provider, Commissioners and Service Agreements.</b>		
M	1..1			
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<a href="#">Rules</a>
	M	1..1	<a href="#">ORGANISATION IDENTIFIER (CODE OF PROVIDER)</a>	F H4
<b>M</b>	<b>1..*</b>	<b>DATA GROUP: COMMISSIONERS</b>		<a href="#">Rules</a>
	M	1..1	<a href="#">ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)</a>	F

	R	0..1	<a href="#">START DATE (COMMISSIONER ASSIGNMENT PERIOD)</a>	F S13
	R	0..1	<a href="#">END DATE (COMMISSIONER ASSIGNMENT PERIOD)</a>	F S13
	R	0..1	<a href="#">NHS SERVICE AGREEMENT IDENTIFIER</a>	F
	O	0..1	<a href="#">NHS SERVICE AGREEMENT LINE IDENTIFIER</a>	F
	O	0..1	<a href="#">PROVIDER REFERENCE IDENTIFIER</a>	F
	R	0..1	<a href="#">COMMISSIONER REFERENCE IDENTIFIER</a>	F
	R	0..1	<a href="#">SPECIALISED SERVICE CODE</a>	F
R	0..1	<a href="#">SERVICE CODE</a>	F	

<u>Notation</u>		DATA GROUP: CARE EPISODE - PERSON GROUP (CARE PROFESSIONAL)			
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the Care Professionals active during the Finished General Care Professional Admitted Care Episode.</b>			
M	1..1	M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER</a>	F
		<del>M</del>	<del>1..1</del>	<del><a href="#">CARE PROFESSIONAL MAIN SPECIALTY CODE</a></del>	<del>F</del> H4
		R	0..1	<a href="#">CARE PROFESSIONAL MAIN SPECIALTY CODE</a>	F H4
		M	1..1	<a href="#">ACTIVITY TREATMENT FUNCTION CODE</a>	F H4
		O	0..1	<a href="#">LOCAL SUB-SPECIALTY CODE</a>	F
M	1..1	<a href="#">RESPONSIBLE CARE PROFESSIONAL INDICATOR</a>	V		

<u>Notation</u>		DATA GROUP: CARE EPISODE - CLINICAL DIAGNOSIS GROUP (ICD)		
<b>Group Status</b> R	<b>Group Repeats</b> 0..1	<b>FUNCTION: To carry the details of the ICD coded Clinical Diagnoses for the Patient.</b>		
M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>
		M	1..1	<a href="#">DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET)</a>
M	1..1	<b>DATA GROUP: PRIMARY DIAGNOSIS</b>		<a href="#">Rules</a>
		M	1..1	<a href="#">PRIMARY DIAGNOSIS (ICD)</a>

		O	0..1	<a href="#">PRESENT ON ADMISSION INDICATOR</a>	V
R	0..*	DATA GROUP: SECONDARY DIAGNOSES			<a href="#">Rules</a>
		M	1..1	<a href="#">SECONDARY DIAGNOSIS (ICD)</a>	F H4
		O	0..1	<a href="#">PRESENT ON ADMISSION INDICATOR</a>	V

<a href="#">Notation</a>		<b>DATA GROUP: CARE EPISODE - CLINICAL DIAGNOSIS GROUP (SNOMED CT)</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the SNOMED CT coded Clinical Diagnoses for the Patient.</b>			
R	0..*				

One of the following DATA GROUPS may be used:

M	1..1	DATA GROUP: SNOMED CT DIAGNOSIS			<a href="#">Rules</a>
		M	1..1	<a href="#">DIAGNOSIS (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">CODED CLINICAL ENTRY SEQUENCE NUMBER</a>	F
		M	1..1	<a href="#">CODED DIAGNOSIS TIMESTAMP</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON			<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: CARE EPISODE - COMORBIDITY (SNOMED CT)</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the SNOMED CT coded Comorbidities for the Patient.</b>			
R	0..*				

One of the following DATA GROUPS may be used:

M	1..1	DATA GROUP: SNOMED CT COMORBIDITY			<a href="#">Rules</a>
		M	1..1	<a href="#">COMORBIDITY (SNOMED CT EXPRESSION)</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON			<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: CARE EPISODE - EMED3 FIT NOTE</b>				
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the EMED3 Fit Note issued.</b>				
R	0..1					
M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>		
		M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>
				R	0..1	<a href="#">EMED3 FIT NOTE ASSESSMENT DATE</a>
		R	0..1		F	

				<a href="#">EMED3 FIT NOTE CONDITION (SNOMED CT EXPRESSION)</a>		
			R	0..1	<a href="#">EMED3 FIT NOTE DIAGNOSIS (ICD)</a>	F
			R	0..1	<a href="#">EMED3 FIT NOTE START DATE</a>	F S13
			R	0..1	<a href="#">EMED3 FIT NOTE END DATE</a>	F S13
			R	0..1	<a href="#">EMED3 FIT NOTE DURATION</a>	F
			R	0..1	<a href="#">EMED3 FIT NOTE RECORDED DATE</a>	F S13
R	0..1				<a href="#">EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR</a>	V
X	0..1				<a href="#">EMED3 FIT NOTE ISSUER</a>	N2

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	<b>Data Element Components</b>			<a href="#">Rules</a>
M	1..1	<a href="#">PROCEDURE SCHEME IN USE (COMMISSIONING DATA SET)</a>			V
M	1..1	<b>DATA GROUP: PRIMARY PROCEDURE</b>			<a href="#">Rules</a>
M	1..1	<a href="#">PRIMARY PROCEDURE (OPCS)</a>			F H4
R	0..1	<a href="#">PROCEDURE DATE</a>			F S13
O	0..1	<b>DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL</b>			<a href="#">Rules</a>
M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>			V
M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)</a>			F
O	0..1	<b>DATA GROUP: RESPONSIBLE ANAESTHETIST</b>			<a href="#">Rules</a>
M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>			V
M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)</a>			F
R	0..*	<b>DATA GROUP: SECONDARY PROCEDURES</b>			<a href="#">Rules</a>
M	1..1	<a href="#">PROCEDURE (OPCS)</a>			F H4

		R	0..1	<a href="#">PROCEDURE DATE</a>	F S13
O	0..1	DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL			<a href="#">Rules</a>
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)</a>	F
O	0..1	DATA GROUP: RESPONSIBLE ANAESTHETIST			<a href="#">Rules</a>
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: CARE EPISODE - PROCEDURE GROUP (SNOMED CT)</b>
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the SNOMED CT coded Procedures for the Patient.</b>

One of the following DATA GROUPS may be used:

M	1..1	DATA GROUP: SNOMED CT PROCEDURE			<a href="#">Rules</a>
		M	1..1	<a href="#">PROCEDURE (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">CODED CLINICAL ENTRY SEQUENCE NUMBER</a>	F
		M	1..1	<a href="#">CODED PROCEDURE TIMESTAMP</a>	F
O	0..1	DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL			<a href="#">Rules</a>
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)</a>	F
O	0..1	DATA GROUP: RESPONSIBLE ANAESTHETIST			<a href="#">Rules</a>
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON			<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: CARE EPISODE - OBSERVATION GROUP (SNOMED CT)</b>
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the SNOMED CT coded Clinical Observations for the Patient.</b>

One of the following DATA GROUPS may be used:

M	1..1	DATA GROUP: SNOMED CT OBSERVATION			<a href="#">Rules</a>
		M	1..1	<a href="#">OBSERVATION (SNOMED CT EXPRESSION)</a>	F

		R	0..1	<a href="#">OBSERVATION VALUE</a>	F
		R	0..1	<a href="#">UCUM UNIT OF MEASUREMENT</a>	F
		M	1..1	<a href="#">CODED OBSERVATION TIMESTAMP</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON			<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: CARE EPISODE - FINDING GROUP (SNOMED CT)</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the SNOMED CT coded Clinical Findings for the Patient.</b>			
R	0..*				

One of the following DATA GROUPS may be used:

M	0..1	DATA GROUP: SNOMED CT FINDING			<a href="#">Rules</a>
		M	1..1	<a href="#">FINDING (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">CODED FINDING TIMESTAMP</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON			<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: CARE EPISODE - ASSESSMENT TOOL GROUP (SNOMED CT)</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the SNOMED CT coded Assessment Tools for the Patient.</b>			
R	0..*				

One of the following DATA GROUPS may be used:

M	1..1	DATA GROUP: SNOMED CT ASSESSMENT TOOL			<a href="#">Rules</a>
		M	1..1	<a href="#">ASSESSMENT TOOL (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">PERSON SCORE</a>	F
		M	1..1	<a href="#">ASSESSMENT TOOL COMPLETION TIMESTAMP</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON			<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: LOCATION GROUP (AT START OF CARE EPISODE)</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Location at the Start of the Finished General Care Professional Admitted Care Episode.</b>			
R	0..1				
M	1..1	Data Element Components			<a href="#">Rules</a>
		R	0..1	<a href="#">ORGANISATION SITE IDENTIFIER (OF TREATMENT)</a>	F
		R	0..1	<a href="#">ACTIVITY LOCATION TYPE CODE</a>	F

	O	0..1	<a href="#">WARD INTENDED CLINICAL CARE INTENSITY</a>	V
	O	0..1	<a href="#">WARD INTENDED AGE GROUP</a>	V
	O	0..1	<a href="#">WARD INTENDED SEX OF PATIENTS</a>	V
	O	0..1	<a href="#">WARD INTENDED DAY PERIOD AVAILABILITY</a>	V
	O	0..1	<a href="#">WARD INTENDED NIGHT PERIOD AVAILABILITY</a>	V
	O	0..1	<a href="#">WARD SECURITY LEVEL</a>	V
	O	0..1	<a href="#">WARD CODE</a>	F

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

M	1..1	Data Element Components	Rules	
	R	0..1	<a href="#">ORGANISATION SITE IDENTIFIER (OF TREATMENT)</a>	F
	R	0..1	<a href="#">ACTIVITY LOCATION TYPE CODE</a>	F
	O	0..1	<a href="#">WARD INTENDED CLINICAL CARE INTENSITY</a>	V
	O	0..1	<a href="#">WARD INTENDED AGE GROUP</a>	V
	O	0..1	<a href="#">WARD INTENDED SEX OF PATIENTS</a>	V
	O	0..1	<a href="#">WARD INTENDED DAY PERIOD AVAILABILITY</a>	V
	O	0..1	<a href="#">WARD INTENDED NIGHT PERIOD AVAILABILITY</a>	V
	O	0..1	<a href="#">START DATE (WARD STAY)</a>	F S13
	O	0..1	<a href="#">START TIME (WARD STAY)</a>	F S14
	O	0..1	<a href="#">END DATE (WARD STAY)</a>	F S13
	O	0..1	<a href="#">END TIME (WARD STAY)</a>	F S14
	O	0..1	<a href="#">WARD SECURITY LEVEL</a>	V
	O	0..1	<a href="#">WARD CODE</a>	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 Finished General Care Professional Admitted Care Episode.
R	0..1	

M	1..1	Data Element Components	Rules	
	R	0..1	<a href="#">ORGANISATION SITE IDENTIFIER (OF TREATMENT)</a>	F
	R	0..1	<a href="#">ACTIVITY LOCATION TYPE CODE</a>	F
	O	0..1	<a href="#">WARD INTENDED CLINICAL CARE INTENSITY</a>	V
	O	0..1	<a href="#">WARD INTENDED AGE GROUP</a>	V

	O	0..1	<a href="#">WARD INTENDED SEX OF PATIENTS</a>	V
	O	0..1	<a href="#">WARD INTENDED DAY PERIOD AVAILABILITY</a>	V
	O	0..1	<a href="#">WARD INTENDED NIGHT PERIOD AVAILABILITY</a>	V
	O	0..1	<a href="#">WARD SECURITY LEVEL</a>	V
	O	0..1	<a href="#">WARD CODE</a>	F

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

<u>Notation</u>		<b>DATA GROUP: CARE EPISODE - NEONATAL CRITICAL CARE PERIOD</b>		
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			
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: NEONATAL CARE - ADMISSION CHARACTERISTICS</b>		<a href="#">Rules</a>
	M	1..1	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>	F
	M	1..1	<a href="#">CRITICAL CARE START DATE</a>	F H4 S13
	M	1..1	<a href="#">CRITICAL CARE START TIME</a>	F S14
	M	1..1	<a href="#">CRITICAL CARE UNIT FUNCTION</a>	V H4
	M	1..1	<a href="#">GESTATION LENGTH (AT DELIVERY)</a>	V
<b>M</b>	<b>1..999</b>	<b>DATA GROUP: NEONATAL DAILY CARE - ACTIVITY CHARACTERISTICS</b>		<a href="#">Rules</a>
	M	1..1	<a href="#">ACTIVITY DATE (CRITICAL CARE)</a>	F S13
	R	0..1	<a href="#">PERSON WEIGHT</a>	F
	M	1..20	<a href="#">CRITICAL CARE ACTIVITY CODE</a>	

				F N4	
		R	0..20	<a href="#">HIGH COST DRUGS (OPCS)</a> F N4	
R	0..1	DATA GROUP: NEONATAL CARE - DISCHARGE CHARACTERISTICS			<a href="#">Rules</a>
		M	1..1	<a href="#">CRITICAL CARE DISCHARGE DATE</a> F H4 S13	
		M	1..1	<a href="#">CRITICAL CARE DISCHARGE TIME</a> F S14	

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

<u>Notation</u>		<b>DATA GROUP: CARE EPISODE - ADULT CRITICAL CARE PERIOD</b>	
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: See CRITICAL CARE PERIOD. To carry the details of the first 9 Critical Care Periods for care provided using Adult Care facilities.</b>	
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: ADULT CRITICAL CARE - ADMISSION CHARACTERISTICS</b>	<a href="#">Rules</a>
<b>M</b>	<b>1..1</b>	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>	F
<b>M</b>	<b>1..1</b>	<a href="#">CRITICAL CARE START DATE</a>	F H4 S13
<b>O</b>	<b>0..1</b>	<a href="#">CRITICAL CARE START TIME</a>	F S14
<b>M</b>	<b>1..1</b>	<a href="#">CRITICAL CARE UNIT FUNCTION</a>	V H4
<b>O</b>	<b>0..1</b>	<a href="#">CRITICAL CARE UNIT BED CONFIGURATION</a>	V
<b>O</b>	<b>0..1</b>	<a href="#">CRITICAL CARE ADMISSION SOURCE</a>	V
<b>O</b>	<b>0..1</b>	<a href="#">CRITICAL CARE SOURCE LOCATION</a>	V
<b>O</b>	<b>0..1</b>	<a href="#">CRITICAL CARE ADMISSION TYPE</a>	V
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: ADULT CRITICAL CARE - ACTIVITY CHARACTERISTICS</b>	<a href="#">Rules</a>
<b>R</b>	<b>0..1</b>	<a href="#">ADVANCED RESPIRATORY SUPPORT DAYS</a>	F H4
<b>R</b>	<b>0..1</b>	<a href="#">BASIC RESPIRATORY SUPPORT DAYS</a>	F H4
<b>R</b>	<b>0..1</b>	<a href="#">ADVANCED CARDIOVASCULAR SUPPORT DAYS</a>	F H4
<b>R</b>	<b>0..1</b>	<a href="#">BASIC CARDIOVASCULAR SUPPORT DAYS</a>	F H4
<b>R</b>	<b>0..1</b>	<a href="#">RENAL SUPPORT DAYS</a>	F H4
<b>R</b>	<b>0..1</b>	<a href="#">NEUROLOGICAL SUPPORT DAYS</a>	F H4
<b>O</b>	<b>0..1</b>	<a href="#">GASTRO-INTESTINAL SUPPORT DAYS</a>	F
<b>R</b>	<b>0..1</b>	<a href="#">DERMATOLOGICAL SUPPORT DAYS</a>	F H4
<b>R</b>	<b>0..1</b>	<a href="#">LIVER SUPPORT DAYS</a>	F H4
<b>O</b>	<b>0..1</b>	<a href="#">ORGAN SUPPORT MAXIMUM</a>	V
<b>R</b>	<b>0..1</b>	<a href="#">CRITICAL CARE LEVEL 2 DAYS</a>	F H4
<b>R</b>	<b>0..1</b>	<a href="#">CRITICAL CARE LEVEL 3 DAYS</a>	F H4

R	0..*	DATA GROUP: ADULT CRITICAL CARE - DAILY CARE ACTIVITY CHARACTERISTICS		<a href="#">Rules</a>	
		M	1..1	<a href="#">ACTIVITY DATE (CRITICAL CARE)</a>	F S13
		M	1..9	<a href="#">ORGAN SYSTEM SUPPORTED</a>	V
		M	1..1	<a href="#">CRITICAL CARE LEVEL</a>	V
R	0..1	DATA GROUP: ADULT CRITICAL CARE - DISCHARGE CHARACTERISTICS		<a href="#">Rules</a>	
		M	1..1	<a href="#">CRITICAL CARE DISCHARGE DATE</a>	F H4 S13
		M	1..1	<a href="#">CRITICAL CARE DISCHARGE TIME</a>	F S14
		O	0..1	<a href="#">CRITICAL CARE DISCHARGE READY DATE</a>	F S13
		O	0..1	<a href="#">CRITICAL CARE DISCHARGE READY TIME</a>	F S14
		O	0..1	<a href="#">CRITICAL CARE DISCHARGE STATUS</a>	V
		O	0..1	<a href="#">CRITICAL CARE DISCHARGE DESTINATION</a>	V
		O	0..1	<a href="#">CRITICAL CARE DISCHARGE LOCATION</a>	V

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

<a href="#">Notation</a>		<b>DATA GROUP: REFERRER</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Referrer.</b>			
R	0..1				
M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		R	0..1	<a href="#">REFERRER CODE</a>	F
		R	0..1	<a href="#">ORGANISATION IDENTIFIER (REFERRING ORGANISATION)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: REFERRAL</b>	
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Referral.</b>	
O	0..1		

M	1..1	Data Element Components		<a href="#">Rules</a>
		O	0..1	<a href="#">DIRECT ACCESS REFERRAL INDICATOR</a>

<a href="#">Notation</a>		<b>DATA GROUP: ELECTIVE ADMISSION LIST ENTRY</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Elective Admission List Entry.</b>
R	0..1	

M	1..1	Data Element Components		<a href="#">Rules</a>	
		R	0..1	<a href="#">DURATION OF ELECTIVE WAIT</a>	F
		R	0..1	<a href="#">INTENDED MANAGEMENT CODE</a>	V
		R	0..1	<a href="#">DECIDED TO ADMIT DATE</a>	F S13
		R	0..1	<a href="#">EARLIEST REASONABLE OFFER DATE</a>	F S13
		R	0..1	<a href="#">EARLIEST CLINICALLY APPROPRIATE DATE</a>	F S13
		R	0..1	<a href="#">LATEST CLINICALLY APPROPRIATE DATE</a>	F S13

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

M	1..*	<b>DATA GROUP: <a href="#">CDS V6-3 Type 004 - Commissioning Data Set Message Trailer</a></b> 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.	
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<a href="#">Notation</a>		<b>DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.</b>

M	1..1	<b>DATA GROUP: <a href="#">CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer</a></b> One per Interchange submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.	
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<b>CDS V6-3 TYPE 140 - FINISHED DELIVERY EPISODE COMMISSIONING DATA SET</b>	
<b>FUNCTION: To support the details of a Finished Care Professional Admitted Care Delivery Episode.</b>	

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

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

<u>Notation</u>		<b>DATA GROUP: CDS V6-3 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>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.</b>
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: <a href="#">CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol</a></b> One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

**OR**

<u>Notation</u>		<b>DATA GROUP: CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL</b>

<b>Group Status</b>	<b>Group Repeats</b>	<b>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.</b>
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: <a href="#">CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol</a></b> One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

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

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

One of the following DATA GROUPS must be used:

<b>1..1</b>	<b>DATA GROUP: WITHHELD IDENTITY STRUCTURE</b>	<b>Must be used where the Commissioning Data Set record has been anonymised</b>
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>
		<b>Rules</b>
<b>M</b>	<b>1..1</b>	<b><a href="#">NHS NUMBER STATUS INDICATOR CODE</a></b>
		<b>V</b>
<b>R</b>	<b>0..1</b>	<b><a href="#">ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)</a></b>
		<b>F</b>

		R	0..1	<a href="#">WITHHELD IDENTITY REASON</a>	V
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OR

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

OR

1..1		<b>DATA GROUP: UNVERIFIED IDENTITY STRUCTURE</b> Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE NOT included in the above			
R	0..1	<b>DATA GROUP: LOCAL IDENTIFIER STRUCTURE</b>			<a href="#">Rules</a>
M	1..1		<a href="#">LOCAL PATIENT IDENTIFIER (EXTENDED)</a>	F S3	
M	1..1		<a href="#">ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)</a>	F	
M	1..1	<b>Data Element Components</b>			<a href="#">Rules</a>
R	0..1		<a href="#">NHS NUMBER</a>	F S3	
M	1..1		<a href="#">NHS NUMBER STATUS INDICATOR CODE</a>	V	
R	0..1	<b>Data Element Components</b>			<a href="#">Rules</a>
M	1..1		<a href="#">PATIENT FULL NAME</a>	F	
OR	OR	OR		S3	
O	0..1		<a href="#">PATIENT TITLE</a>	I4	
and	and	and			
M	1..1		<a href="#">PATIENT GIVEN NAME</a>		
and	and	and			
M	1..1		<a href="#">PATIENT FAMILY NAME</a>		
and	and	and			
O	0..1		<a href="#">PATIENT NAME SUFFIX</a>		

		and O	and 0..1	and <a href="#">PATIENT INITIALS</a>	
R	0..1	Data Element Components			<a href="#">Rules</a>
		M	1..1	<a href="#">PATIENT USUAL ADDRESS (UNSTRUCTURED)</a>	F
		OR M	OR 2..5	OR <a href="#">PATIENT USUAL ADDRESS (STRUCTURED)</a>	S3 I5
M	1..1	Data Element Components			<a href="#">Rules</a>
		R	0..1	<a href="#">POSTCODE OF USUAL ADDRESS</a>	F S3
		R	0..1	<a href="#">ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)</a>	F
		R	0..1	<a href="#">PERSON BIRTH DATE</a>	F S3 S12

<a href="#">Notation</a>		<b>DATA GROUP: PATIENT CHARACTERISTICS</b>			
Group Status R	Group Repeats 0..1	<b>FUNCTION: To carry the characteristics of the Patient (the Mother).</b>			
M	1..1	Data Element Components	<a href="#">Rules</a>		
		R	0..1	<a href="#">PERSON STATED GENDER CODE</a>	V H4
		O	0..1	<a href="#">CARER SUPPORT INDICATOR</a>	V
		R	0..1	<a href="#">ETHNIC CATEGORY</a>	V
		X	0..1	<a href="#">ETHNIC CATEGORY 2021</a>	N2
		R	0..1	<a href="#">PERSON MARITAL STATUS</a>	V
		R	0..1	<a href="#">MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: DELIVERY CHARACTERISTICS</b>	
Group Status R	Group Repeats 0..1	<b>FUNCTION: To carry the delivery characteristics of the Patient (the Mother).</b>	
M	1..1	Data Element Components	<a href="#">Rules</a>
		R	0..1

<a href="#">Notation</a>		<b>DATA GROUP: PATIENT CHARACTERISTICS - SOCIAL AND PERSONAL CIRCUMSTANCES (SNOMED CT)</b>
Group Status R	Group Repeats 0..*	<b>FUNCTION: To carry the Social and Personal Circumstances for the Patient (the Mother).</b>

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT SOCIAL AND PERSONAL CIRCUMSTANCES</b>		<a href="#">Rules</a>	
		M	1..1	<a href="#">SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>		<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>

<a href="#">Notation</a>		<b>DATA GROUP: HOSPITAL PROVIDER SPELL - ADMISSION CHARACTERISTICS</b>		
Group Status	Group Repeats	FUNCTION: To carry the admission details of the Hospital Provider Spell containing the Finished Delivery Care Professional Admitted Care Episode.		
M	1..1			
M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>
R	0..1	<a href="#">HOSPITAL PROVIDER SPELL IDENTIFIER</a>		F H4
R	0..1	<a href="#">ADMINISTRATIVE CATEGORY CODE (ON ADMISSION)</a>		V
R	0..1	<a href="#">PATIENT CLASSIFICATION CODE</a>		V H4
R	0..1	<a href="#">METHOD OF ADMISSION (HOSPITAL PROVIDER SPELL)</a>		V H4
R	0..1	<a href="#">ADMISSION SOURCE (HOSPITAL PROVIDER SPELL)</a>		V H4
M	1..1	<a href="#">START DATE (HOSPITAL PROVIDER SPELL)</a>		F H4 S13
O	0..1	<a href="#">START TIME (HOSPITAL PROVIDER SPELL)</a>		F S14
M	1..1	<a href="#">AGE ON ADMISSION</a>		F H4
R	0..1	<a href="#">AMBULANCE CALL IDENTIFIER</a>		F
R	0..1	<a href="#">ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST)</a>		F
R	0..1	<a href="#">CARE CONTACT IDENTIFIER (AMBULANCE SERVICE)</a>		F

<a href="#">Notation</a>		<b>DATA GROUP: HOSPITAL PROVIDER SPELL - DISCHARGE CHARACTERISTICS</b>		

Group Status	Group Repeats	FUNCTION: To carry the discharge details of the Hospital Provider Spell containing the Finished Delivery Care Professional Admitted Care Episode.			
R	0..1				
M	1..1	<b>Data Element Components</b>		<b>Rules</b>	
		R	0..1	<a href="#">DESTINATION OF DISCHARGE (HOSPITAL PROVIDER SPELL)</a>	V H4
		R	0..1	<a href="#">METHOD OF DISCHARGE (HOSPITAL PROVIDER SPELL)</a>	V H4
		R	0..1	<a href="#">DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL)</a>	F S13
		R	0..1	<a href="#">DISCHARGE DATE (HOSPITAL PROVIDER SPELL)</a>	F S13
		O	0..1	<a href="#">DISCHARGE TIME (HOSPITAL PROVIDER SPELL)</a>	F S14
		R	0..1	<a href="#">DISCHARGED TO NHS AT HOME SERVICE INDICATOR</a>	V

<u>Notation</u>		DATA GROUP: DELIVERY EPISODE - ACTIVITY CHARACTERISTICS			
Group Status	Group Repeats	FUNCTION: To carry the details of the Finished Delivery Care Professional Admitted Care Episode.			
M	1..1				
M	1..1	<b>Data Element Components</b>		<b>Rules</b>	
		R	0..1	<a href="#">EPISODE NUMBER</a>	F H4
		R	0..1	<a href="#">LAST EPISODE IN SPELL INDICATOR CODE</a>	V
		R	0..1	<a href="#">PSYCHIATRIC PATIENT STATUS CODE</a>	V
		M	1..1	<a href="#">START DATE (EPISODE)</a>	F H4 S13
		O	0..1	<a href="#">START TIME (EPISODE)</a>	F S14
		M	1..1	<a href="#">END DATE (EPISODE)</a>	F H4 S1 S13
		O	0..1	<a href="#">END TIME (EPISODE)</a>	F S14
		M	1..1	<a href="#">AGE AT CDS ACTIVITY DATE</a>	F H4
O	0..1	<a href="#">REHABILITATION ASSESSMENT TEAM TYPE</a>	V N3		

<u>Notation</u>	

		<b>DATA GROUP: DELIVERY EPISODE - OVERSEAS VISITOR CHARGING CATEGORY</b>			
<b>Group Status</b> R	<b>Group Repeats</b> 0..5	<b>FUNCTION: To carry the details of the Overseas Visitor Charging Categories of the Patient (the Mother) during the Finished Delivery Care Professional Admitted Care Episode.</b>			
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<a href="#">Rules</a>	
		<b>M</b>	<b>1..1</b>	<a href="#">OVERSEAS VISITOR CHARGING CATEGORY</a>	V
		<b>M</b>	<b>1..1</b>	<a href="#">OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE FROM DATE</a>	F S13
		<b>R</b>	<b>0..1</b>	<a href="#">OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE END DATE</a>	F S13

<a href="#">Notation</a>		<b>DATA GROUP: DELIVERY EPISODE - SERVICE AGREEMENT DETAILS</b>			
<b>Group Status</b> M	<b>Group Repeats</b> 1..1	<b>FUNCTION: To carry the details of the Provider, Commissioners and Service Agreements.</b>			
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<a href="#">Rules</a>	
		<b>M</b>	<b>1..1</b>	<a href="#">ORGANISATION IDENTIFIER (CODE OF PROVIDER)</a>	F H4
<b>M</b>	<b>1..*</b>	<b>DATA GROUP: COMMISSIONERS</b>		<a href="#">Rules</a>	
		<b>M</b>	<b>1..1</b>	<a href="#">ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)</a>	F
		<b>R</b>	<b>0..1</b>	<a href="#">START DATE (COMMISSIONER ASSIGNMENT PERIOD)</a>	F S13
		<b>R</b>	<b>0..1</b>	<a href="#">END DATE (COMMISSIONER ASSIGNMENT PERIOD)</a>	F S13
		<b>R</b>	<b>0..1</b>	<a href="#">NHS SERVICE AGREEMENT IDENTIFIER</a>	F
		<b>O</b>	<b>0..1</b>	<a href="#">NHS SERVICE AGREEMENT LINE IDENTIFIER</a>	F
		<b>O</b>	<b>0..1</b>	<a href="#">PROVIDER REFERENCE IDENTIFIER</a>	F
		<b>R</b>	<b>0..1</b>	<a href="#">COMMISSIONER REFERENCE IDENTIFIER</a>	F
		<b>R</b>	<b>0..1</b>	<a href="#">SPECIALISED SERVICE CODE</a>	F
<b>R</b>	<b>0..1</b>	<a href="#">SERVICE CODE</a>	F		

<a href="#">Notation</a>		<b>DATA GROUP: DELIVERY EPISODE - PERSON GROUP (CARE PROFESSIONAL)</b>		
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the Care Professionals active during the Finished Delivery Care Professional Admitted Care Episode.</b>		
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<a href="#">Rules</a>

		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER</a>	F
		M	1..1	<a href="#">CARE PROFESSIONAL MAIN SPECIALTY CODE</a>	F H4
		R	0..1	<a href="#">CARE PROFESSIONAL MAIN SPECIALTY CODE</a>	F H4
		M	1..1	<a href="#">ACTIVITY TREATMENT FUNCTION CODE</a>	F H4
		O	0..1	<a href="#">LOCAL SUB-SPECIALTY CODE</a>	F
M	1..1			<a href="#">RESPONSIBLE CARE PROFESSIONAL INDICATOR</a>	V

<a href="#">Notation</a>		<b>DATA GROUP: DELIVERY EPISODE - CLINICAL DIAGNOSIS GROUP (ICD)</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the ICD coded Clinical Diagnoses for the Patient (the Mother).</b>			
R	0..1				
M	1..1	<b>Data Element Components</b>			<a href="#">Rules</a>
		M	1..1	<a href="#">DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET)</a>	V
M	1..1	<b>DATA GROUP: PRIMARY DIAGNOSIS</b>			<a href="#">Rules</a>
		M	1..1	<a href="#">PRIMARY DIAGNOSIS (ICD)</a>	F H4
R	0..*	<b>DATA GROUP: SECONDARY DIAGNOSES</b>			<a href="#">Rules</a>
		M	1..1	<a href="#">SECONDARY DIAGNOSIS (ICD)</a>	F H4

<a href="#">Notation</a>		<b>DATA GROUP: DELIVERY EPISODE - CLINICAL DIAGNOSIS GROUP (SNOMED CT)</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the SNOMED CT coded Clinical Diagnoses for the Patient (the Mother).</b>			
R	0..*				

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT DIAGNOSIS</b>			<a href="#">Rules</a>
		M	1..1	<a href="#">DIAGNOSIS (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">CODED CLINICAL ENTRY SEQUENCE NUMBER</a>	F
		M	1..1	<a href="#">CODED DIAGNOSIS TIMESTAMP</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>			<a href="#">Rules</a>
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		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F
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<u>Notation</u>		<b>DATA GROUP: DELIVERY EPISODE - COMORBIDITY (SNOMED CT)</b>			
Group Status	Group Repeats	FUNCTION: To carry the details of the SNOMED CT coded Comorbidities for the Patient (the Mother).			
R	0..*				

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT COMORBIDITY</b>			<a href="#">Rules</a>
		M	1..1	<a href="#">COMORBIDITY (SNOMED CT EXPRESSION)</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON			<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

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

M	1..1	<b>Data Element Components</b>			<a href="#">Rules</a>
		M	1..1	<a href="#">PROCEDURE SCHEME IN USE (COMMISSIONING DATA SET)</a>	V
M	1..1	<b>DATA GROUP: PRIMARY PROCEDURE</b>			<a href="#">Rules</a>
		M	1..1	<a href="#">PRIMARY PROCEDURE (OPCS)</a>	F H4
		R	0..1	<a href="#">PROCEDURE DATE</a>	F S13
O	0..1	DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL			<a href="#">Rules</a>
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)</a>	F
O	0..1	DATA GROUP: RESPONSIBLE ANAESTHETIST			<a href="#">Rules</a>
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)</a>	F
R	0..*	<b>DATA GROUP: SECONDARY PROCEDURES</b>			<a href="#">Rules</a>
		M	1..1	<a href="#">PROCEDURE (OPCS)</a>	F H4
		R	0..1	<a href="#">PROCEDURE DATE</a>	F S13
O	0..1	DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL			<a href="#">Rules</a>
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1		F

			<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)</a>		
O	0..1	DATA GROUP: RESPONSIBLE ANAESTHETIST		<a href="#">Rules</a>	
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: DELIVERY EPISODE - PROCEDURE GROUP (SNOMED CT)</b>		
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the SNOMED CT coded Procedures for the Patient (the Mother).</b>		

One of the following DATA GROUPS may be used:

M	1..1	DATA GROUP: SNOMED CT PROCEDURE		<a href="#">Rules</a>	
		M	1..1	<a href="#">PROCEDURE (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">CODED CLINICAL ENTRY SEQUENCE NUMBER</a>	F
		M	1..1	<a href="#">CODED PROCEDURE TIMESTAMP</a>	F
O	0..1	DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL		<a href="#">Rules</a>	
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)</a>	F
O	0..1	DATA GROUP: RESPONSIBLE ANAESTHETIST		<a href="#">Rules</a>	
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON		<a href="#">Rules</a>	
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: DELIVERY EPISODE - OBSERVATION GROUP (SNOMED CT)</b>		
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the SNOMED CT coded Clinical Observations for the Patient (the Mother).</b>		

One of the following DATA GROUPS may be used:

M	1..1	DATA GROUP: SNOMED CT OBSERVATION		<a href="#">Rules</a>	
		M	1..1	<a href="#">OBSERVATION (SNOMED CT EXPRESSION)</a>	F
		R	0..1	<a href="#">OBSERVATION VALUE</a>	F
		R	0..1	<a href="#">UCUM UNIT OF MEASUREMENT</a>	F
		M	1..1	<a href="#">CODED OBSERVATION TIMESTAMP</a>	F

OR

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O	0..1	DATA GROUP: DATA ABSENT REASON	<a href="#">Rules</a>
		O 0..1 <a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: DELIVERY EPISODE - FINDING GROUP (SNOMED CT)</b>
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the SNOMED CT coded Clinical Findings for the Patient (the Mother).</b>

One of the following DATA GROUPS may be used:

M	1..1	DATA GROUP: SNOMED CT FINDING	<a href="#">Rules</a>
		M 1..1 <a href="#">FINDING (SNOMED CT EXPRESSION)</a>	F
		M 1..1 <a href="#">CODED FINDING TIMESTAMP</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON	<a href="#">Rules</a>
		O 0..1 <a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: DELIVERY EPISODE - ASSESSMENT TOOL GROUP (SNOMED CT)</b>
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the SNOMED CT coded Assessment Tools for the Patient (the Mother).</b>

One of the following DATA GROUPS may be used:

M	1..1	DATA GROUP: SNOMED CT ASSESSMENT TOOL	<a href="#">Rules</a>
		M 1..1 <a href="#">ASSESSMENT TOOL (SNOMED CT EXPRESSION)</a>	F
		M 1..1 <a href="#">PERSON SCORE</a>	F
		M 1..1 <a href="#">ASSESSMENT TOOL COMPLETION TIMESTAMP</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON	<a href="#">Rules</a>
		O 0..1 <a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: LOCATION GROUP (AT START OF DELIVERY EPISODE)</b>
<b>Group Status</b> R	<b>Group Repeats</b> 0..1	<b>FUNCTION: To carry the details of the Location at the Start of the Finished Delivery Care Professional Admitted Care Episode.</b>

M	1..1	Data Element Components	<a href="#">Rules</a>
		R 0..1 <a href="#">ORGANISATION SITE IDENTIFIER (OF TREATMENT)</a>	F
		R 0..1 <a href="#">ACTIVITY LOCATION TYPE CODE</a>	F
		O 0..1 <a href="#">WARD INTENDED CLINICAL CARE INTENSITY</a>	V
		O 0..1 <a href="#">WARD INTENDED AGE GROUP</a>	V
		O 0..1 <a href="#">WARD INTENDED SEX OF PATIENTS</a>	V

	O	0..1	<a href="#">WARD INTENDED DAY PERIOD AVAILABILITY</a>	V
	O	0..1	<a href="#">WARD INTENDED NIGHT PERIOD AVAILABILITY</a>	V
	O	0..1	<a href="#">WARD SECURITY LEVEL</a>	V
	O	0..1	<a href="#">WARD CODE</a>	F

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

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

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

M	1..1	Data Element Components	Rules
	R	0..1 <a href="#">ORGANISATION SITE IDENTIFIER (OF TREATMENT)</a>	F
	R	0..1 <a href="#">ACTIVITY LOCATION TYPE CODE</a>	F
	O	0..1 <a href="#">WARD INTENDED CLINICAL CARE INTENSITY</a>	V
	O	0..1 <a href="#">WARD INTENDED AGE GROUP</a>	V
	O	0..1 <a href="#">WARD INTENDED SEX OF PATIENTS</a>	V
	O	0..1 <a href="#">WARD INTENDED DAY PERIOD AVAILABILITY</a>	V

	O	0..1	<a href="#">WARD INTENDED NIGHT PERIOD AVAILABILITY</a>	V
	O	0..1	<a href="#">WARD SECURITY LEVEL</a>	V
	O	0..1	<a href="#">WARD CODE</a>	F

<u>Notation</u>		DATA GROUP: LOCATION GROUP - HOME LEAVE		
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION:</b> To carry the details of each separate period of Home Leave within the Finished Delivery Care Professional Admitted Care Episode.		
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<a href="#">Rules</a>
<b>M</b>	<b>1..1</b>	<a href="#">START DATE (HOME LEAVE)</a>		F S13
<b>R</b>	<b>0..1</b>	<a href="#">START TIME (HOME LEAVE)</a>		F S14
<b>R</b>	<b>0..1</b>	<a href="#">END DATE (HOME LEAVE)</a>		F S13
<b>R</b>	<b>0..1</b>	<a href="#">END TIME (HOME LEAVE)</a>		F S14

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

		DATA GROUP: PAEDIATRIC CRITICAL CARE - DISCHARGE CHARACTERISTICS	
M	1..1	<a href="#">CRITICAL CARE DISCHARGE DATE</a>	F H4 S13
M	1..1	<a href="#">CRITICAL CARE DISCHARGE TIME</a>	F S14

<a href="#">Notation</a>		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	<a href="#">Rules</a>
M	1..1	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>	F
M	1..1	<a href="#">CRITICAL CARE START DATE</a>	F H4 S13
O	0..1	<a href="#">CRITICAL CARE START TIME</a>	F S14
M	1..1	<a href="#">CRITICAL CARE UNIT FUNCTION</a>	V H4
O	0..1	<a href="#">CRITICAL CARE UNIT BED CONFIGURATION</a>	V
O	0..1	<a href="#">CRITICAL CARE ADMISSION SOURCE</a>	V
O	0..1	<a href="#">CRITICAL CARE SOURCE LOCATION</a>	V
O	0..1	<a href="#">CRITICAL CARE ADMISSION TYPE</a>	V

M	1..1	DATA GROUP: ADULT CRITICAL CARE - ACTIVITY CHARACTERISTICS	<a href="#">Rules</a>
R	0..1	<a href="#">ADVANCED RESPIRATORY SUPPORT DAYS</a>	F H4
R	0..1	<a href="#">BASIC RESPIRATORY SUPPORT DAYS</a>	F H4
R	0..1	<a href="#">ADVANCED CARDIOVASCULAR SUPPORT DAYS</a>	F H4
R	0..1	<a href="#">BASIC CARDIOVASCULAR SUPPORT DAYS</a>	F H4
R	0..1	<a href="#">RENAL SUPPORT DAYS</a>	F H4
R	0..1	<a href="#">NEUROLOGICAL SUPPORT DAYS</a>	F H4
O	0..1	<a href="#">GASTRO-INTESTINAL SUPPORT DAYS</a>	F

	R	0..1	<a href="#">DERMATOLOGICAL SUPPORT DAYS</a>	F H4
	R	0..1	<a href="#">LIVER SUPPORT DAYS</a>	F H4
	O	0..1	<a href="#">ORGAN SUPPORT MAXIMUM</a>	V
	R	0..1	<a href="#">CRITICAL CARE LEVEL 2 DAYS</a>	F H4
	R	0..1	<a href="#">CRITICAL CARE LEVEL 3 DAYS</a>	F H4
R	0..*	DATA GROUP: ADULT CRITICAL CARE - DAILY CARE ACTIVITY CHARACTERISTICS		<a href="#">Rules</a>
	M	1..1	<a href="#">ACTIVITY DATE (CRITICAL CARE)</a>	F S13
	M	1..9	<a href="#">ORGAN SYSTEM SUPPORTED</a>	V
	M	1..1	<a href="#">CRITICAL CARE LEVEL</a>	V
R	0..1	DATA GROUP: ADULT CRITICAL CARE - DISCHARGE CHARACTERISTICS		<a href="#">Rules</a>
	M	1..1	<a href="#">CRITICAL CARE DISCHARGE DATE</a>	F H4 S13
	M	1..1	<a href="#">CRITICAL CARE DISCHARGE TIME</a>	F S14
	O	0..1	<a href="#">CRITICAL CARE DISCHARGE READY DATE</a>	F S13
	O	0..1	<a href="#">CRITICAL CARE DISCHARGE READY TIME</a>	F S14
	O	0..1	<a href="#">CRITICAL CARE DISCHARGE STATUS</a>	V
	O	0..1	<a href="#">CRITICAL CARE DISCHARGE DESTINATION</a>	V
	O	0..1	<a href="#">CRITICAL CARE DISCHARGE LOCATION</a>	V

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

<a href="#">Notation</a>		<b>DATA GROUP: REFERRER</b>		
		<b>FUNCTION: To carry the details of the Referrer.</b>		

<b>Group Status</b> R	<b>Group Repeats</b> 0..1	
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>
		<a href="#">REFERRER CODE</a>
		<a href="#">ORGANISATION IDENTIFIER (REFERRING ORGANISATION)</a>

<b>Notation</b>	<b>DATA GROUP: PREGNANCY - ACTIVITY CHARACTERISTICS</b>	
<b>Group Status</b> R	<b>Group Repeats</b> 0..1	<b>FUNCTION: To carry the details of the Pregnancy.</b>
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>
		<a href="#">NUMBER OF BABIES INDICATION CODE</a>

<b>Notation</b>	<b>DATA GROUP: ANTENATAL CARE - ACTIVITY CHARACTERISTICS</b>	
<b>Group Status</b> R	<b>Group Repeats</b> 0..1	<b>FUNCTION: To carry the details of the Antenatal Care.</b>
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>
		<a href="#">FIRST ANTENATAL ASSESSMENT DATE</a>

<b>Notation</b>	<b>DATA GROUP: ANTENATAL CARE - PERSON GROUP (RESPONSIBLE CLINICIAN)</b>	
<b>Group Status</b> R	<b>Group Repeats</b> 0..1	<b>FUNCTION: To carry the details of the General Medical Practitioner responsible for the Antenatal Care.</b>
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>
		<a href="#">GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE)</a>
		<a href="#">GENERAL MEDICAL PRACTITIONER PRACTICE (PATIENT ANTENATAL CARE)</a>

<b>Notation</b>	<b>DATA GROUP: ANTENATAL CARE - LOCATION GROUP - DELIVERY PLACE INTENDED</b>	
<b>Group Status</b> R	<b>Group Repeats</b> 0..1	<b>FUNCTION: To carry the details of the Intended Delivery Location.</b>
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>
		<a href="#">ACTIVITY LOCATION TYPE CODE</a>
		<a href="#">DELIVERY PLACE CHANGE REASON CODE</a>
		<a href="#">DELIVERY PLACE TYPE CODE (INTENDED)</a>

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

Notation		DATA GROUP: BIRTH OCCURRENCE			
Group Status	Group Repeats	FUNCTION: To carry the details of up to 9 Birth Occurrences - one per Baby.			
R	0..9				
M	1..1	<b>DATA GROUP: BIRTH OCCURRENCE - ACTIVITY CHARACTERISTICS</b>		<a href="#">Rules</a>	
		R	0..1	<a href="#">BIRTH ORDER</a>	F
		R	0..1	<a href="#">DELIVERY METHOD CODE</a>	V
		R	0..1	<a href="#">GESTATION LENGTH (ASSESSMENT)</a>	F
		R	0..1	<a href="#">RESUSCITATION METHOD CODE</a>	V
		R	0..1	<a href="#">STATUS OF PERSON CONDUCTING DELIVERY CODE</a>	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:

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

OR

1..1		
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	<b>DATA GROUP: VERIFIED IDENTITY STRUCTURE</b> 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		<a href="#">Rules</a>	
		M	1..1	<a href="#">LOCAL PATIENT IDENTIFIER (EXTENDED (BABY))</a>	F S3
		M	1..1	<a href="#">ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (BABY))</a>	F
M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		M	1..1	<a href="#">NHS NUMBER (BABY)</a>	F S3
		M	1..1	<a href="#">NHS NUMBER STATUS INDICATOR CODE (BABY)</a>	V
		R	0..1	<a href="#">PERSON BIRTH DATE (BABY)</a>	F S3 S12

OR

1..1	<b>DATA GROUP: UNVERIFIED IDENTITY STRUCTURE</b> 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		<a href="#">Rules</a>	
		M	1..1	<a href="#">LOCAL PATIENT IDENTIFIER (EXTENDED (BABY))</a>	F S3
		M	1..1	<a href="#">ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (BABY))</a>	F
M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		R	0..1	<a href="#">NHS NUMBER (BABY)</a>	F S3
		M	1..1	<a href="#">NHS NUMBER STATUS INDICATOR CODE (BABY)</a>	V
R	0..1	Data Element Components		<a href="#">Rules</a>	
		R	0..1	<a href="#">PERSON BIRTH DATE (BABY)</a>	F S3 S12

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH OCCURRENCE - PERSON CHARACTERISTICS - BABY</b>			
<b>Group Status</b> R	<b>Group Repeats</b> 0..1	<b>FUNCTION:</b> To carry the characteristics of the Baby.			
M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		R	0..1	<a href="#">PERSON PHENOTYPIC SEX</a>	V
		R	0..1	<a href="#">LIVE OR STILL BIRTH CODE</a>	V
		R	0..1	<a href="#">BIRTH WEIGHT</a>	F

		R	0..1	<a href="#">OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE</a>	V
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<u>Notation</u>		<b>DATA GROUP: BIRTH OCCURRENCE - LOCATION GROUP - DELIVERY PLACE ACTUAL</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Actual Birth Location.</b>			
R	0..1				
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>			<u>Rules</u>
	R	0..1	<a href="#">ACTIVITY LOCATION TYPE CODE</a>		V
	R	0..1	<a href="#">DELIVERY PLACE TYPE CODE (ACTUAL)</a>		V

<u>Notation</u>		<b>DATA GROUP: CDS V6-3 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.</b>			
M	1..*	<b>DATA GROUP: <a href="#">CDS V6-3 Type 004 - Commissioning Data Set Message Trailer</a></b>			
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.					

<u>Notation</u>		<b>DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.</b>			
M	1..1	<b>DATA GROUP: <a href="#">CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer</a></b>			
One per Interchange submitted to the Secondary Uses Service.					
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: Changed Description

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

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

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

<b><a href="#">Notation</a></b>		<b>DATA GROUP: CDS V6-3 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>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.</b>
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: <a href="#">CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol</a></b> One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

**OR**

<b><a href="#">Notation</a></b>		<b>DATA GROUP: CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>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.</b>
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: <a href="#">CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol</a></b> One per Commissioning Data Set record submitted to the Secondary Uses Service.

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: To carry the details of the Patient Pathway.	
O	0..1		
M	1..1	DATA GROUP: PATIENT PATHWAY IDENTITY	<a href="#">Rules</a>
	M	1..1	<a href="#">UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)</a>
	Or		
	M	1..1	<a href="#">PATIENT PATHWAY IDENTIFIER</a>
			F I2
M	1..1	<a href="#">ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)</a>	F I2
M	1..1	DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS	<a href="#">Rules</a>
	M	1..1	<a href="#">REFERRAL TO TREATMENT PERIOD STATUS</a>
	M	1..1	<a href="#">WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)</a>
	O	0..1	<a href="#">REFERRAL TO TREATMENT PERIOD START DATE</a>
	O	0..1	<a href="#">REFERRAL TO TREATMENT PERIOD END DATE</a>
			F S13
			F S13

Notation		DATA GROUP: PATIENT 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:

1..1	DATA GROUP: WITHHELD IDENTITY STRUCTURE		
Must be used where the Commissioning Data Set record has been anonymised			
M	1..1	Data Element Components	<a href="#">Rules</a>
	M	1..1	<a href="#">NHS NUMBER STATUS INDICATOR CODE</a>
	R	0..1	<a href="#">PERSON BIRTH DATE</a>
R	0..1	<a href="#">WITHHELD IDENTITY REASON</a>	V

OR

1..1	DATA GROUP: VERIFIED IDENTITY STRUCTURE		
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	<a href="#">Rules</a>

		M	1..1	<a href="#">LOCAL PATIENT IDENTIFIER (EXTENDED)</a>	F S3
		M	1..1	<a href="#">ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)</a>	F
M	1..1	<b>Data Element Components</b>			<a href="#">Rules</a>
		M	1..1	<a href="#">NHS NUMBER</a>	F S3
		M	1..1	<a href="#">NHS NUMBER STATUS INDICATOR CODE</a>	V
		R	0..1	<a href="#">PERSON BIRTH DATE</a>	F S3 S12

OR

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

<a href="#">Notation</a>		<b>DATA GROUP: PATIENT CHARACTERISTICS</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the characteristics of the Patient (the Baby).</b>
R	0..1	

M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		R	0..1	<a href="#">PERSON PHENOTYPIC SEX</a>	V
		R	0..1	<a href="#">ETHNIC CATEGORY</a>	V
		X	0..1	<a href="#">ETHNIC CATEGORY 2021</a>	N2
		R	0..1	<a href="#">LIVE OR STILL BIRTH CODE</a>	V
R	0..1	<a href="#">BIRTH WEIGHT</a>	F		

<a href="#">Notation</a>		<b>DATA GROUP: PATIENT CHARACTERISTICS - SOCIAL AND PERSONAL CIRCUMSTANCES (SNOMED CT)</b>
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	<b>DATA GROUP: SNOMED CT SOCIAL AND PERSONAL CIRCUMSTANCES</b>		<a href="#">Rules</a>	
		M	1..1	<a href="#">SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>		<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH EPISODE - CLINICAL DIAGNOSIS GROUP (SNOMED CT)</b>
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	<b>DATA GROUP: SNOMED CT DIAGNOSIS</b>		<a href="#">Rules</a>	
		M	1..1	<a href="#">DIAGNOSIS (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">CODED CLINICAL ENTRY SEQUENCE NUMBER</a>	F
		M	1..1	<a href="#">CODED DIAGNOSIS TIMESTAMP</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>		<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH EPISODE - COMORBIDITY (SNOMED CT)</b>
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	<a href="#">Rules</a>
		M 1..1 <a href="#">COMORBIDITY (SNOMED CT EXPRESSION)</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON	<a href="#">Rules</a>
		O 0..1 <a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		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	<a href="#">Rules</a>
		M 1..1 <a href="#">PROCEDURE (SNOMED CT EXPRESSION)</a>	F
		M 1..1 <a href="#">CODED CLINICAL ENTRY SEQUENCE NUMBER</a>	F
		M 1..1 <a href="#">CODED PROCEDURE TIMESTAMP</a>	F
O	0..1	DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL	<a href="#">Rules</a>
		M 1..1 <a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M 1..1 <a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)</a>	F
O	0..1	DATA GROUP: RESPONSIBLE ANAESTHETIST	<a href="#">Rules</a>
		M 1..1 <a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M 1..1 <a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON	<a href="#">Rules</a>
		O 0..1 <a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		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	<a href="#">Rules</a>
		M 1..1 <a href="#">OBSERVATION (SNOMED CT EXPRESSION)</a>	F
		R 0..1 <a href="#">OBSERVATION VALUE</a>	F
		R 0..1 <a href="#">UCUM UNIT OF MEASUREMENT</a>	F
		M 1..1 <a href="#">CODED OBSERVATION TIMESTAMP</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON	<a href="#">Rules</a>
O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH EPISODE - FINDING GROUP (SNOMED CT)</b>
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the SNOMED CT coded Clinical Findings for the Patient (the Baby).</b>

One of the following DATA GROUPS may be used:

M	1..1	DATA GROUP: SNOMED CT FINDING	<a href="#">Rules</a>
M	1..1	<a href="#">FINDING (SNOMED CT EXPRESSION)</a>	F
M	1..1	<a href="#">CODED FINDING TIMESTAMP</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON	<a href="#">Rules</a>
O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH EPISODE - ASSESSMENT TOOL GROUP (SNOMED CT)</b>
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the SNOMED CT coded Assessment Tools for the Patient (the Baby).</b>

One of the following DATA GROUPS may be used:

M	1..1	DATA GROUP: SNOMED CT ASSESSMENT TOOL	<a href="#">Rules</a>
M	1..1	<a href="#">ASSESSMENT TOOL (SNOMED CT EXPRESSION)</a>	F
M	1..1	<a href="#">PERSON SCORE</a>	F
M	1..1	<a href="#">ASSESSMENT TOOL COMPLETION TIMESTAMP</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON	<a href="#">Rules</a>
O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

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

<a href="#">Notation</a>		<b>DATA GROUP: PREGNANCY - ACTIVITY CHARACTERISTICS</b>
<b>Group Status</b> R	<b>Group Repeats</b> 0..1	<b>FUNCTION: To carry the details of the Pregnancy.</b>

M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>
		R	0..1	<a href="#">NUMBER OF BABIES INDICATION CODE</a>

<a href="#">Notation</a>		<b>DATA GROUP: ANTENATAL CARE - ACTIVITY CHARACTERISTICS</b>		
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Antenatal Care.</b>		
R	0..1			

M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>
		R	0..1	<a href="#">FIRST ANTENATAL ASSESSMENT DATE</a>

<a href="#">Notation</a>		<b>DATA GROUP: ANTENATAL CARE - PERSON GROUP (RESPONSIBLE CLINICIAN)</b>		
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the General Medical Practitioner responsible for the Antenatal Care.</b>		
R	0..1			

M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		R	0..1	<a href="#">GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE)</a>	F
		O	0..1	<a href="#">GENERAL MEDICAL PRACTITIONER PRACTICE (PATIENT ANTENATAL CARE)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: ANTENATAL CARE - LOCATION GROUP - DELIVERY PLACE INTENDED</b>		
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Intended Delivery Location.</b>		
R	0..1			

M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		R	0..1	<a href="#">ACTIVITY LOCATION TYPE CODE</a>	F
		R	0..1	<a href="#">DELIVERY PLACE CHANGE REASON CODE</a>	V
		R	0..1	<a href="#">DELIVERY PLACE TYPE CODE (INTENDED)</a>	V

<a href="#">Notation</a>		<b>DATA GROUP: LABOUR/DELIVERY - ACTIVITY CHARACTERISTICS</b>		
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Labour/Delivery.</b>		
M	1..1			

M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		R	0..1	<a href="#">ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY CODE</a>	V
		R	0..1	<a href="#">ANAESTHETIC GIVEN POST LABOUR OR DELIVERY CODE</a>	V
		O	0..1	<a href="#">GESTATION LENGTH (LABOUR ONSET)</a>	V
R	0..1	<a href="#">LABOUR OR DELIVERY ONSET METHOD CODE</a>	V		

		M	1..1	<a href="#">DELIVERY TIMESTAMP</a>	F S1
		M	1..1	<a href="#">AGE AT CDS ACTIVITY DATE</a>	F
		R	0..1	<a href="#">OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE</a>	V

<a href="#">Notation</a>		<b>DATA GROUP: LABOUR/DELIVERY - SERVICE AGREEMENT DETAILS</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Provider, Commissioners and Service Agreements.</b>			
M	1..1				
		<b>Data Element Components</b>			<a href="#">Rules</a>
		M	1..1	<a href="#">ORGANISATION IDENTIFIER (CODE OF PROVIDER)</a>	F
		<b>DATA GROUP: COMMISSIONERS</b>			<a href="#">Rules</a>
M	1..*				
		M	1..1	<a href="#">ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)</a>	F
		R	0..1	<a href="#">START DATE (COMMISSIONER ASSIGNMENT PERIOD)</a>	F S13
		R	0..1	<a href="#">END DATE (COMMISSIONER ASSIGNMENT PERIOD)</a>	F S13
		R	0..1	<a href="#">NHS SERVICE AGREEMENT IDENTIFIER</a>	F
		O	0..1	<a href="#">NHS SERVICE AGREEMENT LINE IDENTIFIER</a>	F
		O	0..1	<a href="#">PROVIDER REFERENCE IDENTIFIER</a>	F
		R	0..1	<a href="#">COMMISSIONER REFERENCE IDENTIFIER</a>	F
		R	0..1	<a href="#">SPECIALISED SERVICE CODE</a>	F
R	0..1	<a href="#">SERVICE CODE</a>	F		

<a href="#">Notation</a>		<b>DATA GROUP: DELIVERY OCCURRENCE - ACTIVITY CHARACTERISTICS</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Birth Occurrence.</b>			
R	0..1				
		<b>Data Element Components</b>			<a href="#">Rules</a>
		R	0..1	<a href="#">BIRTH ORDER</a>	F
		R	0..1	<a href="#">DELIVERY METHOD CODE</a>	V
		R	0..1	<a href="#">GESTATION LENGTH (ASSESSMENT)</a>	V
		R	0..1	<a href="#">RESUSCITATION METHOD CODE</a>	V
		R	0..1	<a href="#">STATUS OF PERSON CONDUCTING DELIVERY CODE</a>	V

<a href="#">Notation</a>	<b>DATA GROUP: PERSON IDENTITY (MOTHER)</b>
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<b>Group Status</b> M	<b>Group Repeats</b> 1..1	<b>FUNCTION: To carry the Identity details of the Baby's mother. See Note: S3 in Commissioning Data Set Business Rules.</b>
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One of the following DATA GROUPS must be used:

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

OR

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

OR

<b>1..1</b>	<b>DATA GROUP: UNVERIFIED IDENTITY STRUCTURE</b>		
	Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE (MOTHER) NOT included in the above		
<b>O</b>	<b>0..1</b>	<b>DATA GROUP: LOCAL IDENTIFIER STRUCTURE</b>	<a href="#">Rules</a>
	<b>M</b>	<b>1..1</b> <a href="#">LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER))</a>	F S3
	<b>M</b>	<b>1..1</b> <a href="#">ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER))</a>	F
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>	<a href="#">Rules</a>
	<b>R</b>	<b>0..1</b> <a href="#">NHS NUMBER (MOTHER)</a>	

					F S3
		M	1..1	<a href="#">NHS NUMBER STATUS INDICATOR CODE (MOTHER)</a>	V
O	0..1	Data Element Components			<a href="#">Rules</a>
		M OR M	1..1 OR 2..5	<a href="#">PATIENT USUAL ADDRESS (UNSTRUCTURED (MOTHER))</a> OR <a href="#">PATIENT USUAL ADDRESS (STRUCTURED (MOTHER))</a>	F S3 I5
M	1..1	Data Element Components			<a href="#">Rules</a>
		R	0..1	<a href="#">POSTCODE OF USUAL ADDRESS (MOTHER)</a>	F S3
		R	0..1	<a href="#">ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)</a>	F
		R	0..1	<a href="#">PERSON BIRTH DATE (MOTHER)</a>	F S3 S12

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

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH OCCURRENCE - LOCATION GROUP - DELIVERY PLACE ACTUAL</b>			
Group Status	Group Repeats	FUNCTION: To carry the details of the Actual Delivery Location.			
R	0..1				
M	1..1	Data Element Components			<a href="#">Rules</a>
		R	0..1	<a href="#">ACTIVITY LOCATION TYPE CODE</a>	F
		R	0..1	<a href="#">DELIVERY PLACE TYPE CODE (ACTUAL)</a>	V

<a href="#">Notation</a>		<b>DATA GROUP: CDS V6-3 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER</b>			
Group Status	Group Repeats	FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.			
M	1..*	DATA GROUP: <a href="#">CDS V6-3 Type 004 - Commissioning Data Set Message Trailer</a> 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.

<u>Notation</u>		<b>DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.</b>
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: <a href="#">CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer</a></b> 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 160 - ADMITTED PATIENT CARE - OTHER DELIVERY EVENT CDS**

Change to Data Set: Changed Description

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

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

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

<u>Notation</u>	
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		<b>DATA GROUP: CDS V6-3 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>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.</b>
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: <a href="#">CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol</a></b> One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

**OR**

<b><a href="#">Notation</a></b>		<b>DATA GROUP: CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>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.</b>
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: <a href="#">CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol</a></b> One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

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

	O	0..1	<a href="#">REFERRAL TO TREATMENT PERIOD END DATE</a>	F S13
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<b>Notation</b>		<b>DATA GROUP: PATIENT IDENTITY (MOTHER)</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the Identity of the Patient (the Mother). See Note: S3 in Commissioning Data Set Business Rules.</b>
M	1..1	

One of the following DATA GROUPS must be used:

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

OR

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

OR

1..1	<b>DATA GROUP: UNVERIFIED IDENTITY STRUCTURE</b>				
Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE NOT included in the above					
R	0..1	<b>DATA GROUP: LOCAL IDENTIFIER STRUCTURE</b>		<a href="#">Rules</a>	
		M	1..1	<a href="#">LOCAL PATIENT IDENTIFIER (EXTENDED)</a>	F S3
		M	1..1	<a href="#">ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)</a>	F

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

<a href="#">Notation</a>		<b>DATA GROUP: PATIENT CHARACTERISTICS</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the characteristics of the Patient (the Mother).</b>
<b>R</b>	<b>0..1</b>	

<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<a href="#">Rules</a>	
		R	0..1	<a href="#">PERSON STATED GENDER CODE</a>	V
		O	0..1	<a href="#">CARER SUPPORT INDICATOR</a>	V
		R	0..1	<a href="#">ETHNIC CATEGORY</a>	V
		X	0..1	<a href="#">ETHNIC CATEGORY 2021</a>	N2
		R	0..1	<a href="#">PERSON MARITAL STATUS</a>	V

<a href="#">Notation</a>		<b>DATA GROUP: DELIVERY CHARACTERISTICS</b>
		<b>FUNCTION: To carry the delivery characteristics of the Patient (the Mother).</b>

<b>Group Status</b> R	<b>Group Repeats</b> 0..1	
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>
	<b>R</b>	<b>0..1</b>
		<a href="#">NUMBER OF PREVIOUS PREGNANCIES RESULTING IN REGISTRABLE BIRTH</a>
		<a href="#">Rules</a>
		F

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

One of the following DATA GROUPS may be used:

<b>M</b>	<b>1..1</b>	<b>DATA GROUP: SNOMED CT SOCIAL AND PERSONAL CIRCUMSTANCES</b>	<a href="#">Rules</a>
	<b>M</b>	<b>1..1</b>	<a href="#">SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION)</a>
			F
	<b>M</b>	<b>1..1</b>	<a href="#">SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP</a>
			F

OR

<b>O</b>	<b>0..1</b>	<b>DATA GROUP: DATA ABSENT REASON</b>	<a href="#">Rules</a>
	<b>O</b>	<b>0..1</b>	<a href="#">DATA ABSENT REASON (FHIR R4)</a>
			F

<a href="#">Notation</a>	<b>DATA GROUP: DELIVERY EPISODE - CLINICAL DIAGNOSIS GROUP (SNOMED CT)</b>	
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the SNOMED CT coded Clinical Diagnoses for the Patient (the Mother).</b>

One of the following DATA GROUPS may be used:

<b>M</b>	<b>1..1</b>	<b>DATA GROUP: SNOMED CT DIAGNOSIS</b>	<a href="#">Rules</a>
	<b>M</b>	<b>1..1</b>	<a href="#">DIAGNOSIS (SNOMED CT EXPRESSION)</a>
			F
	<b>M</b>	<b>1..1</b>	<a href="#">CODED CLINICAL ENTRY SEQUENCE NUMBER</a>
			F
	<b>M</b>	<b>1..1</b>	<a href="#">CODED DIAGNOSIS TIMESTAMP</a>
			F

OR

<b>O</b>	<b>0..1</b>	<b>DATA GROUP: DATA ABSENT REASON</b>	<a href="#">Rules</a>
	<b>O</b>	<b>0..1</b>	<a href="#">DATA ABSENT REASON (FHIR R4)</a>
			F

<a href="#">Notation</a>	<b>DATA GROUP: DELIVERY EPISODE - COMORBIDITY (SNOMED CT)</b>	
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the SNOMED CT coded Comorbidities for the Patient (the Mother).</b>

One of the following DATA GROUPS may be used:

M	1..1	DATA GROUP: SNOMED CT COMORBIDITY	<a href="#">Rules</a>
		M 1..1 <a href="#">COMORBIDITY (SNOMED CT EXPRESSION)</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON	<a href="#">Rules</a>
		O 0..1 <a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: DELIVERY EPISODE - PROCEDURE GROUP (SNOMED CT)</b>
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the SNOMED CT coded Procedures for the Patient (the Mother).</b>

One of the following DATA GROUPS may be used:

M	1..1	DATA GROUP: SNOMED CT PROCEDURE	<a href="#">Rules</a>
		M 1..1 <a href="#">PROCEDURE (SNOMED CT EXPRESSION)</a>	F
		M 1..1 <a href="#">CODED CLINICAL ENTRY SEQUENCE NUMBER</a>	F
		M 1..1 <a href="#">CODED PROCEDURE TIMESTAMP</a>	F
O	0..1	DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL	<a href="#">Rules</a>
		M 1..1 <a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M 1..1 <a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)</a>	F
O	0..1	DATA GROUP: RESPONSIBLE ANAESTHETIST	<a href="#">Rules</a>
		M 1..1 <a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M 1..1 <a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON	<a href="#">Rules</a>
		O 0..1 <a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: DELIVERY EPISODE - OBSERVATION GROUP (SNOMED CT)</b>
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the SNOMED CT coded Clinical Observations for the Patient (the Mother).</b>

One of the following DATA GROUPS may be used:

M	1..1	DATA GROUP: SNOMED CT OBSERVATION	<a href="#">Rules</a>
		M 1..1 <a href="#">OBSERVATION (SNOMED CT EXPRESSION)</a>	F
		R 0..1 <a href="#">OBSERVATION VALUE</a>	F
		R 0..1 <a href="#">UCUM UNIT OF MEASUREMENT</a>	F
		M 1..1 <a href="#">CODED OBSERVATION TIMESTAMP</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON	<a href="#">Rules</a>
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		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F
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<u>Notation</u>		<b>DATA GROUP: DELIVERY EPISODE - FINDING GROUP (SNOMED CT)</b>			
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the SNOMED CT coded Clinical Findings for the Patient (the Mother).</b>			

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT FINDING</b>			<a href="#">Rules</a>
		M	1..1	<a href="#">FINDING (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">CODED FINDING TIMESTAMP</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>			<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

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

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT ASSESSMENT TOOL</b>			<a href="#">Rules</a>
		M	1..1	<a href="#">ASSESSMENT TOOL (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">PERSON SCORE</a>	F
		M	1..1	<a href="#">ASSESSMENT TOOL COMPLETION TIMESTAMP</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>			<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<u>Notation</u>		<b>DATA GROUP: GP REGISTRATION</b>			
<b>Group Status</b> R	<b>Group Repeats</b> 0..1	<b>FUNCTION: To carry the Patient's General Medical Practitioner and the General Practice details.</b>			
M	1..1	<b>Data Element Components</b>			<a href="#">Rules</a>
		O	0..1	<a href="#">GENERAL MEDICAL PRACTITIONER (SPECIFIED)</a>	F
		R	0..1	<a href="#">GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION)</a>	F

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

M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>
		R	0..1	<a href="#">NUMBER OF BABIES INDICATION CODE</a>

<a href="#">Notation</a>		<b>DATA GROUP: ANTENATAL CARE - ACTIVITY CHARACTERISTICS</b>		
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Antenatal Care.</b>		
R	0..1			
M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>
		R	0..1	<a href="#">FIRST ANTENATAL ASSESSMENT DATE</a>

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

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

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

		M	1..1	<a href="#">DELIVERY TIMESTAMP</a>	F S1
		M	1..1	<a href="#">AGE AT CDS ACTIVITY DATE</a>	F
		R	0..1	<a href="#">OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE</a>	V

<a href="#">Notation</a>		<b>DATA GROUP: LABOUR/DELIVERY - SERVICE AGREEMENT DETAILS</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Provider, Commissioners and Service Agreements.</b>			
M	1..1				
M	1..1	<b>Data Element Components</b>			<a href="#">Rules</a>
M	1..1	<a href="#">ORGANISATION IDENTIFIER (CODE OF PROVIDER)</a>			F
M	1..*	<b>DATA GROUP: COMMISSIONERS</b>			<a href="#">Rules</a>
M	1..1	<a href="#">ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)</a>			F
R	0..1	<a href="#">START DATE (COMMISSIONER ASSIGNMENT PERIOD)</a>			F S13
R	0..1	<a href="#">END DATE (COMMISSIONER ASSIGNMENT PERIOD)</a>			F S13
R	0..1	<a href="#">NHS SERVICE AGREEMENT IDENTIFIER</a>			F
O	0..1	<a href="#">NHS SERVICE AGREEMENT LINE IDENTIFIER</a>			F
O	0..1	<a href="#">PROVIDER REFERENCE IDENTIFIER</a>			F
R	0..1	<a href="#">COMMISSIONER REFERENCE IDENTIFIER</a>			F
R	0..1	<a href="#">SPECIALISED SERVICE CODE</a>			F
R	0..1	<a href="#">SERVICE CODE</a>	F		

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH OCCURRENCE - ACTIVITY CHARACTERISTICS</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of up to 9 Birth Occurrences - one per Baby.</b>			
R	0..9				
M	1..1	<b>DATA GROUP: BIRTH OCCURRENCE - ACTIVITY CHARACTERISTICS</b>			<a href="#">Rules</a>
R	0..1	<a href="#">BIRTH ORDER</a>			F
R	0..1	<a href="#">DELIVERY METHOD CODE</a>			V
R	0..1	<a href="#">GESTATION LENGTH (ASSESSMENT)</a>			V
R	0..1	<a href="#">RESUSCITATION METHOD CODE</a>			V
R	0..1	<a href="#">STATUS OF PERSON CONDUCTING DELIVERY CODE</a>			V

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

One of the following DATA GROUPS must be used:

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

OR

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

OR

<b>1..1</b>	<b>DATA GROUP: UNVERIFIED IDENTITY STRUCTURE</b>		
	<b>Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE (BABY) NOT included in the above</b>		
<b>O</b>	<b>0..1</b>	<b>DATA GROUP: LOCAL IDENTIFIER STRUCTURE</b>	<a href="#">Rules</a>
		<b>M</b> <b>1..1</b>	<a href="#">LOCAL PATIENT IDENTIFIER (EXTENDED (BABY))</a> F S3
		<b>M</b> <b>1..1</b>	<a href="#">ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (BABY))</a> F
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>	<a href="#">Rules</a>
		<b>R</b> <b>0..1</b>	<a href="#">NHS NUMBER (BABY)</a> F S3
		<b>M</b> <b>1..1</b>	<a href="#">NHS NUMBER STATUS INDICATOR CODE (BABY)</a> V

R	0..1	Data Element Components		<a href="#">Rules</a>
		R	0..1	<a href="#">PERSON BIRTH DATE (BABY)</a>

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH OCCURRENCE - PERSON CHARACTERISTICS - BABY</b>		
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the characteristics of the Baby.</b>		
R	0..1			

M	1..1	Data Element Components		<a href="#">Rules</a>	
		R	0..1	<a href="#">PERSON PHENOTYPIC SEX</a>	V
		R	0..1	<a href="#">LIVE OR STILL BIRTH CODE</a>	V
		R	0..1	<a href="#">BIRTH WEIGHT</a>	F
		R	0..1	<a href="#">OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE</a>	V

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH OCCURRENCE - LOCATION GROUP - DELIVERY PLACE ACTUAL</b>		
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Actual Birth Location.</b>		
R	0..1			

M	1..1	Data Element Components		<a href="#">Rules</a>	
		R	0..1	<a href="#">ACTIVITY LOCATION TYPE CODE</a>	F
		R	0..1	<a href="#">DELIVERY PLACE TYPE CODE (ACTUAL)</a>	V

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

M	1..*	<b>DATA GROUP: <a href="#">CDS V6-3 Type 004 - Commissioning Data Set Message Trailer</a></b> 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.		
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<a href="#">Notation</a>		<b>DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER</b>		
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.</b>		

M	1..1			
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**DATA GROUP: [CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer](#)**

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 180 - ADMITTED PATIENT CARE - UNFINISHED BIRTH EPISODE CDS**

Change to Data Set: Changed Description

**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](#)**

One per Interchange submitted to the Secondary Uses Service.  
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](#)**

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**

		<b>DATA GROUP: <a href="#">CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol</a></b> One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.
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OR

<b>Notation</b>		<b>DATA GROUP: CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>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.</b>
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: <a href="#">CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol</a></b> One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

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

<b>Notation</b>		<b>DATA GROUP: PATIENT IDENTITY (BABY)</b>
		<b>FUNCTION: To carry the Identity of the Patient (the Baby). See Note: S3 in Commissioning Data Set Business Rules.</b>

<b>Group Status</b> M	<b>Group Repeats</b> 1..1	
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One of the following DATA GROUPS must be used:

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

OR

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

OR

1..1	<b>DATA GROUP: UNVERIFIED IDENTITY STRUCTURE</b> Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE NOT included in the above		
R	0..1	<b>DATA GROUP: LOCAL IDENTIFIER STRUCTURE</b>	<a href="#">Rules</a>
	M	1..1 <a href="#">LOCAL PATIENT IDENTIFIER (EXTENDED)</a>	F S3
	M	1..1 <a href="#">ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)</a>	F
M	1..1	<b>Data Element Components</b>	<a href="#">Rules</a>
	R	0..1 <a href="#">NHS NUMBER</a>	F S3
	M	1..1 <a href="#">NHS NUMBER STATUS INDICATOR CODE</a>	V
R	0..1	<b>Data Element Components</b>	<a href="#">Rules</a>
	M OR OR	1..1 <a href="#">PATIENT FULL NAME</a>	

		O	0..1	<a href="#">PATIENT TITLE</a>		F	
		and	and	and		S3	
		<b>M</b>	<b>1..1</b>	<a href="#">PATIENT GIVEN NAME</a>		I4	
		and	and	and			
		<b>M</b>	<b>1..1</b>	<a href="#">PATIENT FAMILY NAME</a>			
		and	and	and			
		O	0..1	<a href="#">PATIENT NAME SUFFIX</a>			
		and	and	and			
		O	0..1	<a href="#">PATIENT INITIALS</a>			
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>				<a href="#">Rules</a>	
		R	0..1	<a href="#">PERSON BIRTH DATE</a>		F	
						S3	
						S12	

<a href="#">Notation</a>		<b>DATA GROUP: PATIENT CHARACTERISTICS</b>				
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the characteristics of the Patient (the Baby).</b>				
<b>R</b>	<b>0..1</b>					
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>				<a href="#">Rules</a>
		R	0..1	<a href="#">PERSON PHENOTYPIC SEX</a>		V
		R	0..1	<a href="#">ETHNIC CATEGORY</a>		V
		X	0..1	<a href="#">ETHNIC CATEGORY 2021</a>		N2
		R	0..1	<a href="#">LIVE OR STILL BIRTH CODE</a>		V
		R	0..1	<a href="#">BIRTH WEIGHT</a>		F

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

One of the following DATA GROUPS may be used:

<b>M</b>	<b>1..1</b>	<b>DATA GROUP: SNOMED CT SOCIAL AND PERSONAL CIRCUMSTANCES</b>				<a href="#">Rules</a>
		<b>M</b>	<b>1..1</b>	<a href="#">SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION)</a>		F
		<b>M</b>	<b>1..1</b>	<a href="#">SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP</a>		F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON				<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>		F

<a href="#">Notation</a>		<b>DATA GROUP: HOSPITAL PROVIDER SPELL - ADMISSION CHARACTERISTICS</b>				
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Group Status	Group Repeats	FUNCTION: To carry the admission details of the Hospital Provider Spell containing the Unfinished Birth Care Professional Admitted Care Episode.			
M	1..1				
M	1..1	<b>Data Element Components</b>		<b>Rules</b>	
		R	0..1	<a href="#">HOSPITAL PROVIDER SPELL IDENTIFIER</a>	F
		R	0..1	<a href="#">ADMINISTRATIVE CATEGORY CODE (ON ADMISSION)</a>	V
		R	0..1	<a href="#">PATIENT CLASSIFICATION CODE</a>	V
		R	0..1	<a href="#">METHOD OF ADMISSION (HOSPITAL PROVIDER SPELL)</a>	V
		R	0..1	<a href="#">ADMISSION SOURCE (HOSPITAL PROVIDER SPELL)</a>	V
		M	1..1	<a href="#">START DATE (HOSPITAL PROVIDER SPELL)</a>	F S13
		O	0..1	<a href="#">START TIME (HOSPITAL PROVIDER SPELL)</a>	F S14
		M	1..1	<a href="#">AGE ON ADMISSION</a>	F

<u>Notation</u>		DATA GROUP: HOSPITAL PROVIDER SPELL - DISCHARGE CHARACTERISTICS			
Group Status	Group Repeats	FUNCTION: To carry the discharge details of the Hospital Provider Spell containing the Unfinished Birth Care Professional Admitted Care Episode.			
R	0..1				
M	1..1	<b>Data Element Components</b>		<b>Rules</b>	
		R	0..1	<a href="#">DESTINATION OF DISCHARGE (HOSPITAL PROVIDER SPELL)</a>	V
		R	0..1	<a href="#">METHOD OF DISCHARGE (HOSPITAL PROVIDER SPELL)</a>	V
		R	0..1	<a href="#">DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL)</a>	F S13
		R	0..1	<a href="#">DISCHARGE DATE (HOSPITAL PROVIDER SPELL)</a>	F S13
		O	0..1	<a href="#">DISCHARGE TIME (HOSPITAL PROVIDER SPELL)</a>	F S14
		R	0..1	<a href="#">DISCHARGED TO NHS AT HOME SERVICE INDICATOR</a>	V

<u>Notation</u>		DATA GROUP: BIRTH EPISODE - ACTIVITY CHARACTERISTICS			
Group Status	Group Repeats	FUNCTION: To carry the details of the Unfinished Birth Care Professional Admitted Care Episode.			
M	1..1				
M	1..1	<b>Data Element Components</b>		<b>Rules</b>	
		R	0..1	<a href="#">EPISODE NUMBER</a>	F
		R	0..1	<a href="#">LAST EPISODE IN SPELL INDICATOR CODE</a>	V
		R	0..1	<a href="#">NEONATAL LEVEL OF CARE CODE</a>	V
M	1..1	<a href="#">START DATE (EPISODE)</a>			

				F S1 S13
O	0..1	<a href="#">START TIME (EPISODE)</a>		F S14
R	0..1	<a href="#">END DATE (EPISODE)</a>		F S13
O	0..1	<a href="#">END TIME (EPISODE)</a>		F S14
M	1..1	<a href="#">AGE AT CDS ACTIVITY DATE</a>		F

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

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

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

<u>Notation</u>		DATA GROUP: BIRTH EPISODE - CLINICAL DIAGNOSIS GROUP (ICD)		
<b>Group Status</b> R	<b>Group Repeats</b> 0..1	FUNCTION: To carry the details of the ICD coded Clinical Diagnoses for the Patient (the Baby).		
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<a href="#">Rules</a>
		<b>M</b>	<b>1..1</b>	<a href="#">DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET)</a>
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: PRIMARY DIAGNOSIS</b>		<a href="#">Rules</a>
		<b>M</b>	<b>1..1</b>	<a href="#">PRIMARY DIAGNOSIS (ICD)</a>
<b>R</b>	<b>0..*</b>	<b>DATA GROUP: SECONDARY DIAGNOSES</b>		<a href="#">Rules</a>
		<b>M</b>	<b>1..1</b>	<a href="#">SECONDARY DIAGNOSIS (ICD)</a>

<u>Notation</u>		DATA GROUP: BIRTH EPISODE - CLINICAL DIAGNOSIS GROUP (SNOMED CT)	
<b>Group Status</b> R	<b>Group Repeats</b> 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	<b>DATA GROUP: SNOMED CT DIAGNOSIS</b>		<a href="#">Rules</a>	
		M	1..1	<a href="#">DIAGNOSIS (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">CODED CLINICAL ENTRY SEQUENCE NUMBER</a>	F
		M	1..1	<a href="#">CODED DIAGNOSIS TIMESTAMP</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>		<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH EPISODE - COMORBIDITY (SNOMED CT)</b>		
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the SNOMED CT coded Comorbidities for the Patient (the Baby).</b>		
R	0..*			

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT COMORBIDITY</b>		<a href="#">Rules</a>
		M	1..1	<a href="#">COMORBIDITY (SNOMED CT EXPRESSION)</a>

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>		<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH EPISODE - PROCEDURE GROUP (OPCS)</b>		
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the OPCS coded Procedures for the Patient (the Baby).</b>		
R	0..1			

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

		M	1..1	<a href="#">PROCEDURE (OPCS)</a>	F
		R	0..1	<a href="#">PROCEDURE DATE</a>	F S13
O	0..1	DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL			<a href="#">Rules</a>
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)</a>	F
O	0..1	DATA GROUP: RESPONSIBLE ANAESTHETIST			<a href="#">Rules</a>
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH EPISODE - PROCEDURE GROUP (SNOMED CT)</b>			
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the SNOMED CT coded Procedures for the Patient (the Baby).</b>			

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT PROCEDURE</b>			<a href="#">Rules</a>
		M	1..1	<a href="#">PROCEDURE (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">CODED CLINICAL ENTRY SEQUENCE NUMBER</a>	F
		M	1..1	<a href="#">CODED PROCEDURE TIMESTAMP</a>	F
O	0..1	DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL			<a href="#">Rules</a>
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)</a>	F
O	0..1	DATA GROUP: RESPONSIBLE ANAESTHETIST			<a href="#">Rules</a>
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON			<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH EPISODE - OBSERVATION GROUP (SNOMED CT)</b>			
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the SNOMED CT coded Clinical Observations for the Patient (the baby).</b>			

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT OBSERVATION</b>			<a href="#">Rules</a>
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		M	1..1	<a href="#">OBSERVATION (SNOMED CT EXPRESSION)</a>	F
		R	0..1	<a href="#">OBSERVATION VALUE</a>	F
		R	0..1	<a href="#">UCUM UNIT OF MEASUREMENT</a>	F
		M	1..1	<a href="#">CODED OBSERVATION TIMESTAMP</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON			<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH EPISODE - FINDING GROUP (SNOMED CT)</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the SNOMED CT coded Clinical Findings for the Patient (the Baby).</b>			
R	0..*				

One of the following DATA GROUPS may be used:

M	1..1	DATA GROUP: SNOMED CT FINDING			<a href="#">Rules</a>
		M	1..1	<a href="#">FINDING (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">CODED FINDING TIMESTAMP</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON			<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH EPISODE - ASSESSMENT TOOL GROUP (SNOMED CT)</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the SNOMED CT coded Assessment Tools for the Patient (the Baby).</b>			
R	0..*				

One of the following DATA GROUPS may be used:

M	1..1	DATA GROUP: SNOMED CT ASSESSMENT TOOL			<a href="#">Rules</a>
		M	1..1	<a href="#">ASSESSMENT TOOL (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">PERSON SCORE</a>	F
		M	1..1	<a href="#">ASSESSMENT TOOL COMPLETION TIMESTAMP</a>	F

OR

O	0..1	DATA GROUP: DATA ABSENT REASON			<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: LOCATION GROUP (AT START OF BIRTH EPISODE)</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Location at the Start of the Unfinished Birth Care Professional Admitted Care Episode.</b>			
R	0..1				
M	1..1	Data Element Components			<a href="#">Rules</a>
		R	0..1	<a href="#">ORGANISATION SITE IDENTIFIER (OF TREATMENT)</a>	F

	R	0..1	<a href="#">ACTIVITY LOCATION TYPE CODE</a>	F
	O	0..1	<a href="#">WARD INTENDED CLINICAL CARE INTENSITY</a>	V
	O	0..1	<a href="#">WARD INTENDED AGE GROUP</a>	V
	O	0..1	<a href="#">WARD INTENDED SEX OF PATIENTS</a>	V
	O	0..1	<a href="#">WARD INTENDED DAY PERIOD AVAILABILITY</a>	V
	O	0..1	<a href="#">WARD INTENDED NIGHT PERIOD AVAILABILITY</a>	V
	O	0..1	<a href="#">WARD SECURITY LEVEL</a>	V
	O	0..1	<a href="#">WARD CODE</a>	F

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

<u>Notation</u>		<b>DATA GROUP: LOCATION GROUP (AT END OF BIRTH EPISODE)</b>		
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Location at the End of the Unfinished Birth Care Professional Admitted Care Episode.</b>		
R	0..1			
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<b><u>Rules</u></b>
	R	0..1	<a href="#">ORGANISATION SITE IDENTIFIER (OF TREATMENT)</a>	F
	R	0..1	<a href="#">ACTIVITY LOCATION TYPE CODE</a>	F
	O	0..1	<a href="#">WARD INTENDED CLINICAL CARE INTENSITY</a>	V

	O	0..1	<a href="#">WARD INTENDED AGE GROUP</a>	V
	O	0..1	<a href="#">WARD INTENDED SEX OF PATIENTS</a>	V
	O	0..1	<a href="#">WARD INTENDED DAY PERIOD AVAILABILITY</a>	V
	O	0..1	<a href="#">WARD INTENDED NIGHT PERIOD AVAILABILITY</a>	V
	O	0..1	<a href="#">WARD SECURITY LEVEL</a>	V
	O	0..1	<a href="#">WARD CODE</a>	F

<u>Notation</u>		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 Birth Care Professional Admitted Care Episode.		
R	0..*			
M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>
M	1..1	<a href="#">START DATE (HOME LEAVE)</a>		F S13
R	0..1	<a href="#">START TIME (HOME LEAVE)</a>		F S14
R	0..1	<a href="#">END DATE (HOME LEAVE)</a>		F S13
R	0..1	<a href="#">END TIME (HOME LEAVE)</a>		F S14

<u>Notation</u>		DATA GROUP: BIRTH 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	<b>DATA GROUP: NEONATAL CARE - ADMISSION CHARACTERISTICS</b>		<a href="#">Rules</a>
M	1..1	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>		F
M	1..1	<a href="#">CRITICAL CARE START DATE</a>		F S13
M	1..1	<a href="#">CRITICAL CARE START TIME</a>		F S14
M	1..1	<a href="#">CRITICAL CARE UNIT FUNCTION</a>		V
M	1..1	<a href="#">GESTATION LENGTH (AT DELIVERY)</a>		V
M	1..999	<b>DATA GROUP: NEONATAL DAILY CARE - ACTIVITY CHARACTERISTICS</b>		<a href="#">Rules</a>
M	1..1	<a href="#">ACTIVITY DATE (CRITICAL CARE)</a>		F S13
R	0..1	<a href="#">PERSON WEIGHT</a>		F
M	1..20	<a href="#">CRITICAL CARE ACTIVITY CODE</a>		F N4

		R	0..20	<a href="#">HIGH COST DRUGS (OPCS)</a>	F N4
R	0..1	DATA GROUP: NEONATAL CARE - DISCHARGE CHARACTERISTICS			<a href="#">Rules</a>
		M	1..1	<a href="#">CRITICAL CARE DISCHARGE DATE</a>	F S13
		M	1..1	<a href="#">CRITICAL CARE DISCHARGE TIME</a>	F S14

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

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH EPISODE - ADULT CRITICAL CARE PERIOD</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: See CRITICAL CARE PERIOD. To carry the details of the first 9 Critical Care Periods for care provided using Adult Care facilities.</b>			
R	0..9				
M	1..1	DATA GROUP: ADULT CRITICAL CARE - ADMISSION CHARACTERISTICS			<a href="#">Rules</a>

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

		O	0..1	<a href="#">CRITICAL CARE DISCHARGE STATUS</a>	V
		O	0..1	<a href="#">CRITICAL CARE DISCHARGE DESTINATION</a>	V
		O	0..1	<a href="#">CRITICAL CARE DISCHARGE LOCATION</a>	V

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

<b>Notation</b>		<b>DATA GROUP: REFERRER</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Referrer.</b>			
R	0..1				
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>			<b>Rules</b>
		R	0..1	<a href="#">REFERRER CODE</a>	F
		R	0..1	<a href="#">ORGANISATION IDENTIFIER (REFERRING ORGANISATION)</a>	F

<b>Notation</b>		<b>DATA GROUP: PREGNANCY - ACTIVITY CHARACTERISTICS</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Pregnancy.</b>			
R	0..1				
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>			<b>Rules</b>
		R	0..1	<a href="#">NUMBER OF BABIES INDICATION CODE</a>	V

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

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

M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		R	0..1	<a href="#">GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE)</a>	F
		O	0..1	<a href="#">GENERAL MEDICAL PRACTITIONER PRACTICE (PATIENT ANTENATAL CARE)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: ANTENATAL CARE - LOCATION GROUP - DELIVERY PLACE INTENDED</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Intended Delivery Location.</b>
R	0..1	

M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		R	0..1	<a href="#">ACTIVITY LOCATION TYPE CODE</a>	F
		R	0..1	<a href="#">DELIVERY PLACE CHANGE REASON CODE</a>	V
		R	0..1	<a href="#">DELIVERY PLACE TYPE CODE (INTENDED)</a>	V

<a href="#">Notation</a>		<b>DATA GROUP: LABOUR/DELIVERY - ACTIVITY CHARACTERISTICS</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Labour/Delivery.</b>
R	0..1	

M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		R	0..1	<a href="#">ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY CODE</a>	V
		R	0..1	<a href="#">ANAESTHETIC GIVEN POST LABOUR OR DELIVERY CODE</a>	V
		O	0..1	<a href="#">GESTATION LENGTH (LABOUR ONSET)</a>	F
		R	0..1	<a href="#">LABOUR OR DELIVERY ONSET METHOD CODE</a>	V
		R	0..1	<a href="#">DELIVERY TIMESTAMP</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: DELIVERY OCCURRENCE - ACTIVITY CHARACTERISTICS</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Delivery of the Baby.</b>
R	0..1	

M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		R	0..1	<a href="#">BIRTH ORDER</a>	F
		R	0..1	<a href="#">DELIVERY METHOD CODE</a>	V
		R	0..1	<a href="#">GESTATION LENGTH (ASSESSMENT)</a>	F
		R	0..1	<a href="#">RESUSCITATION METHOD CODE</a>	V
		R	0..1	<a href="#">STATUS OF PERSON CONDUCTING DELIVERY CODE</a>	V

<a href="#">Notation</a>		<b>DATA GROUP: PERSON IDENTITY (MOTHER)</b>

<b>Group Status</b> M	<b>Group Repeats</b> 1..1	<b>FUNCTION: To carry the Identity details of the Baby's mother. See Note: S3 in Commissioning Data Set Business Rules.</b>
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One of the following DATA GROUPS must be used:

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

OR

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

OR

<b>1..1</b>	<b>DATA GROUP: UNVERIFIED IDENTITY STRUCTURE</b>		
<b>Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE (MOTHER) NOT included in the above</b>			
<b>O</b>	<b>0..1</b>	<b>DATA GROUP: LOCAL IDENTIFIER STRUCTURE</b>	<a href="#">Rules</a>
<b>M</b>	<b>1..1</b>	<a href="#">LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER))</a>	F S3
<b>M</b>	<b>1..1</b>	<a href="#">ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER))</a>	F
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>	<a href="#">Rules</a>
<b>R</b>	<b>0..1</b>	<a href="#">NHS NUMBER (MOTHER)</a>	

					F S3
		M	1..1	<a href="#">NHS NUMBER STATUS INDICATOR CODE (MOTHER)</a>	V
O	0..1	Data Element Components			<a href="#">Rules</a>
		M OR M	1..1 OR 2..5	<a href="#">PATIENT USUAL ADDRESS (UNSTRUCTURED (MOTHER))</a> OR <a href="#">PATIENT USUAL ADDRESS (STRUCTURED (MOTHER))</a>	F S3 I5
M	1..1	Data Element Components			<a href="#">Rules</a>
		R	0..1	<a href="#">POSTCODE OF USUAL ADDRESS (MOTHER)</a>	F S3
		R	0..1	<a href="#">ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)</a>	F
		R	0..1	<a href="#">PERSON BIRTH DATE (MOTHER)</a>	F S3 S12

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

<a href="#">Notation</a>		<b>DATA GROUP: DELIVERY OCCURRENCE - LOCATION GROUP - DELIVERY PLACE ACTUAL</b>			
Group Status	Group Repeats	FUNCTION: To carry the details of the Actual Delivery Location.			
R	0..1				
M	1..1	Data Element Components			<a href="#">Rules</a>
		R	0..1	<a href="#">ACTIVITY LOCATION TYPE CODE</a>	F
		R	0..1	<a href="#">DELIVERY PLACE TYPE CODE (ACTUAL)</a>	V

<a href="#">Notation</a>		<b>DATA GROUP: CDS V6-3 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER</b>			
Group Status	Group Repeats	FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.			
M	1..*	DATA GROUP: <a href="#">CDS V6-3 Type 004 - Commissioning Data Set Message Trailer</a> 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.

<u>Notation</u>		<b>DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.</b>
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: <a href="#">CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer</a></b> One per Interchange submitted to the Secondary Uses Service. 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: Changed Description

**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.**

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

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

<u>Notation</u>		<b>DATA GROUP: CDS V6-3 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>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.</b>
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: <a href="#">CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol</a></b> One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

**OR**

<u>Notation</u>		<b>DATA GROUP: CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>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.</b>
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: <a href="#">CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol</a></b> One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

<u>Notation</u>		<b>DATA GROUP: PATIENT PATHWAY</b>	
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: 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.</b>	
<b>R</b>	<b>0..1</b>		
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: PATIENT PATHWAY IDENTITY</b>	<a href="#">Rules</a>
<b>M</b>	<b>1..1</b>	<a href="#">UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)</a>	<b>F</b>
<i>Or</i>	<i>Or</i>		
<b>M</b>	<b>1..1</b>	<a href="#">PATIENT PATHWAY IDENTIFIER</a>	<b>F</b> <b>I2</b>
<b>M</b>	<b>1..1</b>	<a href="#">ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)</a>	<b>F</b> <b>I2</b>
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS</b>	<a href="#">Rules</a>
<b>M</b>	<b>1..1</b>	<a href="#">REFERRAL TO TREATMENT PERIOD STATUS</a>	<b>V</b>
<b>M</b>	<b>1..1</b>		<b>V</b>

		<a href="#">WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)</a>	
O	0..1	<a href="#">REFERRAL TO TREATMENT PERIOD START DATE</a>	F S13
O	0..1	<a href="#">REFERRAL TO TREATMENT PERIOD END DATE</a>	F S13

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

One of the following DATA GROUPS must be used:

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

OR

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

OR

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

<a href="#">Notation</a>		DATA GROUP: PATIENT CHARACTERISTICS			
Group Status	Group Repeats	FUNCTION: To carry the characteristics of the Patient.			
R	0..1				
M	1..1	Data Element Components	<a href="#">Rules</a>		
		R	0..1	<a href="#">PERSON STATED GENDER CODE</a>	V
		O	0..1	<a href="#">CARER SUPPORT INDICATOR</a>	V
		R	0..1	<a href="#">ETHNIC CATEGORY</a>	V
		X	0..1	<a href="#">ETHNIC CATEGORY 2021</a>	N2
		R	0..1	<a href="#">PERSON MARITAL STATUS</a>	V

		R	0..1	<a href="#">MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)</a>	F
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<u>Notation</u>		<b>DATA GROUP: PATIENT CHARACTERISTICS - SOCIAL AND PERSONAL CIRCUMSTANCES (SNOMED CT)</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION:</b>			
R	0..*	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	<b>DATA GROUP: SNOMED CT SOCIAL AND PERSONAL CIRCUMSTANCES</b>			<a href="#">Rules</a>
		M	1..1	<a href="#">SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>			<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<u>Notation</u>		<b>DATA GROUP: HOSPITAL PROVIDER SPELL - ADMISSION CHARACTERISTICS</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION:</b> To carry the admission details of the Hospital Provider Spell containing the Unfinished General Care Professional Admitted Care Episode.			
M	1..1				
M	1..1	<b>Data Element Components</b>			<a href="#">Rules</a>
		R	0..1	<a href="#">HOSPITAL PROVIDER SPELL IDENTIFIER</a>	F
		R	0..1	<a href="#">ADMINISTRATIVE CATEGORY CODE (ON ADMISSION)</a>	V
		R	0..1	<a href="#">PATIENT CLASSIFICATION CODE</a>	V
		R	0..1	<a href="#">METHOD OF ADMISSION (HOSPITAL PROVIDER SPELL)</a>	V
		R	0..1	<a href="#">ADMISSION SOURCE (HOSPITAL PROVIDER SPELL)</a>	V
		M	1..1	<a href="#">START DATE (HOSPITAL PROVIDER SPELL)</a>	F S13
		O	0..1	<a href="#">START TIME (HOSPITAL PROVIDER SPELL)</a>	F S14
		M	1..1	<a href="#">AGE ON ADMISSION</a>	F
		R	0..1	<a href="#">AMBULANCE CALL IDENTIFIER</a>	F
		R	0..1	<a href="#">ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST)</a>	F
		R	0..1	<a href="#">CARE CONTACT IDENTIFIER (AMBULANCE SERVICE)</a>	F

<u>Notation</u>	
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		<b>DATA GROUP: HOSPITAL PROVIDER SPELL - DISCHARGE CHARACTERISTICS</b>	
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the discharge details of the Hospital Provider Spell containing the Unfinished General Care Professional Admitted Care Episode.</b>	
<b>R</b>	<b>0..1</b>		
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>	
		<b>Rules</b>	
R	0..1	<a href="#">DESTINATION OF DISCHARGE (HOSPITAL PROVIDER SPELL)</a>	V
R	0..1	<a href="#">METHOD OF DISCHARGE (HOSPITAL PROVIDER SPELL)</a>	V
R	0..1	<a href="#">DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL)</a>	F S13
R	0..1	<a href="#">DISCHARGE DATE (HOSPITAL PROVIDER SPELL)</a>	F S13
O	0..1	<a href="#">DISCHARGE TIME (HOSPITAL PROVIDER SPELL)</a>	F S14
R	0..1	<a href="#">DISCHARGED TO NHS AT HOME SERVICE INDICATOR</a>	V

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

<b>Notation</b>		<b>DATA GROUP: CARE EPISODE - LENGTH OF STAY ADJUSTMENT</b>	
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<b>Group Status</b> R	<b>Group Repeats</b> 0..1	<b>FUNCTION: To carry details of length of stay adjustments to the Unfinished General Care Professional Admitted Care Episode.</b>			
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<a href="#">Rules</a>	
		R	0..1	<a href="#">LENGTH OF STAY ADJUSTMENT (REHABILITATION)</a>	F
		R	0..1	<a href="#">LENGTH OF STAY ADJUSTMENT (SPECIALIST PALLIATIVE CARE)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: CARE EPISODE - OVERSEAS VISITOR CHARGING CATEGORY</b>			
<b>Group Status</b> R	<b>Group Repeats</b> 0..5	<b>FUNCTION: To carry the details of the Overseas Visitor Charging Categories of the Patient during the Unfinished General Care Professional Admitted Care Episode.</b>			
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<a href="#">Rules</a>	
		M	1..1	<a href="#">OVERSEAS VISITOR CHARGING CATEGORY</a>	V
		M	1..1	<a href="#">OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE FROM DATE</a>	F S13
		R	0..1	<a href="#">OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE END DATE</a>	F S13

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

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

<u>Notation</u>		<b>DATA GROUP: CARE EPISODE - CLINICAL DIAGNOSIS GROUP (ICD)</b>			
<b>Group Status</b> R	<b>Group Repeats</b> 0..1	<b>FUNCTION: To carry the details of the ICD coded Clinical Diagnoses for the Patient.</b>			
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<u>Rules</u>	
		<b>M</b>	<b>1..1</b>	<a href="#">DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET)</a>	V
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: PRIMARY DIAGNOSIS</b>		<u>Rules</u>	
		<b>M</b>	<b>1..1</b>	<a href="#">PRIMARY DIAGNOSIS (ICD)</a>	F H4
		<b>O</b>	<b>0..1</b>	<a href="#">PRESENT ON ADMISSION INDICATOR</a>	V
<b>R</b>	<b>0..*</b>	<b>DATA GROUP: SECONDARY DIAGNOSES</b>		<u>Rules</u>	
		<b>M</b>	<b>1..1</b>	<a href="#">SECONDARY DIAGNOSIS (ICD)</a>	F H4
		<b>O</b>	<b>0..1</b>	<a href="#">PRESENT ON ADMISSION INDICATOR</a>	V

<u>Notation</u>		<b>DATA GROUP: CARE EPISODE - CLINICAL DIAGNOSIS GROUP (SNOMED CT)</b>		
		<b>FUNCTION: To carry the details of the SNOMED CT coded Clinical Diagnoses for the Patient.</b>		

<b>Group Status</b> R	<b>Group Repeats</b> 0..*	
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One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT DIAGNOSIS</b>		<a href="#">Rules</a>	
		M	1..1	<a href="#">DIAGNOSIS (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">CODED CLINICAL ENTRY SEQUENCE NUMBER</a>	F
		M	1..1	<a href="#">CODED DIAGNOSIS TIMESTAMP</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>		<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>

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

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT COMORBIDITY</b>		<a href="#">Rules</a>
		M	1..1	<a href="#">COMORBIDITY (SNOMED CT EXPRESSION)</a>

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>		<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>

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

M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		M	1..1	<b>Data Element Components</b>	<a href="#">Rules</a>
		R	0..1	<a href="#">EMED3 FIT NOTE ASSESSMENT DATE</a>	F S13
		R	0..1	<a href="#">EMED3 FIT NOTE CONDITION (SNOMED CT EXPRESSION)</a>	F
		R	0..1	<a href="#">EMED3 FIT NOTE DIAGNOSIS (ICD)</a>	F
		R	0..1	<a href="#">EMED3 FIT NOTE START DATE</a>	F S13
		R	0..1	<a href="#">EMED3 FIT NOTE END DATE</a>	F S13
		R	0..1	<a href="#">EMED3 FIT NOTE DURATION</a>	F
		R	0..1	<a href="#">EMED3 FIT NOTE RECORDED DATE</a>	



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

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT PROCEDURE</b>		<a href="#">Rules</a>	
		M	1..1	<a href="#">PROCEDURE (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">CODED CLINICAL ENTRY SEQUENCE NUMBER</a>	F
		M	1..1	<a href="#">CODED PROCEDURE TIMESTAMP</a>	F
O	0..1	<b>DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL</b>		<a href="#">Rules</a>	
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)</a>	F
O	0..1	<b>DATA GROUP: RESPONSIBLE ANAESTHETIST</b>		<a href="#">Rules</a>	
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>		<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>

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

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT OBSERVATION</b>		<a href="#">Rules</a>	
		M	1..1	<a href="#">OBSERVATION (SNOMED CT EXPRESSION)</a>	F
		R	0..1	<a href="#">OBSERVATION VALUE</a>	F
		R	0..1	<a href="#">UCUM UNIT OF MEASUREMENT</a>	F
		M	1..1	<a href="#">CODED OBSERVATION TIMESTAMP</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>		<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>

<u>Notation</u>		<b>DATA GROUP: CARE EPISODE - FINDING GROUP (SNOMED CT)</b>
		<b>FUNCTION: To carry the details of the SNOMED CT coded Clinical Findings for the Patient.</b>

<b>Group Status</b> R	<b>Group Repeats</b> 0..*	
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One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT FINDING</b>	<a href="#">Rules</a>		
		M	1..1	<a href="#">FINDING (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">CODED FINDING TIMESTAMP</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>	<a href="#">Rules</a>
		O	0..1

<a href="#">Notation</a>		<b>DATA GROUP: CARE EPISODE - ASSESSMENT TOOL GROUP (SNOMED CT)</b>
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the SNOMED CT coded Assessment Tools for the Patient.</b>

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT ASSESSMENT TOOL</b>	<a href="#">Rules</a>		
		M	1..1	<a href="#">ASSESSMENT TOOL (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">PERSON SCORE</a>	F
		M	1..1	<a href="#">ASSESSMENT TOOL COMPLETION TIMESTAMP</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>	<a href="#">Rules</a>
		O	0..1

<a href="#">Notation</a>		<b>DATA GROUP: LOCATION GROUP (AT START OF CARE EPISODE)</b>
<b>Group Status</b> R	<b>Group Repeats</b> 0..1	<b>FUNCTION: To carry the details of the Location at the Start of the Unfinished General Care Professional Admitted Care Episode.</b>

M	1..1	<b>Data Element Components</b>	<a href="#">Rules</a>		
		R	0..1	<a href="#">ORGANISATION SITE IDENTIFIER (OF TREATMENT)</a>	F
		R	0..1	<a href="#">ACTIVITY LOCATION TYPE CODE</a>	F
		O	0..1	<a href="#">WARD INTENDED CLINICAL CARE INTENSITY</a>	V
		O	0..1	<a href="#">WARD INTENDED AGE GROUP</a>	V
		O	0..1	<a href="#">WARD INTENDED SEX OF PATIENTS</a>	V
		O	0..1	<a href="#">WARD INTENDED DAY PERIOD AVAILABILITY</a>	V
		O	0..1	<a href="#">WARD INTENDED NIGHT PERIOD AVAILABILITY</a>	V
		O	0..1	<a href="#">WARD SECURITY LEVEL</a>	V
		O	0..1	<a href="#">WARD CODE</a>	F

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

Notation		DATA GROUP: LOCATION GROUP - HOME LEAVE	

<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION:</b> To carry the details of each separate period of Home Leave within the Unfinished General Care Professional Admitted Care Episode.		
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>	<a href="#">Rules</a>	
		<b>M</b> 1..1	<a href="#">START DATE (HOME LEAVE)</a>	F S13
		<b>R</b> 0..1	<a href="#">START TIME (HOME LEAVE)</a>	F S14
		<b>R</b> 0..1	<a href="#">END DATE (HOME LEAVE)</a>	F S13
		<b>R</b> 0..1	<a href="#">END TIME (HOME LEAVE)</a>	F S14

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

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

<a href="#">Notation</a>		<b>DATA GROUP: CARE EPISODE - ADULT CRITICAL CARE PERIOD</b>	
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: See CRITICAL CARE PERIOD. To carry the details of the first 9 Critical Care Periods for care provided using Adult Care facilities.</b>	
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: ADULT CRITICAL CARE - ADMISSION CHARACTERISTICS</b>	<a href="#">Rules</a>
<b>M</b>	<b>1..1</b>	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>	F
<b>M</b>	<b>1..1</b>	<a href="#">CRITICAL CARE START DATE</a>	F S13
<b>O</b>	<b>0..1</b>	<a href="#">CRITICAL CARE START TIME</a>	F S14
<b>M</b>	<b>1..1</b>	<a href="#">CRITICAL CARE UNIT FUNCTION</a>	V
<b>O</b>	<b>0..1</b>	<a href="#">CRITICAL CARE UNIT BED CONFIGURATION</a>	V
<b>O</b>	<b>0..1</b>	<a href="#">CRITICAL CARE ADMISSION SOURCE</a>	V

		O	0..1	<a href="#">CRITICAL CARE SOURCE LOCATION</a>	V
		O	0..1	<a href="#">CRITICAL CARE ADMISSION TYPE</a>	V
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: ADULT CRITICAL CARE - ACTIVITY CHARACTERISTICS</b>			<a href="#">Rules</a>
		R	0..1	<a href="#">ADVANCED RESPIRATORY SUPPORT DAYS</a>	F
		R	0..1	<a href="#">BASIC RESPIRATORY SUPPORT DAYS</a>	F
		R	0..1	<a href="#">ADVANCED CARDIOVASCULAR SUPPORT DAYS</a>	F
		R	0..1	<a href="#">BASIC CARDIOVASCULAR SUPPORT DAYS</a>	F
		R	0..1	<a href="#">RENAL SUPPORT DAYS</a>	F
		R	0..1	<a href="#">NEUROLOGICAL SUPPORT DAYS</a>	F
		O	0..1	<a href="#">GASTRO-INTESTINAL SUPPORT DAYS</a>	F
		R	0..1	<a href="#">DERMATOLOGICAL SUPPORT DAYS</a>	F
		R	0..1	<a href="#">LIVER SUPPORT DAYS</a>	F
		O	0..1	<a href="#">ORGAN SUPPORT MAXIMUM</a>	V
		R	0..1	<a href="#">CRITICAL CARE LEVEL 2 DAYS</a>	F
		R	0..1	<a href="#">CRITICAL CARE LEVEL 3 DAYS</a>	F
<b>R</b>	<b>0..*</b>	<b>DATA GROUP: ADULT CRITICAL CARE - DAILY CARE ACTIVITY CHARACTERISTICS</b>			<a href="#">Rules</a>
		<b>M</b>	<b>1..1</b>	<a href="#">ACTIVITY DATE (CRITICAL CARE)</a>	F S13
		<b>M</b>	<b>1..9</b>	<a href="#">ORGAN SYSTEM SUPPORTED</a>	V
		<b>M</b>	<b>1..1</b>	<a href="#">CRITICAL CARE LEVEL</a>	V
<b>R</b>	<b>0..1</b>	<b>DATA GROUP: ADULT CRITICAL CARE - DISCHARGE CHARACTERISTICS</b>			<a href="#">Rules</a>
		<b>M</b>	<b>1..1</b>	<a href="#">CRITICAL CARE DISCHARGE DATE</a>	F S13
		<b>M</b>	<b>1..1</b>	<a href="#">CRITICAL CARE DISCHARGE TIME</a>	F S14
		O	0..1	<a href="#">CRITICAL CARE DISCHARGE READY DATE</a>	F S13
		O	0..1	<a href="#">CRITICAL CARE DISCHARGE READY TIME</a>	F S14
		O	0..1	<a href="#">CRITICAL CARE DISCHARGE STATUS</a>	V
		O	0..1	<a href="#">CRITICAL CARE DISCHARGE DESTINATION</a>	V
		O	0..1	<a href="#">CRITICAL CARE DISCHARGE LOCATION</a>	V

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

M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		O	0..1	<a href="#">GENERAL MEDICAL PRACTITIONER (SPECIFIED)</a>	F
		R	0..1	<a href="#">GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: REFERRER</b>		
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Referrer.</b>		
R	0..1			

M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		R	0..1	<a href="#">REFERRER CODE</a>	F
		R	0..1	<a href="#">ORGANISATION IDENTIFIER (REFERRING ORGANISATION)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: REFERRAL</b>		
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Referral.</b>		
O	0..1			

M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>
		O	0..1	<a href="#">DIRECT ACCESS REFERRAL INDICATOR</a>

<a href="#">Notation</a>		<b>DATA GROUP: ELECTIVE ADMISSION LIST ENTRY</b>		
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Elective Admission List Entry.</b>		
R	0..1			

M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		R	0..1	<a href="#">DURATION OF ELECTIVE WAIT</a>	F
		R	0..1	<a href="#">INTENDED MANAGEMENT CODE</a>	V
		R	0..1	<a href="#">DECIDED TO ADMIT DATE</a>	F S13
		R	0..1	<a href="#">EARLIEST REASONABLE OFFER DATE</a>	F S13
		R	0..1	<a href="#">EARLIEST CLINICALLY APPROPRIATE DATE</a>	F S13
		R	0..1	<a href="#">LATEST CLINICALLY APPROPRIATE DATE</a>	F S13

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

M	1..*	<b>DATA GROUP: <a href="#">CDS V6-3 Type 004 - Commissioning Data Set Message Trailer</a></b>		
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	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.
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<u>Notation</u>		<b>DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.</b>
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: <a href="#">CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer</a></b> One per Interchange submitted to the Secondary Uses Service. 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: Changed Description

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

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

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

<u>Notation</u>		<b>DATA GROUP: CDS V6-3 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>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.</b>
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: <a href="#">CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol</a></b> One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

**OR**

<u>Notation</u>		<b>DATA GROUP: CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>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.</b>
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: <a href="#">CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol</a></b> One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

<u>Notation</u>		<b>DATA GROUP: PATIENT PATHWAY</b>	
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Patient Pathway.</b>	
<b>O</b>	<b>0..1</b>		
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: PATIENT PATHWAY IDENTITY</b>	<b><a href="#">Rules</a></b>
<b>M</b>	<b>1..1</b>	<b><a href="#">UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)</a></b>	<b>F</b>
<b>Or</b>		<b>Or</b>	
<b>M</b>	<b>1..1</b>	<b><a href="#">PATIENT PATHWAY IDENTIFIER</a></b>	<b>F</b>
<b>M</b>	<b>1..1</b>	<b><a href="#">ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)</a></b>	<b>F</b> <b>I2</b>
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS</b>	<b><a href="#">Rules</a></b>
<b>M</b>	<b>1..1</b>	<b><a href="#">REFERRAL TO TREATMENT PERIOD STATUS</a></b>	<b>V</b>
<b>M</b>	<b>1..1</b>	<b><a href="#">WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)</a></b>	<b>V</b>

O	0..1	<a href="#">REFERRAL TO TREATMENT PERIOD START DATE</a>	F S13
O	0..1	<a href="#">REFERRAL TO TREATMENT PERIOD END DATE</a>	F S13

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

One of the following DATA GROUPS must be used:

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

OR

1..1	<b>DATA GROUP: VERIFIED IDENTITY STRUCTURE</b> 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	<a href="#">Rules</a>
	M	1..1	<a href="#">LOCAL PATIENT IDENTIFIER (EXTENDED)</a> F S3
	M	1..1	<a href="#">ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)</a> F
M	1..1	Data Element Components	<a href="#">Rules</a>
	M	1..1	<a href="#">NHS NUMBER</a> F S3
	M	1..1	<a href="#">NHS NUMBER STATUS INDICATOR CODE</a> V
	M	1..1	<a href="#">POSTCODE OF USUAL ADDRESS</a> F S3
	R	0..1	<a href="#">ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)</a> F
	R	0..1	<a href="#">PERSON BIRTH DATE</a> F S3 S12

OR

1..1	<b>DATA GROUP: UNVERIFIED IDENTITY STRUCTURE</b> 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	<a href="#">Rules</a>

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

<a href="#">Notation</a>		<b>DATA GROUP: PATIENT CHARACTERISTICS</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the characteristics of the Patient (the Mother).</b>			
R	0..1				
M	1..1	<b>Data Element Components</b>			<a href="#">Rules</a>
		R	0..1	<a href="#">PERSON STATED GENDER CODE</a>	V
		O	0..1	<a href="#">CARER SUPPORT INDICATOR</a>	V
		R	0..1	<a href="#">ETHNIC CATEGORY</a>	V
		X	0..1	<a href="#">ETHNIC CATEGORY 2021</a>	N2
		R	0..1	<a href="#">PERSON MARITAL STATUS</a>	V
		R	0..1		F

				<a href="#">MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)</a>	
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<a href="#">Notation</a>		<b>DATA GROUP: DELIVERY CHARACTERISTICS</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the delivery characteristics of the Patient (the Mother).</b>			
R	0..1				
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>			<a href="#">Rules</a>
		R	0..1	<a href="#">NUMBER OF PREVIOUS PREGNANCIES RESULTING IN REGISTRABLE BIRTH</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: PATIENT CHARACTERISTICS - SOCIAL AND PERSONAL CIRCUMSTANCES (SNOMED CT)</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the Social and Personal Circumstances for the Patient (the Mother).</b>			
R	0..*				

One of the following DATA GROUPS may be used:

<b>M</b>	<b>1..1</b>	<b>DATA GROUP: SNOMED CT SOCIAL AND PERSONAL CIRCUMSTANCES</b>			<a href="#">Rules</a>
		<b>M</b>	<b>1..1</b>	<a href="#">SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION)</a>	F
		<b>M</b>	<b>1..1</b>	<a href="#">SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP</a>	F

OR

<b>O</b>	<b>0..1</b>	<b>DATA GROUP: DATA ABSENT REASON</b>			<a href="#">Rules</a>
		<b>O</b>	<b>0..1</b>	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<a href="#">Notation</a>		<b>DATA GROUP: HOSPITAL PROVIDER SPELL - ADMISSION CHARACTERISTICS</b>				
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the admission details of the Hospital Provider Spell containing the Unfinished Delivery Care Professional Admitted Care Episode.</b>				
M	1..1					
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>			<a href="#">Rules</a>	
		R	0..1	<a href="#">HOSPITAL PROVIDER SPELL IDENTIFIER</a>	F	
		R	0..1	<a href="#">ADMINISTRATIVE CATEGORY CODE (ON ADMISSION)</a>	V	
		R	0..1	<a href="#">PATIENT CLASSIFICATION CODE</a>	V	
		R	0..1	<a href="#">METHOD OF ADMISSION (HOSPITAL PROVIDER SPELL)</a>	V	
		R	0..1	<a href="#">ADMISSION SOURCE (HOSPITAL PROVIDER SPELL)</a>	V	
		<b>M</b>	<b>1..1</b>	<a href="#">START DATE (HOSPITAL PROVIDER SPELL)</a>	F	S13
		<b>O</b>	<b>0..1</b>	<a href="#">START TIME (HOSPITAL PROVIDER SPELL)</a>	F	S14

	<b>M</b>	<b>1..1</b>	<a href="#">AGE ON ADMISSION</a>	F
	<b>R</b>	<b>0..1</b>	<a href="#">AMBULANCE CALL IDENTIFIER</a>	F
	<b>R</b>	<b>0..1</b>	<a href="#">ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST)</a>	F
	<b>R</b>	<b>0..1</b>	<a href="#">CARE CONTACT IDENTIFIER (AMBULANCE SERVICE)</a>	F

<u>Notation</u>		<b>DATA GROUP: HOSPITAL PROVIDER SPELL - DISCHARGE CHARACTERISTICS</b>		
Group Status	Group Repeats	FUNCTION: To carry the discharge details of the Hospital Provider Spell containing the Unfinished Delivery Care Professional Admitted Care Episode.		
<b>R</b>	<b>0..1</b>			
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<a href="#">Rules</a>
	<b>R</b>	<b>0..1</b>	<a href="#">DESTINATION OF DISCHARGE (HOSPITAL PROVIDER SPELL)</a>	V
	<b>R</b>	<b>0..1</b>	<a href="#">METHOD OF DISCHARGE (HOSPITAL PROVIDER SPELL)</a>	V
	<b>R</b>	<b>0..1</b>	<a href="#">DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL)</a>	F S13
	<b>R</b>	<b>0..1</b>	<a href="#">DISCHARGE DATE (HOSPITAL PROVIDER SPELL)</a>	F S13
	<b>O</b>	<b>0..1</b>	<a href="#">DISCHARGE TIME (HOSPITAL PROVIDER SPELL)</a>	F S14
	<b>R</b>	<b>0..1</b>	<a href="#">DISCHARGED TO NHS AT HOME SERVICE INDICATOR</a>	V

<u>Notation</u>		<b>DATA GROUP: DELIVERY EPISODE - ACTIVITY CHARACTERISTICS</b>		
Group Status	Group Repeats	FUNCTION: To carry the details of the Unfinished Delivery Care Professional Admitted Care Episode.		
<b>M</b>	<b>1..1</b>			
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<a href="#">Rules</a>
	<b>R</b>	<b>0..1</b>	<a href="#">EPISODE NUMBER</a>	F
	<b>R</b>	<b>0..1</b>	<a href="#">LAST EPISODE IN SPELL INDICATOR CODE</a>	V
	<b>R</b>	<b>0..1</b>	<a href="#">PSYCHIATRIC PATIENT STATUS CODE</a>	V
	<b>M</b>	<b>1..1</b>	<a href="#">START DATE (EPISODE)</a>	F S1 S13
	<b>O</b>	<b>0..1</b>	<a href="#">START TIME (EPISODE)</a>	F S14
	<b>R</b>	<b>0..1</b>	<a href="#">END DATE (EPISODE)</a>	F S13
	<b>O</b>	<b>0..1</b>	<a href="#">END TIME (EPISODE)</a>	F S14
	<b>M</b>	<b>1..1</b>	<a href="#">AGE AT CDS ACTIVITY DATE</a>	F

		O	0..1	<a href="#">REHABILITATION ASSESSMENT TEAM TYPE</a>	V N3
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<a href="#">Notation</a>		<b>DATA GROUP: DELIVERY EPISODE - OVERSEAS VISITOR CHARGING CATEGORY</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Overseas Visitor Charging Categories of the Patient (the Mother) during the Unfinished Delivery Care Professional Admitted Care Episode.</b>			
R	0..5				
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>			<a href="#">Rules</a>
M	1..1	<a href="#">OVERSEAS VISITOR CHARGING CATEGORY</a>			V
M	1..1	<a href="#">OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE FROM DATE</a>			F S13
R	0..1	<a href="#">OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE END DATE</a>			F S13

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

<a href="#">Notation</a>		<b>DATA GROUP: DELIVERY EPISODE - PERSON GROUP (CARE PROFESSIONAL)</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Care Professionals active during the Unfinished Delivery Admitted Patient Care Episode.</b>			
R	0..*				

M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER</a>	F
		M	1..1	<a href="#">CARE PROFESSIONAL MAIN SPECIALTY CODE</a>	F H4
		R	0..1	<a href="#">CARE PROFESSIONAL MAIN SPECIALTY CODE</a>	F H4
		M	1..1	<a href="#">ACTIVITY TREATMENT FUNCTION CODE</a>	F H4
		O	0..1	<a href="#">LOCAL SUB-SPECIALTY CODE</a>	F
M	1..1	<a href="#">RESPONSIBLE CARE PROFESSIONAL INDICATOR</a>	V		

<a href="#">Notation</a>		<b>DATA GROUP: DELIVERY EPISODE - CLINICAL DIAGNOSIS GROUP (ICD)</b>
<b>Group Status</b> R	<b>Group Repeats</b> 0..1	<b>FUNCTION: To carry the details of the ICD coded Clinical Diagnoses for the Patient (the Mother).</b>

M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>
		M	1..1	<a href="#">DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET)</a>
M	1..1	<b>DATA GROUP: PRIMARY DIAGNOSIS</b>		<a href="#">Rules</a>
		M	1..1	<a href="#">PRIMARY DIAGNOSIS (ICD)</a>
R	0..*	<b>DATA GROUP: SECONDARY DIAGNOSES</b>		<a href="#">Rules</a>
		M	1..1	<a href="#">SECONDARY DIAGNOSIS (ICD)</a>

<a href="#">Notation</a>		<b>DATA GROUP: DELIVERY EPISODE - CLINICAL DIAGNOSIS GROUP (SNOMED CT)</b>
<b>Group Status</b> R	<b>Group Repeats</b> 0..*	<b>FUNCTION: To carry the details of the SNOMED CT coded Clinical Diagnoses for the Patient (the Mother).</b>

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT DIAGNOSIS</b>		<a href="#">Rules</a>	
		M	1..1	<a href="#">DIAGNOSIS (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">CODED CLINICAL ENTRY SEQUENCE NUMBER</a>	F
		M	1..1	<a href="#">CODED DIAGNOSIS TIMESTAMP</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>	<a href="#">Rules</a>
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		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F
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<u>Notation</u>		DATA GROUP: DELIVERY EPISODE - COMORBIDITY (SNOMED CT)
Group Status	Group Repeats	FUNCTION: To carry the details of the SNOMED CT coded Comorbidities for the Patient (the Mother).
R	0..*	

One of the following DATA GROUPS may be used:

M	1..1	DATA GROUP: SNOMED CT COMORBIDITY	<a href="#">Rules</a>
		M	1..1

OR

O	0..1	DATA GROUP: DATA ABSENT REASON	<a href="#">Rules</a>
		O	0..1

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

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

		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)</a>	F

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

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT PROCEDURE</b>			<a href="#">Rules</a>
		M	1..1	<a href="#">PROCEDURE (SNOMED CT EXPRESSION)</a>	F
		M	1..1	<a href="#">CODED CLINICAL ENTRY SEQUENCE NUMBER</a>	F
		M	1..1	<a href="#">CODED PROCEDURE TIMESTAMP</a>	F
O	0..1	<b>DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL</b>			<a href="#">Rules</a>
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)</a>	F
O	0..1	<b>DATA GROUP: RESPONSIBLE ANAESTHETIST</b>			<a href="#">Rules</a>
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	V
		M	1..1	<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>			<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

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

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT OBSERVATION</b>			<a href="#">Rules</a>
		M	1..1	<a href="#">OBSERVATION (SNOMED CT EXPRESSION)</a>	F
		R	0..1	<a href="#">OBSERVATION VALUE</a>	F
		R	0..1	<a href="#">UCUM UNIT OF MEASUREMENT</a>	F
		M	1..1	<a href="#">CODED OBSERVATION TIMESTAMP</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>			<a href="#">Rules</a>
		O	0..1	<a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

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

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT FINDING</b>	<a href="#">Rules</a>
		M 1..1 <a href="#">FINDING (SNOMED CT EXPRESSION)</a>	F
		M 1..1 <a href="#">CODED FINDING TIMESTAMP</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>	<a href="#">Rules</a>
		O 0..1 <a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

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

One of the following DATA GROUPS may be used:

M	1..1	<b>DATA GROUP: SNOMED CT ASSESSMENT TOOL</b>	<a href="#">Rules</a>
		M 1..1 <a href="#">ASSESSMENT TOOL (SNOMED CT EXPRESSION)</a>	F
		M 1..1 <a href="#">PERSON SCORE</a>	F
		M 1..1 <a href="#">ASSESSMENT TOOL COMPLETION TIMESTAMP</a>	F

OR

O	0..1	<b>DATA GROUP: DATA ABSENT REASON</b>	<a href="#">Rules</a>
		O 0..1 <a href="#">DATA ABSENT REASON (FHIR R4)</a>	F

<u>Notation</u>		<b>DATA GROUP: LOCATION GROUP (AT START OF DELIVERY EPISODE)</b>
<b>Group Status</b> R	<b>Group Repeats</b> 0..1	<b>FUNCTION: To carry the details of the Location at the Start of the Unfinished Delivery Care Professional Admitted Care Episode.</b>

M	1..1	<b>Data Element Components</b>	<a href="#">Rules</a>
		R 0..1 <a href="#">ORGANISATION SITE IDENTIFIER (OF TREATMENT)</a>	F
		R 0..1 <a href="#">ACTIVITY LOCATION TYPE CODE</a>	F
		O 0..1 <a href="#">WARD INTENDED CLINICAL CARE INTENSITY</a>	V
		O 0..1 <a href="#">WARD INTENDED AGE GROUP</a>	V
		O 0..1 <a href="#">WARD INTENDED SEX OF PATIENTS</a>	V
		O 0..1 <a href="#">WARD INTENDED DAY PERIOD AVAILABILITY</a>	V
		O 0..1 <a href="#">WARD INTENDED NIGHT PERIOD AVAILABILITY</a>	V
		O 0..1 <a href="#">WARD SECURITY LEVEL</a>	V

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

<u>Notation</u>		DATA GROUP: LOCATION GROUP (AT END OF DELIVERY EPISODE)			
Group Status	Group Repeats	FUNCTION: To carry the details of the Location at the End of the Unfinished Delivery Care Professional Admitted Care Episode.			
R	0..1				
M	1..1	<b>Data Element Components</b>			<u>Rules</u>
		R	0..1	<a href="#">ORGANISATION SITE IDENTIFIER (OF TREATMENT)</a>	F
		R	0..1	<a href="#">ACTIVITY LOCATION TYPE CODE</a>	V
		O	0..1	<a href="#">WARD INTENDED CLINICAL CARE INTENSITY</a>	V
		O	0..1	<a href="#">WARD INTENDED AGE GROUP</a>	V
		O	0..1	<a href="#">WARD INTENDED SEX OF PATIENTS</a>	V
		O	0..1	<a href="#">WARD INTENDED DAY PERIOD AVAILABILITY</a>	V
		O	0..1	<a href="#">WARD INTENDED NIGHT PERIOD AVAILABILITY</a>	V
		O	0..1	<a href="#">WARD SECURITY LEVEL</a>	V
		O	0..1	<a href="#">WARD CODE</a>	F

<u>Notation</u>		<b>DATA GROUP: LOCATION GROUP - HOME LEAVE</b>			
Group Status	Group Repeats	FUNCTION: To carry the details of each separate period of Home Leave within the Unfinished Delivery Care Professional Admitted Care Episode.			
R	0..*				
M	1..1	<b>Data Element Components</b>		<a href="#">Rules</a>	
		M	1..1	<a href="#">START DATE (HOME LEAVE)</a>	F S13
		R	0..1	<a href="#">START TIME (HOME LEAVE)</a>	F S14
		R	0..1	<a href="#">END DATE (HOME LEAVE)</a>	F S13
		R	0..1	<a href="#">END TIME (HOME LEAVE)</a>	F S14

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

<u>Notation</u>		DATA GROUP: DELIVERY EPISODE - ADULT 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 Adult Care facilities.			
M	1..1	<b>DATA GROUP: ADULT CRITICAL CARE - ADMISSION CHARACTERISTICS</b>		<a href="#">Rules</a>	
		M	1..1	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>	F
		M	1..1	<a href="#">CRITICAL CARE START DATE</a>	F S13
		O	0..1	<a href="#">CRITICAL CARE START TIME</a>	F S14
		M	1..1	<a href="#">CRITICAL CARE UNIT FUNCTION</a>	V
		O	0..1	<a href="#">CRITICAL CARE UNIT BED CONFIGURATION</a>	V
		O	0..1	<a href="#">CRITICAL CARE ADMISSION SOURCE</a>	V
		O	0..1	<a href="#">CRITICAL CARE SOURCE LOCATION</a>	V
		O	0..1	<a href="#">CRITICAL CARE ADMISSION TYPE</a>	V
		M	1..1	<b>DATA GROUP: ADULT CRITICAL CARE - ACTIVITY CHARACTERISTICS</b>	
R	0..1			<a href="#">ADVANCED RESPIRATORY SUPPORT DAYS</a>	F
R	0..1			<a href="#">BASIC RESPIRATORY SUPPORT DAYS</a>	F
R	0..1			<a href="#">ADVANCED CARDIOVASCULAR SUPPORT DAYS</a>	F
R	0..1			<a href="#">BASIC CARDIOVASCULAR SUPPORT DAYS</a>	F
R	0..1			<a href="#">RENAL SUPPORT DAYS</a>	F
R	0..1			<a href="#">NEUROLOGICAL SUPPORT DAYS</a>	F
O	0..1			<a href="#">GASTRO-INTESTINAL SUPPORT DAYS</a>	F
R	0..1			<a href="#">DERMATOLOGICAL SUPPORT DAYS</a>	F
R	0..1			<a href="#">LIVER SUPPORT DAYS</a>	F
O	0..1			<a href="#">ORGAN SUPPORT MAXIMUM</a>	V
R	0..1			<a href="#">CRITICAL CARE LEVEL 2 DAYS</a>	F
R	0..1			<a href="#">CRITICAL CARE LEVEL 3 DAYS</a>	F
R	0..*	<b>DATA GROUP: ADULT CRITICAL CARE - DAILY CARE ACTIVITY CHARACTERISTICS</b>		<a href="#">Rules</a>	
		M	1..1	<a href="#">ACTIVITY DATE (CRITICAL CARE)</a>	F S13
		M	1..9	<a href="#">ORGAN SYSTEM SUPPORTED</a>	V
		M	1..1	<a href="#">CRITICAL CARE LEVEL</a>	V
R	0..1	<b>DATA GROUP: ADULT CRITICAL CARE - DISCHARGE CHARACTERISTICS</b>		<a href="#">Rules</a>	

	M	1..1	<a href="#">CRITICAL CARE DISCHARGE DATE</a>	F S13
	M	1..1	<a href="#">CRITICAL CARE DISCHARGE TIME</a>	F S14
	O	0..1	<a href="#">CRITICAL CARE DISCHARGE READY DATE</a>	F S13
	O	0..1	<a href="#">CRITICAL CARE DISCHARGE READY TIME</a>	F S14
	O	0..1	<a href="#">CRITICAL CARE DISCHARGE STATUS</a>	V
	O	0..1	<a href="#">CRITICAL CARE DISCHARGE DESTINATION</a>	V
	O	0..1	<a href="#">CRITICAL CARE DISCHARGE LOCATION</a>	V

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

<b>Notation</b>		<b>DATA GROUP: REFERRER</b>		
<b>Group Status</b> R	<b>Group Repeats</b> 0..1	<b>FUNCTION:</b> To carry the details of the Referrer.		
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<a href="#">Rules</a>
	R	0..1	<a href="#">REFERRER CODE</a>	F
	R	0..1	<a href="#">ORGANISATION IDENTIFIER (REFERRING ORGANISATION)</a>	F

<b>Notation</b>		<b>DATA GROUP: PREGNANCY - ACTIVITY CHARACTERISTICS</b>		
<b>Group Status</b> R	<b>Group Repeats</b> 0..1	<b>FUNCTION:</b> To carry the details of the Pregnancy.		
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<a href="#">Rules</a>
	R	0..1	<a href="#">NUMBER OF BABIES INDICATION CODE</a>	V

<b>Notation</b>		<b>DATA GROUP: ANTENATAL CARE - ACTIVITY CHARACTERISTICS</b>		
<b>Group Status</b> R	<b>Group Repeats</b> 0..1	<b>FUNCTION:</b> To carry the details of the Antenatal Care.		
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<a href="#">Rules</a>
	R	0..1	<a href="#">FIRST ANTENATAL ASSESSMENT DATE</a>	

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

<u>Notation</u>		<b>DATA GROUP: ANTENATAL CARE - LOCATION GROUP - DELIVERY PLACE INTENDED</b>			
<b>Group Status</b> R	<b>Group Repeats</b> 0..1	<b>FUNCTION: To carry the details of the Intended Delivery Location.</b>			
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<u>Rules</u>	
		R	0..1	<a href="#">ACTIVITY LOCATION TYPE CODE</a>	F
		R	0..1	<a href="#">DELIVERY PLACE CHANGE REASON CODE</a>	V
		R	0..1	<a href="#">DELIVERY PLACE TYPE CODE (INTENDED)</a>	V

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

<u>Notation</u>		<b>DATA GROUP: BIRTH OCCURRENCE</b>	
<b>Group Status</b> R	<b>Group Repeats</b> 0..9	<b>FUNCTION: To carry the details of up to 9 Birth Occurrences - one per Baby.</b>	
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: BIRTH OCCURRENCE - ACTIVITY CHARACTERISTICS</b>	<u>Rules</u>

	R	0..1	<a href="#">BIRTH ORDER</a>	F
	R	0..1	<a href="#">DELIVERY METHOD CODE</a>	V
	R	0..1	<a href="#">GESTATION LENGTH (ASSESSMENT)</a>	F
	R	0..1	<a href="#">RESUSCITATION METHOD CODE</a>	V
	R	0..1	<a href="#">STATUS OF PERSON CONDUCTING DELIVERY CODE</a>	V

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

One of the following DATA GROUPS must be used:

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

OR

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

OR

1..1	<b>DATA GROUP: UNVERIFIED IDENTITY STRUCTURE</b>			
	Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE (BABY) NOT included in the above			
O	0..1	<b>DATA GROUP: LOCAL IDENTIFIER STRUCTURE</b>		<a href="#">Rules</a>
		M	1..1	<a href="#">LOCAL PATIENT IDENTIFIER (EXTENDED (BABY))</a>

		M	1..1	<a href="#">ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (BABY))</a>	F
M	1..1	<b>Data Element Components</b>			<a href="#">Rules</a>
		R	0..1	<a href="#">NHS NUMBER (BABY)</a>	F S3
		M	1..1	<a href="#">NHS NUMBER STATUS INDICATOR CODE (BABY)</a>	V
R	0..1	<b>Data Element Components</b>			<a href="#">Rules</a>
		R	0..1	<a href="#">PERSON BIRTH DATE (BABY)</a>	F S3 S12

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH OCCURRENCE - PERSON CHARACTERISTICS - BABY</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the characteristics of the Baby.</b>			
R	0..1				
M	1..1	<b>Data Element Components</b>			<a href="#">Rules</a>
		R	0..1	<a href="#">PERSON PHENOTYPIC SEX</a>	V
		R	0..1	<a href="#">LIVE OR STILL BIRTH CODE</a>	V
		R	0..1	<a href="#">BIRTH WEIGHT</a>	F
		R	0..1	<a href="#">OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE</a>	V

<a href="#">Notation</a>		<b>DATA GROUP: BIRTH OCCURRENCE - LOCATION GROUP - DELIVERY PLACE ACTUAL</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the Actual Birth Location.</b>			
R	0..1				
M	1..1	<b>Data Element Components</b>			<a href="#">Rules</a>
		R	0..1	<a href="#">ACTIVITY LOCATION TYPE CODE</a>	F
		R	0..1	<a href="#">DELIVERY PLACE TYPE CODE (ACTUAL)</a>	V

<a href="#">Notation</a>		<b>DATA GROUP: CDS V6-3 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.</b>			
M	1..*	<b>DATA GROUP: <a href="#">CDS V6-3 Type 004 - Commissioning Data Set Message Trailer</a></b>			
		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.			

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

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## DISCHARGE READY DATE

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Change to Supporting Information: Changed Description

[Discharge Ready Date](#) is an [ACTIVITY DATE TIME](#).

[Discharge Ready Date](#) is the date that a [PATIENT](#) was medically ready for discharge from a [Hospital Bed](#) but could not be discharged, thereby qualifying for Delayed Discharge Payments under the provisions of the Community Care (Delayed Discharges etc) Act 2003. [Discharge Ready Date](#) is the date that a [PATIENT](#) no longer met the 'Criteria to Reside' in a [Hospital Bed](#). Note that [Discharge Ready Date](#) is not the same as the [Estimated Discharge Date \(Hospital Provider Spell\)](#) and is recorded separately.

The settings from where the discharge may originate are a health service hospital or an independent hospital in pursuance of arrangements made by an NHS body. The status of a [PATIENT](#) within a [Hospital Provider Spell](#) who is awaiting discharge may change from no longer meeting the 'Criteria to Reside' in a [Hospital Bed](#), to once again meeting the 'Criteria to Reside' in a [Hospital Bed](#), if the clinical condition of the [PATIENT](#) deteriorates while awaiting discharge for any reason.

Within the Act, the relevant community care services are defined under the National Health Service and Community Care Act 1990 section 46 (3). This in turn refers to provisions of other acts as follows: The 'Criteria to Reside' are set out in Annex D of the 'Hospital discharge and community support guidance' document part of the gov.uk website at: [Criteria to Reside](#).

"Community care services" means services which a [Local Authority](#) may provide or arrange to be provided under any of the following provisions: Usage in the [Commissioning Data Sets](#) version 6-2 and [Commissioning Data Sets](#) version 6-3:

(a) Part III of the [1948 c. 29.] National Assistance Act 1948; For Finished [Care Professional Admitted Care Episodes](#), the [Discharge Ready Date](#) should record the [final](#) time that the [PATIENT](#) no longer met the 'Criteria to Reside' in a [Hospital Bed](#), if applicable.

(b) ~~section 45 of the [1968 c. 46.] Health Services and Public Health Act 1968; For Unfinished Care Professional Admitted Care Episodes, the Discharge Ready Date should show the latest date that the PATIENT no longer met the 'Criteria to Reside', if applicable.~~

(c) ~~National Health Service Act 2006;~~ and

(d) ~~section 117 of the [1983 c. 20.] Mental Health Act 1983~~

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#### PRESENT ON ADMISSION INDICATOR

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Change to Attribute: Changed 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](#).~~  
Note: [PRESENT ON ADMISSION INDICATOR](#) is only required for [PATIENTS](#) with a [PATIENT DIAGNOSIS](#) relating to a pre-existing *Pressure Ulcer* or *Venous Thromboembolism (VTE)* 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 Yes - [PATIENT DIAGNOSIS](#) already present
- N No - [PATIENT DIAGNOSIS](#) not already present

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#### LAST PATIENT CANCELLED DATE

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Change to Data Element: Changed Description

Format/Length:	an10 CCYY-MM-DD
National Codes:	
Default Codes:	

**Notes:**

LAST PATIENT CANCELLED DATE is the same as attribute ACTIVITY DATE for the '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. For the CDS V6-3 Type 020 - Outpatient Commissioning Data Set, the LAST PATIENT CANCELLED DATE is the last APPOINTMENT within a Consultant Out-Patient Episode which the PATIENT cancelled, on or prior to the APPOINTMENT DATE carried in that CDS V6-3 Type 020 - Outpatient Commissioning Data Set record.

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#### LAST PATIENT DID NOT ATTEND DATE

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Change to Data Element: Changed Description

Format/Length:	an10 CCYY-MM-DD
National Codes:	
Default Codes:	

#### Notes:

LAST PATIENT DID NOT ATTEND DATE is the same as attribute ACTIVITY DATE for the '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. For the CDS V6-3 Type 020 - Outpatient Commissioning Data Set, the LAST PATIENT DID NOT ATTEND DATE is the last APPOINTMENT within a Consultant Out-Patient Episode 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.

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#### PRESENT ON ADMISSION INDICATOR

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Change to Data Element: Changed Description

Format/Length:	an1
National Codes:	See <u>PRESENT ON ADMISSION INDICATOR</u>
Default Codes:	8 - Not applicable (indication of this <u>PATIENT DIAGNOSIS</u> on admission not required nationally)

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: ~~[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](#).~~ Note: [PRESENT ON ADMISSION INDICATOR](#) is only required for [PATIENTS](#) with a [PATIENT DIAGNOSIS](#) relating to a pre-existing *Pressure Ulcer* or *Venous Thromboembolism (VTE)* 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.

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For enquiries about this Change Request, please email [information.standards@nhs.net](mailto:information.standards@nhs.net)

