NHS Data Model and Dictionary

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

Background:

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

The Commissioning Data Sets version 6-3 changes are designed to update the Commissioning Data Sets in line with current clinical and data recording practices, as well as to support recent policy initiatives, and enable conformance with other Information Standards and legislation introduced since Commissioning Data Sets version 6-2 was published in 2012.

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

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

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

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

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

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

- Recording of information relating to provision of eMED3 Fit Notes to the patient

- Updates to Organisation and Organisation Site Identifiers, including within the CDS Headers, to align with DCB0090: Health and Social Care Organisation Reference Data
- Extended format/length by replacement of some data items (eg replacement of Local Patient Identifier with Local Patient Identifier (Extended), replacement of Attendance Identifier with Outpatient Attendance Identifier)
- Replacement of Person Gender Code Current with Person Stated Gender Code
- Placeholder for the introduction of Ethnic Category 2021 when approved
- Submission of multiple Care Professionals involved in the care of the patient, including the ability to submit actual Nursing/Midwifery/Allied Health Professional registration codes, to replace the use of 'dummy' codes for Nurse, Midwife and Allied Health Professionals
- Removal of validation in the CDS-XML schema for fields which are likely to change outside of Commissioning Data Set releases (Care Professional Main Specialty Code, Activity Treatment Function Code, Mental Health Act Legal Status Classification Code, Critical Care Activity Code, Activity Location Type Code)
- Introduction of Overseas Visitor Charging Category data items to support DCB3017 Overseas Visitor Charging Category
- Update to Service Agreement group to allow submission of multiple associated Commissioners and Specialised Service Code
- Removal of some data items which are unused or are now better represented with other data items
- Separate Last Patient Did Not Attend and Last Patient Cancelled Date, with better definitional guidance
- Separate new data group for the recording of Home Leave, and associated changes to the Ward Stays data groups
- Cosmetic changes to the Unverified Identity Structure data group, to better reflect the requirements of the CDS-XML schema in the NHS Data Model and Dictionary data set view
- Additional data group within the Adult Critical Care structure, allowing submission of all details of organ systems supported and critical care levels for each day of critical care
- Changes to the Commissioning Data Set header types, to reflect current Secondary Uses Service processing of data recipients (replacing CDS Prime and Copy Recipient fields)
- Updates to enable better data linkage with the forthcoming Ambulance Data Set, including the addition of Care Contact Identifier (Ambulance Service)
- Updates to support the NHS @Home programme

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

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

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

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

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

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

Summary of changes:

Data Set	
CDS V6-3 TYPE 001 - CDS INTERCHANGE HEADER	New Data Set
CDS V6-3 TYPE 002 - CDS INTERCHANGE TRAILER	New Data Set

CDS V6-3 TYPE 003 - CDS MESSAGE HEADER	New Data Set
CDS V6-3 TYPE 004 - CDS MESSAGE TRAILER	New Data Set
CDS V6-3 TYPE 005B - CDS TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL	New Data Set
CDS V6-3 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL	New Data Set
CDS V6-3 TYPE 020 - OUTPATIENT CDS	New Data Set
CDS V6-3 TYPE 120 - ADMITTED PATIENT CARE - FINISHED BIRTH EPISODE CDS	New Data Set
CDS V6-3 TYPE 130 - ADMITTED PATIENT CARE - FINISHED GENERAL EPISODE CDS	New Data Set
CDS V6-3 TYPE 140 - ADMITTED PATIENT CARE - FINISHED DELIVERY EPISODE CDS	New Data Set
CDS V6-3 TYPE 150 - ADMITTED PATIENT CARE - OTHER BIRTH EVENT CDS	New Data Set
CDS V6-3 TYPE 160 - ADMITTED PATIENT CARE - OTHER DELIVERY EVENT CDS	New Data Set
CDS V6-3 TYPE 180 - ADMITTED PATIENT CARE - UNFINISHED BIRTH EPISODE CDS	New Data Set
CDS V6-3 TYPE 190 - ADMITTED PATIENT CARE - UNFINISHED GENERAL EPISODE CDS	New Data Set
CDS V6-3 TYPE 200 - ADMITTED PATIENT CARE - UNFINISHED DELIVERY EPISODE CDS	New Data Set

Supporting Information

ALLIED HEALTH PROFESSIONAL REFERRAL TO TREATMENT MEASUREMENT	Changed Description
CARE PROFESSIONAL ADMITTED CARE EPISODE	Changed Description
CARE PROFESSIONAL OUT-PATIENT ATTENDANCE	New Supporting Information
CARE PROFESSIONAL OUT-PATIENT EPISODE	New Supporting Information
CDS TYPE	Changed Description
CDS V6-3 TYPE 001 - CDS INTERCHANGE HEADER OVERVIEW	New Supporting Information
CDS V6-3 TYPE 002 - CDS INTERCHANGE TRAILER OVERVIEW	New Supporting Information
CDS V6-3 TYPE 003 - CDS MESSAGE HEADER OVERVIEW	New Supporting Information
CDS V6-3 TYPE 004 - CDS MESSAGE TRAILER OVERVIEW	New Supporting Information
CDS V6-3 TYPE 005B - CDS TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL OVERVIEW	New Supporting Information
CDS V6-3 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL OVERVIEW	New Supporting Information
CDS V6-3 TYPE 020 - OUTPATIENT CDS OVERVIEW	New Supporting Information
CDS V6-3 TYPE 120 - ADMITTED PATIENT CARE - FINISHED BIRTH EPISODE CDS OVERVIEW	New Supporting Information
CDS V6-3 TYPE 130 - ADMITTED PATIENT CARE - FINISHED GENERAL EPISODE CDS OVERVIEW	New Supporting Information
CDS V6-3 TYPE 140 - ADMITTED PATIENT CARE - FINISHED DELIVERY EPISODE CDS OVERVIEW	New Supporting Information
CDS V6-3 TYPE 150 - ADMITTED PATIENT CARE - OTHER BIRTH EVENT CDS OVERVIEW	New Supporting Information
CDS V6-3 TYPE 160 - ADMITTED PATIENT CARE - OTHER DELIVERY EVENT CDS OVERVIEW	New Supporting Information
CDS V6-3 TYPE 180 - ADMITTED PATIENT CARE - UNFINISHED BIRTH EPISODE CDS OVERVIEW	New Supporting Information

CDS V6-3 TYPE 190 - ADMITTED PATIENT CARE - UNFINISHED GENERAL EPISODE CDS OVERVIEW	New Supporting Information
CDS V6-3 TYPE 200 - ADMITTED PATIENT CARE - UNFINISHED DELIVERY EPISODE CDS OVERVIEW	New Supporting Information
CDS VERSION 6-3 MENU	New Supporting Information
COMMISSIONING DATA SET ADDRESSING GRID	Changed Description
COMMISSIONING DATA SET BUSINESS RULES	Changed Description
COMMISSIONING DATA SET MANDATED DATA FLOWS	Changed Description
COMMISSIONING DATA SET NOTATION	Changed Description
COMMISSIONING DATA SETS INTRODUCTION	Changed Description
COMMISSIONING DATA SETS MENU	Changed Description
COMMISSIONING DATA SETS OVERVIEW	Changed Description
COMMISSIONING DATA SET SUBMISSION PROTOCOL	Changed Description
COMMISSIONING DATA SET VERSION 6-3 TYPE LIST	New Supporting Information
COMMISSIONING DATA SET VERSIONS	Changed Description
COMMISSIONING DATA SET XML SCHEMA DESIGN	Changed Description
COMMISSIONING DATA SET XML SCHEMA DOCUMENTATION	Changed Description
COMMISSIONING DATA SET XML SCHEMA OVERVIEW	Changed Description
COMMISSIONING DATA SET XML SCHEMA VERSION NUMBERING	Changed Description
EMED3 FIT NOTE	New Supporting Information
EMED3 FIT NOTE APPLICABLE PERIOD	New Supporting Information
EMED3 FIT NOTE ASSESSMENT DATE	New Supporting Information
EMED3 FIT NOTE RECORDED DATE	New Supporting Information
FAST HEALTHCARE INTEROPERABILITY RESOURCES	New Supporting Information
FIRST CONTACT PRACTITIONER	New Supporting Information
LAST PATIENT CANCELLED DATE	New Supporting Information
LAST PATIENT DID NOT ATTEND DATE	New Supporting Information
MAIN SPECIALTY AND TREATMENT FUNCTION CODES TABLE	Changed Description
NHS ALLIED HEALTH PROFESSIONAL SERVICE (REFERRAL TO TREATMENT MEASUREMENT)	Changed Description
NHS AT HOME SERVICE	New Supporting Information
PATIENT INITIATED OUT-PATIENT FOLLOW UP APPOINTMENT	New Supporting Information
PATIENT INITIATED OUT-PATIENT FOLLOW-UP PATHWAY	New Supporting Information
PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY	New Supporting Information
PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE	New Supporting Information
PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY REVIEW DATE	New Supporting Information
REFERRAL TO TREATMENT CLOCK STOP ADMINISTRATIVE EVENT	Changed Description
REMOTE MONITORING	New Supporting Information
REMOTE MONITORING TRIGGERED OUT-PATIENT FOLLOW UP APPOINTMENT	New Supporting Information
SECURITY ISSUES AND PATIENT CONFIDENTIALITY	Changed Description
SUPPORTING DEFINITIONS MENU	Changed Description
TIMED OUT-PATIENT FOLLOW UP APPOINTMENT	New Supporting Information

Class Definitions

ACTIVITY GROUP	Changed Attributes
ALLIED HEALTH PROFESSIONAL	New Class
APPOINTMENT	Changed Attributes
CARE PROFESSIONAL TEAM	Changed Attributes

CLINICAL INTERVENTION	Changed Attributes
CODED CLINICAL ENTRY	Changed Relationships, Description, Attributes
NHS SERVICE AGREEMENT	Changed Attributes
NHS SERVICE AGREEMENT LINE	Changed Attributes
PATIENT PATHWAY	Changed Attributes
PERSON PROPERTY ASSIGNMENT PERIOD	Changed Attributes
SERVICE PROVIDED UNDER AGREEMENT	Changed Attributes
SERVICE REQUEST	Changed Attributes
WARD OPERATIONAL PLAN	Changed Description, Attributes

Attribute Definitions

ACTIVITY DATE TYPE	Changed Description
ACTIVITY GROUP TYPE	Changed Description
ACTIVITY LOCATION TYPE CODE	Changed Description
AGE GROUP INTENDED	Changed Description
APPOINTMENT BOOKED REASON	New Attribute
CARE CONTACT TYPE	Changed Description
CARE PROFESSIONAL TYPE	Changed Description
CDS BULK REPLACEMENT GROUP CODE	Changed Description
CDS MESSAGE VERSION NUMBER	Changed Description
CDS TYPE CODE	Changed Description
CDS UPDATE TYPE	Changed Description
CLINICAL CARE INTENSITY	Changed Description
CLINICAL INTERVENTION TYPE	Changed Description
COMMISSIONER REFERENCE IDENTIFIER	New Attribute
COMMISSIONER REFERENCE NUMBER	Changed Description
CRITICAL CARE ACTIVITY CODE	Changed Description
CRITICAL CARE UNIT FUNCTION	Changed Description
DATA ABSENT REASON	New Attribute
DISCHARGED TO NHS AT HOME SERVICE INDICATOR	New Attribute
EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR	New Attribute
NHS SERVICE AGREEMENT IDENTIFIER	New Attribute
NHS SERVICE AGREEMENT LINE IDENTIFIER	New Attribute
NHS SERVICE AGREEMENT LINE NUMBER	Changed Description
NHS SERVICE AGREEMENT NUMBER	Changed Description
OUT-PATIENT ATTENDANCE OUTCOME	New Attribute
PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR	New Attribute
PATIENT SUBJECT TO REMOTE MONITORING INDICATOR	New Attribute
PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE	New Attribute
PERSON PROPERTY ASSIGNMENT PERIOD DURATION	New Attribute
PERSON PROPERTY ASSIGNMENT PERIOD TYPE	Changed Description
PLANNED ACTIVITY DATE TYPE	Changed Description
PRESENT ON ADMISSION INDICATOR	Changed Description
PROVIDER REFERENCE IDENTIFIER	New Attribute
PROVIDER REFERENCE NUMBER	Changed Description

REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR	New Attribute
RESPONSIBLE CARE PROFESSIONAL INDICATOR	New Attribute
SEX OF PATIENTS	Changed Description
WARD DAY PERIOD AVAILABILITY	Changed Description
WARD INTENDED AGE GROUP	New Attribute
WARD INTENDED CLINICAL CARE INTENSITY	New Attribute
WARD INTENDED DAY PERIOD AVAILABILITY	New Attribute
WARD INTENDED NIGHT PERIOD AVAILABILITY	New Attribute
WARD INTENDED SEX OF PATIENTS	New Attribute
WARD NIGHT PERIOD AVAILABILITY	Changed Description

Data Elements

ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY CODE	Changed Description
ANAESTHETIC GIVEN POST LABOUR OR DELIVERY CODE	Changed Description
APPOINTMENT BOOKED REASON	New Data Element
APPOINTMENT DATE	Changed Description
ATTENDANCE STATUS	Changed Description
CDS ACTIVITY DATE	Changed Description
CDS BULK REPLACEMENT GROUP CODE	Changed Description
CDS INTERCHANGE CONTROL REFERENCE	Changed Description
CDS MESSAGE REFERENCE	Changed Description
CDS PRIME RECIPIENT IDENTITY	Changed Description
CDS RECORD IDENTIFIER	Changed Description
CDS UNIQUE IDENTIFIER	Changed Description
COMMISSIONER REFERENCE IDENTIFIER	New Data Element
COMMISSIONER REFERENCE NUMBER	Changed Description, linked Attribute
COMMISSIONING SERIAL NUMBER	Changed Description
CONSULTATION MECHANISM	New Data Element
CONSULTATION MEDIUM USED	Changed Description
CRITICAL CARE LEVEL	New Data Element
DATA ABSENT REASON (FHIR R4)	New Data Element
DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET)	New Data Element
DISCHARGED TO NHS AT HOME SERVICE INDICATOR	New Data Element
EMED3 FIT NOTE ASSESSMENT DATE	New Data Element
EMED3 FIT NOTE CONDITION (SNOMED CT EXPRESSION)	New Data Element
EMED3 FIT NOTE DIAGNOSIS (ICD)	New Data Element
EMED3 FIT NOTE DURATION	New Data Element
EMED3 FIT NOTE END DATE	New Data Element
EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR	New Data Element
EMED3 FIT NOTE RECORDED DATE	New Data Element
EMED3 FIT NOTE START DATE	New Data Element
LAST PATIENT CANCELLED DATE	New Data Element
LAST PATIENT DID NOT ATTEND DATE	New Data Element
LATEST CLINICALLY APPROPRIATE DATE	New Data Element
MULTI-PROFESSIONAL OR MULTI-DISCIPLINARY INDICATION CODE (NATIONAL TARIFF PAYMENT SYSTEM)	New Data Element
NHS SERVICE AGREEMENT IDENTIFIER	New Data Element

NHS SERVICE AGREEMENT LINE IDENTIFIER	New Data Element
NHS SERVICE AGREEMENT LINE NUMBER	Changed Description
ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	Changed Description
ORGAN SYSTEM SUPPORTED	New Data Element
OUTPATIENT ATTENDANCE IDENTIFIER	Changed Description
OUT-PATIENT ATTENDANCE OUTCOME	New Data Element
PATIENT FAMILY NAME	New Data Element
PATIENT FULL NAME	New Data Element
PATIENT GIVEN NAME	New Data Element
PATIENT INITIALS	New Data Element
PATIENT NAME SUFFIX	New Data Element
PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR AT CDS ACTIVITY DATE	New Data Element
PATIENT PATHWAY IDENTIFIER	Changed Description
PATIENT SUBJECT TO REMOTE MONITORING INDICATOR AT CDS ACTIVITY DATE	New Data Element
PATIENT TITLE	New Data Element
PATIENT USUAL ADDRESS (STRUCTURED (BABY))	New Data Element
PATIENT USUAL ADDRESS (STRUCTURED (MOTHER))	New Data Element
PATIENT USUAL ADDRESS (STRUCTURED)	New Data Element
PATIENT USUAL ADDRESS (UNSTRUCTURED (BABY))	New Data Element
PATIENT USUAL ADDRESS (UNSTRUCTURED (MOTHER))	New Data Element
PATIENT USUAL ADDRESS (UNSTRUCTURED)	New Data Element
PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE	New Data Element
PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY REVIEW DATE	New Data Element
PRESENT ON ADMISSION INDICATOR	Changed Description
PROCEDURE SCHEME IN USE (COMMISSIONING DATA SET)	New Data Element
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)	Changed Description
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)	Changed Description
PROFESSIONAL REGISTRATION ISSUER CODE	Changed Description
PROVIDER REFERENCE IDENTIFIER	New Data Element
PROVIDER REFERENCE NUMBER	Changed Description
REFERRAL TO TREATMENT PERIOD END DATE	Changed Description
REFERRAL TO TREATMENT PERIOD START DATE	Changed Description
REFERRAL TO TREATMENT PERIOD STATUS	Changed Description
REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR	New Data Element
RESPONSIBLE CARE PROFESSIONAL INDICATOR	New Data Element
SEX OF PATIENTS CODE	Changed Description
UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	Changed Description
WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)	New Data Element
WARD INTENDED AGE GROUP	New Data Element
WARD INTENDED CLINICAL CARE INTENSITY	New Data Element
WARD INTENDED DAY PERIOD AVAILABILITY	New Data Element
WARD INTENDED NIGHT PERIOD AVAILABILITY	New Data Element
WARD INTENDED SEX OF PATIENTS	New Data Element

XML Schema Constraint

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

Date: 14 June 2021

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

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

CDS V6-3 TYPE 001 - CDS INTERCHANGE HEADER

Change to Data Set: New Data Set

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

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

CDS V6-3 TYPE 002 - CDS INTERCHANGE TRAILER

Change to Data Set: New Data Set

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

M	1..1	Data Element Components			Rules
		M	1..1	CDS INTERCHANGE CONTROL REFERENCE	F S8
		M	1..1	CDS INTERCHANGE CONTROL COUNT	F S8
		O	0..1	CDS INTERCHANGE SENDER IDENTITY	F
		O	0..1	CDS INTERCHANGE RECEIVER IDENTITY	F

CDS V6-3 TYPE 003 - CDS MESSAGE HEADER

Change to Data Set: New Data Set

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

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

CDS V6-3 TYPE 004 - CDS MESSAGE TRAILER

Change to Data Set: New Data Set

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

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

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

Change to Data Set: New Data Set

Notation		DATA GROUP: CDS V6-3 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL

Group Status	Group Repeats	FUNCTION:
M	1..1	To carry the details of the mandatory Commissioning Data Set Submission Protocol controls for when using the Bulk Update mechanism. One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

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

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

Change to Data Set: New Data Set

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

M	**1..1**	**Data Element Components**			**Rules**
		M	**1..1**	CDS TYPE CODE	V
		M	**1..1**	CDS PROTOCOL IDENTIFIER CODE	V
		M	**1..1**	CDS UNIQUE IDENTIFIER	F S9
		M	**1..1**	CDS UPDATE TYPE	V
		M	**1..1**	CDS APPLICABLE DATE	

					F S8 S13
		M	1..1	CDS APPLICABLE TIME	F S8 S14
		M	1..1	CDS ACTIVITY DATE	F S6 S13
		M	1..1	ORGANISATION IDENTIFIER (CDS SENDER)	F S5
		O	0..7	ORGANISATION IDENTIFIER (CDS RECIPIENT)	F S5

CDS V6-3 TYPE 020 - OUTPATIENT CDS

Change to Data Set: New Data Set

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

Notation		DATA GROUP: CDS V6-3 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER
Group Status	Group Repeats	FUNCTION: 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	DATA GROUP: CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol One per Commissioning Data Set record submitted to the Secondary Uses Service.

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

OR

Notation		DATA GROUP: CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL
Group Status	Group Repeats	FUNCTION: To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of one of the Net Change Update Mechanism of the Commissioning Data Set Submission Protocol.
M	1..1	DATA GROUP: CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol 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 R	Group Repeats 0..1	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.		
M	1..1	DATA GROUP: PATIENT PATHWAY IDENTITY		Rules
	M *Or* M	1..1 1..1	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) *Or* PATIENT PATHWAY IDENTIFIER	F F I2
	M	1..1	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	F I2
M	1..1	DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS		Rules
	M	1..1	REFERRAL TO TREATMENT PERIOD STATUS	V
	M	1..1	WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)	V
	O	0..1	REFERRAL TO TREATMENT PERIOD START DATE	F S13
	O	0..1	REFERRAL TO TREATMENT PERIOD END DATE	F S13

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

One of the following DATA GROUPS must be used:

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

OR

1..1		

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

OR

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

					Rules
					F S3 S12

Notation	DATA GROUP: PATIENT CHARACTERISTICS
Group Status: R / Group Repeats: 0..1	FUNCTION: To carry the characteristics of the Patient.

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

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

One of the following DATA GROUPS may be used:

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

OR

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

Notation	DATA GROUP: CARE EPISODE - PERSON GROUP (CARE PROFESSIONAL)
Group Status: R / Group Repeats: 0..*	FUNCTION: To carry the details of the Care Professionals active during the Care Attendance.

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

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

M	1..1	Data Element Components			Rules
		M	1..1	DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET)	V

M	1..1	DATA GROUP: PRIMARY DIAGNOSIS			Rules
		M	1..1	PRIMARY DIAGNOSIS (ICD)	F
O	0..*	DATA GROUP: SECONDARY DIAGNOSES			Rules
		M	1..1	SECONDARY DIAGNOSIS (ICD)	F

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

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

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

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

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

M	1..1	Data Element Components			Rules
		M	1..1	ORGANISATION IDENTIFIER (CODE OF PROVIDER)	F

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

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

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

Notation		DATA GROUP: CARE ATTENDANCE - PROCEDURE GROUP (SNOMED CT)

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

One of the following DATA GROUPS may be used:

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

OR

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

Notation	DATA GROUP: CARE ATTENDANCE - OBSERVATION GROUP (SNOMED CT)

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

One of the following DATA GROUPS may be used:

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

OR

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

Notation	DATA GROUP: CARE ATTENDANCE - FINDING GROUP (SNOMED CT)

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

One of the following DATA GROUPS may be used:

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

OR

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

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

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

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

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

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

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

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

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

Notation		DATA GROUP: CARE REFERRAL - MISSED APPOINTMENT OCCURRENCE
Group Status	Group Repeats	FUNCTION: To carry the details of a Missed Appointment.
R	0..1	

M	1..1	Data Element Components			Rules
		R	0..1	LAST PATIENT DID NOT ATTEND DATE	F S13
		R	0..1	LAST PATIENT CANCELLED DATE	F S13

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

Notation		DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER
Group Status	Group Repeats	FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.
M	1..1	DATA GROUP: CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer 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 120 - ADMITTED PATIENT CARE - FINISHED BIRTH EPISODE CDS

Change to Data Set: New Data Set

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

Notation		DATA GROUP: CDS V6-3 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER
Group Status	Group Repeats	FUNCTION: 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	DATA GROUP: CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

OR

Notation		DATA GROUP: CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL
Group Status	Group Repeats	FUNCTION: To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of one of the Net Change Update Mechanism of the Commissioning Data Set Submission Protocol.
M	1..1	DATA GROUP: CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol 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 O	Group Repeats 0..1			FUNCTION: To carry the details of the Patient Pathway.	
M	1..1			DATA GROUP: PATIENT PATHWAY IDENTITY	Rules
		M *Or* M	1..1 1..1	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) *Or* PATIENT PATHWAY IDENTIFIER	F F I2
		M	1..1	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	F I2
M	1..1			DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS	Rules
		M	1..1	REFERRAL TO TREATMENT PERIOD STATUS	V
		M	1..1	WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)	V
		O	0..1	REFERRAL TO TREATMENT PERIOD START DATE	F S13
		O	0..1	REFERRAL TO TREATMENT PERIOD END DATE	F S13

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

One of the following DATA GROUPS must be used:

1..1	**DATA GROUP: WITHHELD IDENTITY STRUCTURE** **Must be used where the Commissioning Data Set record has been anonymised**				
M	**1..1**	**Data Element Components**			**Rules**
		M	**1..1**	NHS NUMBER STATUS INDICATOR CODE	V
		R	0..1	PERSON BIRTH DATE	F S3 S12
		R	0..1	WITHHELD IDENTITY REASON	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			**Rules**
		M	**1..1**	LOCAL PATIENT IDENTIFIER (EXTENDED)	F S3
		M	**1..1**	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	F
M	**1..1**	**Data Element Components**			**Rules**
		M	**1..1**	NHS NUMBER	F S3
		M	**1..1**	NHS NUMBER STATUS INDICATOR CODE	V
		R	0..1	PERSON BIRTH DATE	F S3 S12

OR

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

		O and O	0..1 and 0..1	PATIENT NAME SUFFIX and PATIENT INITIALS	
M	1..1	Data Element Components			Rules
		R	0..1	PERSON BIRTH DATE	F S3 S12

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

M	1..1	Data Element Components			Rules
		R	0..1	PERSON PHENOTYPIC SEX	V H4
		R	0..1	ETHNIC CATEGORY	V
		X	0..1	ETHNIC CATEGORY 2021	N2
		R	0..1	LIVE OR STILL BIRTH CODE	V
		R	0..1	BIRTH WEIGHT	F

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

One of the following DATA GROUPS may be used:

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

OR

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

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

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

					Rules
					F H4 S13
		O	0..1	START TIME (HOSPITAL PROVIDER SPELL)	F S14
		M	**1..1**	AGE ON ADMISSION	F H4

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

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

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

M	1..1	Data Element Components			Rules
		R	0..1	EPISODE NUMBER	F H4
		R	0..1	LAST EPISODE IN SPELL INDICATOR CODE	V
		R	0..1	NEONATAL LEVEL OF CARE CODE	V H4
		M	**1..1**	START DATE (EPISODE)	F H4 S13
		O	0..1	START TIME (EPISODE)	F S14
		M	**1..1**	END DATE (EPISODE)	F H4 S1 S13
		O	0..1	END TIME (EPISODE)	F S14
		M	**1..1**	AGE AT CDS ACTIVITY DATE	F H4

Notation	DATA GROUP: BIRTH EPISODE- OVERSEAS VISITOR CHARGING CATEGORY

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

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

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

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

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

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

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

M	1..1	Data Element Components			Rules

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

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

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

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

Notation	DATA GROUP: LOCATION GROUP (AT WARD STAY)

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

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

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

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

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

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

					Rules
					F S13
		R	0..1	END TIME (HOME LEAVE)	F S14

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

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

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

M	**1..1**	**DATA GROUP: PAEDIATRIC CRITICAL CARE - ADMISSION CHARACTERISTICS**			**Rules**
		M	**1..1**	CRITICAL CARE LOCAL IDENTIFIER	F
		M	**1..1**	CRITICAL CARE START DATE	F H4 S13
		M	**1..1**	CRITICAL CARE START TIME	F S14
		M	**1..1**	CRITICAL CARE UNIT FUNCTION	V H4
M	**1..999**	**DATA GROUP: PAEDIATRIC DAILY CARE - ACTIVITY CHARACTERISTICS**			**Rules**

		M	**1..1**	ACTIVITY DATE (CRITICAL CARE)	F S13
		M	**1..20**	CRITICAL CARE ACTIVITY CODE	F N4
		R	0..20	HIGH COST DRUGS (OPCS)	F N4
R	0..1	DATA GROUP: PAEDIATRIC CRITICAL CARE - DISCHARGE CHARACTERISTICS			**Rules**
		M	**1..1**	CRITICAL CARE DISCHARGE DATE	F H4 S13
		M	**1..1**	CRITICAL CARE DISCHARGE TIME	F S14

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

					Rules
		R	0..1	CRITICAL CARE LEVEL 2 DAYS	F H4
		R	0..1	CRITICAL CARE LEVEL 3 DAYS	F H4
R	0..*	DATA GROUP: ADULT CRITICAL CARE - DAILY CARE ACTIVITY CHARACTERISTICS			**Rules**
		M	**1..1**	ACTIVITY DATE (CRITICAL CARE)	F S13
		M	**1..9**	ORGAN SYSTEM SUPPORTED	V
		M	**1..1**	CRITICAL CARE LEVEL	V
R	0..1	DATA GROUP: ADULT CRITICAL CARE - DISCHARGE CHARACTERISTICS			**Rules**
		M	**1..1**	CRITICAL CARE DISCHARGE DATE	F H4 S13
		M	**1..1**	CRITICAL CARE DISCHARGE TIME	F S14
		O	0..1	CRITICAL CARE DISCHARGE READY DATE	F S13
		O	0..1	CRITICAL CARE DISCHARGE READY TIME	F S14
		O	0..1	CRITICAL CARE DISCHARGE STATUS	V
		O	0..1	CRITICAL CARE DISCHARGE DESTINATION	V
		O	0..1	CRITICAL CARE DISCHARGE LOCATION	V

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

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

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

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

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

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

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

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

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

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

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

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

Notation	DATA GROUP: LABOUR/DELIVERY - ACTIVITY CHARACTERISTICS

Group Status	Group Repeats	FUNCTION:
R	0..1	To carry the details of the Labour/Delivery.

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

Notation	DATA GROUP: DELIVERY OCCURRENCE - ACTIVITY CHARACTERISTICS

Group Status	Group Repeats	FUNCTION:
R	0..1	To carry the details of the Delivery of the Baby.

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

Notation	DATA GROUP: PERSON IDENTITY (MOTHER)

Group Status	Group Repeats	FUNCTION:
M	1..1	To carry the Identity details of the Baby's mother. See Note: S3 in Commissioning Data Set Business Rules.

One of the following DATA GROUPS must be used:

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

OR

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

OR

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

					F S3 S12

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

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

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

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

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

Notation		DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER
Group Status	Group Repeats	FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.
M	1..1	DATA GROUP: CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer 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 130 - ADMITTED PATIENT CARE - FINISHED GENERAL EPISODE CDS

Change to Data Set: New Data Set

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

Notation		DATA GROUP: CDS V6-3 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER
Group Status	Group Repeats	

		FUNCTION: 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..***	**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**	**DATA GROUP: CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol** One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

OR

Notation		DATA GROUP: CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL
Group Status	Group Repeats	FUNCTION: To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of one of the Net Change Update Mechanism of the Commissioning Data Set Submission Protocol.
M	**1..1**	**DATA GROUP: CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol** 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 R	Group Repeats 0..1	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.	
M	**1..1**	**DATA GROUP: PATIENT PATHWAY IDENTITY**	**Rules**
M *Or* **M**	**1..1** **1..1**	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) *Or* PATIENT PATHWAY IDENTIFIER	F F I2

	M	1..1	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	F I2
M	**1..1**	**DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS**		**Rules**
	M	**1..1**	REFERRAL TO TREATMENT PERIOD STATUS	V
	M	**1..1**	WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)	V
	O	0..1	REFERRAL TO TREATMENT PERIOD START DATE	F S13
	O	0..1	REFERRAL TO TREATMENT PERIOD END DATE	F S13

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

One of the following DATA GROUPS must be used:

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

OR

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

OR

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

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

Notation		DATA GROUP: PATIENT CHARACTERISTICS			
Group Status R	Group Repeats 0..1	FUNCTION: To carry the characteristics of the Patient.			
M	**1..1**	**Data Element Components**			**Rules**
		R	0..1	PERSON STATED GENDER CODE	V H4
		O	0..1	CARER SUPPORT INDICATOR	V
		R	0..1	ETHNIC CATEGORY	V
		X	0..1	ETHNIC CATEGORY 2021	N2
		R	0..1	PERSON MARITAL STATUS	V N1
		R	0..1	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)	F N1

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

One of the following DATA GROUPS may be used:

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

		M	1..1	SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP	F

OR

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

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

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

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

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

Notation	DATA GROUP: CARE EPISODE - ACTIVITY CHARACTERISTICS

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

M	1..1	Data Element Components			Rules
		R	0..1	EPISODE NUMBER	F H4
		R	0..1	LAST EPISODE IN SPELL INDICATOR CODE	V
		R	0..1	NEONATAL LEVEL OF CARE CODE	V H4
		O	0..1	FIRST REGULAR DAY OR NIGHT ADMISSION CODE	V
		R	0..1	PSYCHIATRIC PATIENT STATUS CODE	V
		M	**1..1**	START DATE (EPISODE)	F S13
		O	0..1	START TIME (EPISODE)	F S14
		M	**1..1**	END DATE (EPISODE)	F H4 S1 S13
		O	0..1	END TIME (EPISODE)	F S14
		M	**1..1**	AGE AT CDS ACTIVITY DATE	F H4 S8
		O	0..1	REHABILITATION ASSESSMENT TEAM TYPE	V N3

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

M	1..1	Data Element Components			Rules
		R	0..1	LENGTH OF STAY ADJUSTMENT (REHABILITATION)	F H4
		R	0..1	LENGTH OF STAY ADJUSTMENT (SPECIALIST PALLIATIVE CARE)	F H4

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

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

Notation	DATA GROUP: CARE EPISODE - SERVICE AGREEMENT DETAILS

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

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

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

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

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

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

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

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

One of the following DATA GROUPS may be used:

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

OR

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

Notation	DATA GROUP: CARE EPISODE - EMED3 FIT NOTE

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

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

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

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

					Rules
M	**1..1**	**Data Element Components**			
		M	**1..1**	PROCEDURE SCHEME IN USE (COMMISSIONING DATA SET)	V

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

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

		O	0..1	WARD INTENDED SEX OF PATIENTS	V
		O	0..1	WARD INTENDED DAY PERIOD AVAILABILITY	V
		O	0..1	WARD INTENDED NIGHT PERIOD AVAILABILITY	V
		O	0..1	WARD SECURITY LEVEL	V
		O	0..1	WARD CODE	F

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

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

Notation		DATA GROUP: LOCATION GROUP - HOME LEAVE

Group Status	Group Repeats	FUNCTION:
R	0..*	To carry the details of each separate period of Home Leave within the Finished General Care Professional Admitted Care Episode.

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

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

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

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

M	1..1	DATA GROUP: PAEDIATRIC CRITICAL CARE - ADMISSION CHARACTERISTICS			Rules
		M	1..1	CRITICAL CARE LOCAL IDENTIFIER	F

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

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

M	**1..1**	**DATA GROUP: ADULT CRITICAL CARE - ADMISSION CHARACTERISTICS**			**Rules**
		M	**1..1**	CRITICAL CARE LOCAL IDENTIFIER	F
		M	**1..1**	CRITICAL CARE START DATE	F H4 S13
		O	0..1	CRITICAL CARE START TIME	F S14
		M	**1..1**	CRITICAL CARE UNIT FUNCTION	V H4
		O	0..1	CRITICAL CARE UNIT BED CONFIGURATION	V
		O	0..1	CRITICAL CARE ADMISSION SOURCE	V
		O	0..1	CRITICAL CARE SOURCE LOCATION	V
		O	0..1	CRITICAL CARE ADMISSION TYPE	V
M	**1..1**	**DATA GROUP: ADULT CRITICAL CARE - ACTIVITY CHARACTERISTICS**			**Rules**
		R	0..1	ADVANCED RESPIRATORY SUPPORT DAYS	F H4
		R	0..1	BASIC RESPIRATORY SUPPORT DAYS	F H4
		R	0..1	ADVANCED CARDIOVASCULAR SUPPORT DAYS	F H4
		R	0..1	BASIC CARDIOVASCULAR SUPPORT DAYS	F H4
		R	0..1	RENAL SUPPORT DAYS	F H4

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

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

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

Notation	**DATA GROUP: REFERRAL**

Group Status	Group Repeats	FUNCTION: To carry the details of the Referral.
O	0..1	

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

Notation	DATA GROUP: ELECTIVE ADMISSION LIST ENTRY

Group Status	Group Repeats	FUNCTION: To carry the details of the Elective Admission List Entry.
R	0..1	

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

Notation	DATA GROUP: CDS V6-3 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER

Group Status	Group Repeats	FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.

M	1..*	DATA GROUP: CDS V6-3 Type 004 - Commissioning Data Set Message Trailer 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.

Notation	DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER

Group Status	Group Repeats	FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.

M	1..1	DATA GROUP: CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer One per Interchange submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

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

Change to Data Set: New Data Set

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

Notation	DATA GROUP: CDS V6-3 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER

Group Status	Group Repeats	FUNCTION: 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..*	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	DATA GROUP: CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

OR

Notation		DATA GROUP: CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL
Group Status	Group Repeats	FUNCTION: To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of one of the Net Change Update Mechanism of the Commissioning Data Set Submission Protocol.
M	1..1	DATA GROUP: CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol 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 O	Group Repeats 0..1			FUNCTION: To carry the details of the Patient Pathway.	
M	1..1			DATA GROUP: PATIENT PATHWAY IDENTITY	Rules
		M *Or* M	1..1 1..1	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) *Or* PATIENT PATHWAY IDENTIFIER	F F
		M	1..1	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	F I2

M	1..1	DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS			Rules
		M	1..1	REFERRAL TO TREATMENT PERIOD STATUS	V
		M	1..1	WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)	V
		O	0..1	REFERRAL TO TREATMENT PERIOD START DATE	F S13
		O	0..1	REFERRAL TO TREATMENT PERIOD END DATE	F S13

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

One of the following DATA GROUPS must be used:

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

OR

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

OR

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

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

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

Notation		DATA GROUP: DELIVERY CHARACTERISTICS			
Group Status	Group Repeats	**FUNCTION:** **To carry the delivery characteristics of the Patient (the Mother).**			
R	**0..1**				
M	**1..1**	**Data Element Components**			**Rules**
		R	0..1	NUMBER OF PREVIOUS PREGNANCIES RESULTING IN REGISTRABLE BIRTH	V

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

Group Status	Group Repeats	
R	0..*	

One of the following DATA GROUPS may be used:

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

OR

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

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

Notation		DATA GROUP: HOSPITAL PROVIDER SPELL - DISCHARGE CHARACTERISTICS
Group Status	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	Data Element Components			Rules
		R	0..1	DESTINATION OF DISCHARGE (HOSPITAL PROVIDER SPELL)	V H4
		R	0..1	METHOD OF DISCHARGE (HOSPITAL PROVIDER SPELL)	V H4
		R	0..1	DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL)	F S13
		R	0..1	DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	F S13

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

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

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

Notation		DATA GROUP: DELIVERY EPISODE - SERVICE AGREEMENT DETAILS			
Group Status M	Group Repeats 1..1	FUNCTION: To carry the details of the Provider, Commissioners and Service Agreements.			
M	**1..1**	**Data Element Components**			**Rules**
		M	**1..1**	ORGANISATION IDENTIFIER (CODE OF PROVIDER)	F
M	**1..***	**DATA GROUP: COMMISSIONERS**			**Rules**
		M	**1..1**	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	F

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

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

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

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

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

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

One of the following DATA GROUPS may be used:

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

OR

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

Notation	DATA GROUP: DELIVERY EPISODE - FINDING GROUP (SNOMED CT)

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

One of the following DATA GROUPS may be used:

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

OR

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

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

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

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

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

		O	0..1	WARD SECURITY LEVEL	V
		O	0..1	WARD CODE	F

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

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

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

		M	1..20	CRITICAL CARE ACTIVITY CODE	F N4
		R	0..20	HIGH COST DRUGS (OPCS)	F N4

R	0..1	DATA GROUP: PAEDIATRIC CRITICAL CARE - DISCHARGE CHARACTERISTICS			Rules
		M	1..1	CRITICAL CARE DISCHARGE DATE	F H4 S13
		M	1..1	CRITICAL CARE DISCHARGE TIME	F S14

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

		R	0..1	CRITICAL CARE LEVEL 3 DAYS	F H4
R	0..*	DATA GROUP: ADULT CRITICAL CARE - DAILY CARE ACTIVITY CHARACTERISTICS			Rules
		M	**1..1**	ACTIVITY DATE (CRITICAL CARE)	F S13
		M	**1..9**	ORGAN SYSTEM SUPPORTED	V
		M	**1..1**	CRITICAL CARE LEVEL	V
R	0..1	DATA GROUP: ADULT CRITICAL CARE - DISCHARGE CHARACTERISTICS			Rules
		M	**1..1**	CRITICAL CARE DISCHARGE DATE	F H4 S13
		M	**1..1**	CRITICAL CARE DISCHARGE TIME	F S14
		O	0..1	CRITICAL CARE DISCHARGE READY DATE	F S13
		O	0..1	CRITICAL CARE DISCHARGE READY TIME	F S14
		O	0..1	CRITICAL CARE DISCHARGE STATUS	V
		O	0..1	CRITICAL CARE DISCHARGE DESTINATION	V
		O	0..1	CRITICAL CARE DISCHARGE LOCATION	V

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

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

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

Notation		**DATA GROUP: ANTENATAL CARE - ACTIVITY CHARACTERISTICS**
		FUNCTION: To carry the details of the Antenatal Care.

Group Status	Group Repeats	
R	0..1	

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

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

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

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

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

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

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

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

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

Notation	DATA GROUP: PERSON IDENTITY (BABY)

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

One of the following DATA GROUPS must be used:

					Rules
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**			**Rules**
		M	**1..1**	NHS NUMBER STATUS INDICATOR CODE (BABY)	V
		R	0..1	PERSON BIRTH DATE (BABY)	F S3 S12
		R	0..1	WITHHELD IDENTITY REASON	V

OR

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

OR

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

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

			Rules
M	**1..1**	**Data Element Components**	**Rules**

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

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

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

Notation		DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER
Group Status	Group Repeats	FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.
M	1..1	DATA GROUP: CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer 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 150 - ADMITTED PATIENT CARE - OTHER BIRTH EVENT CDS

Change to Data Set: New Data Set

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

Notation		DATA GROUP: CDS V6-3 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER
Group Status	Group Repeats	FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.
M	1..1	DATA GROUP: CDS V6-3 Type 001 - Commissioning Data Set Interchange Header 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..*	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	DATA GROUP: CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

OR

Notation		DATA GROUP: CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL
Group Status	Group Repeats	FUNCTION: To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of one of the Net Change Update Mechanism of the Commissioning Data Set Submission Protocol.
M	1..1	DATA GROUP: CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol 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 O	Group Repeats 0..1			FUNCTION: To carry the details of the Patient Pathway.	
M	1..1			DATA GROUP: PATIENT PATHWAY IDENTITY	Rules
		M *Or* M	1..1 1..1	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) *Or* PATIENT PATHWAY IDENTIFIER	F F I2
		M	1..1	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	F I2
M	1..1			DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS	Rules
		M	1..1	REFERRAL TO TREATMENT PERIOD STATUS	V
		M	1..1	WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)	V
		O	0..1	REFERRAL TO TREATMENT PERIOD START DATE	F S13
		O	0..1	REFERRAL TO TREATMENT PERIOD END DATE	F S13

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

One of the following DATA GROUPS must be used:

					Rules
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**			**Rules**
		M	**1..1**	NHS NUMBER STATUS INDICATOR CODE	V
		R	0..1	PERSON BIRTH DATE	F S3 S12
		R	0..1	WITHHELD IDENTITY REASON	V

OR

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

OR

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

		O and O	0..1 and 0..1	PATIENT NAME SUFFIX and PATIENT INITIALS	
M	**1..1**	**Data Element Components**			**Rules**
		R	0..1	PERSON BIRTH DATE	F S3 S12

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

M	**1..1**	**Data Element Components**			**Rules**
		R	0..1	PERSON PHENOTYPIC SEX	V H4
		R	0..1	ETHNIC CATEGORY	V
		X	0..1	ETHNIC CATEGORY 2021	N2
		R	0..1	LIVE OR STILL BIRTH CODE	V
		R	0..1	BIRTH WEIGHT	F

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

Notation		**DATA GROUP: BIRTH EPISODE - COMORBIDITY (SNOMED CT)**

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

Notation	DATA GROUP: BIRTH EPISODE - FINDING GROUP (SNOMED CT)

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

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

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

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

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

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

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

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

Notation		DATA GROUP: LABOUR/DELIVERY - ACTIVITY CHARACTERISTICS			
Group Status M	Group Repeats 1..1	FUNCTION: To carry the details of the Labour/Delivery.			
M	1..1	Data Element Components			Rules
		R	0..1	ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY CODE	V
		R	0..1	ANAESTHETIC GIVEN POST LABOUR OR DELIVERY CODE	V
		O	0..1	GESTATION LENGTH (LABOUR ONSET)	F
		R	0..1	LABOUR OR DELIVERY ONSET METHOD CODE	V
		M	**1..1**	DELIVERY TIMESTAMP	F S1 S13
		M	**1..1**	AGE AT CDS ACTIVITY DATE	F H4
		R	0..1	OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE	V

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

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

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

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

One of the following DATA GROUPS must be used:

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

OR

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

OR

1..1	**DATA GROUP: UNVERIFIED IDENTITY STRUCTURE** **Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE (MOTHER) NOT included in the above**	

O	0..1	DATA GROUP: LOCAL IDENTIFIER STRUCTURE			Rules
		M	1..1	LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER))	F S3
		M	1..1	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER))	F
M	**1..1**	**Data Element Components**			Rules
		R	0..1	NHS NUMBER (MOTHER)	F S3
		M	**1..1**	NHS NUMBER STATUS INDICATOR CODE (MOTHER)	V
O	0..1	Data Element Components			Rules
		M OR **M**	**1..1** OR **2..5**	PATIENT USUAL ADDRESS (UNSTRUCTURED (MOTHER)) **OR** PATIENT USUAL ADDRESS (STRUCTURED (MOTHER))	F S3 I5
M	**1..1**	**Data Element Components**			Rules
		R	0..1	POSTCODE OF USUAL ADDRESS (MOTHER)	F S3
		R	0..1	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	F
		R	0..1	PERSON BIRTH DATE (MOTHER)	F S3 S12

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

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

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

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

M	1..1	DATA GROUP: CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer 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: New Data Set

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

Notation		DATA GROUP: CDS V6-3 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER
Group Status	Group Repeats	FUNCTION: 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..*	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	DATA GROUP: CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

OR

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

		DATA GROUP: CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol 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**			**Rules**
		M *Or* **M**	**1..1** **1..1**	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) *Or* PATIENT PATHWAY IDENTIFIER	F F I2
		M	**1..1**	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	F I2
M	**1..1**	**DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS**			**Rules**
		M	**1..1**	REFERRAL TO TREATMENT PERIOD STATUS	V
		M	**1..1**	WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)	V
		O	0..1	REFERRAL TO TREATMENT PERIOD START DATE	F S13
		O	0..1	REFERRAL TO TREATMENT PERIOD END DATE	F S13

Notation		DATA GROUP: PATIENT IDENTITY (MOTHER)
Group Status	Group Repeats	FUNCTION: To carry the Identity of the Patient (the Mother). 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**			**Rules**
		M	**1..1**	NHS NUMBER STATUS INDICATOR CODE	V
		R	0..1	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	F
		R	0..1	WITHHELD IDENTITY REASON	V

OR

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

					Rules
					F S3
		R	0..1	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	F
		R	0..1	PERSON BIRTH DATE	F S3 S12

OR

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

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

M	**1..1**	**Data Element Components**			**Rules**
		R	0..1	PERSON STATED GENDER CODE	V H4
		O	0..1	CARER SUPPORT INDICATOR	V

		R	0..1	ETHNIC CATEGORY	V
		X	0..1	ETHNIC CATEGORY 2021	N2
		R	0..1	PERSON MARITAL STATUS	V

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

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

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

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

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

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

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

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

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

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

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

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

Notation	DATA GROUP: LABOUR/DELIVERY - ACTIVITY CHARACTERISTICS

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

M	1..1			Data Element Components	Rules
		R	0..1	ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY CODE	V
		R	0..1	ANAESTHETIC GIVEN POST LABOUR OR DELIVERY CODE	V
		O	0..1	GESTATION LENGTH (LABOUR ONSET)	F
		R	0..1	LABOUR OR DELIVERY ONSET METHOD CODE	V
		M	**1..1**	DELIVERY TIMESTAMP	F S1 S13
		M	**1..1**	AGE AT CDS ACTIVITY DATE	F H4
		R	0..1	OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE	V

Notation	DATA GROUP: LABOUR/DELIVERY - SERVICE AGREEMENT DETAILS

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

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

Notation	DATA GROUP: BIRTH OCCURRENCE - ACTIVITY CHARACTERISTICS

Group Status	Group Repeats	FUNCTION:
R	0..9	To carry the details of up to 9 Birth Occurrences - one per Baby.

M	1..1	DATA GROUP: BIRTH OCCURRENCE - ACTIVITY CHARACTERISTICS	Rules

		R	0..1	BIRTH ORDER	F
		R	0..1	DELIVERY METHOD CODE	V
		R	0..1	GESTATION LENGTH (ASSESSMENT)	F
		R	0..1	RESUSCITATION METHOD CODE	V
		R	0..1	STATUS OF PERSON CONDUCTING DELIVERY CODE	V

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

One of the following DATA GROUPS must be used:

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

OR

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

OR

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

					F S3 S12

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

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

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

Notation	DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER
Group Status	Group Repeats	FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.
M	1..1	DATA GROUP: CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer 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: New Data Set

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

Notation	DATA GROUP: CDS V6-3 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER
Group Status / Group Repeats	FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.

Group Status	Group Repeats	Data Group
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.

Group Status	Group Repeats	Data Group
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.

Group Status	Group Repeats	Data Group
M	1..1	DATA GROUP: CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

OR

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

Group Status	Group Repeats	Data Group
M	1..1	DATA GROUP: CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol 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: O / Group Repeats: 0..1	FUNCTION: To carry the details of the Patient Pathway.

Group Status	Group Repeats			DATA GROUP: PATIENT PATHWAY IDENTITY	Rules
M	1..1			DATA GROUP: PATIENT PATHWAY IDENTITY	Rules
		M	1..1	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	F
		Or		*Or*	
		M	1..1	PATIENT PATHWAY IDENTIFIER	F I2

	M	**1..1**	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	F I2
M	**1..1**	**DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS**		**Rules**
	M	**1..1**	REFERRAL TO TREATMENT PERIOD STATUS	V
	M	**1..1**	WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)	V
	O	0..1	REFERRAL TO TREATMENT PERIOD START DATE	F S13
	O	0..1	REFERRAL TO TREATMENT PERIOD END DATE	F S13

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

One of the following DATA GROUPS must be used:

1..1	**DATA GROUP: WITHHELD IDENTITY STRUCTURE** **Must be used where the Commissioning Data Set record has been anonymised**				
M	**1..1**	**Data Element Components**			**Rules**
		M	**1..1**	NHS NUMBER STATUS INDICATOR CODE	V
		R	0..1	PERSON BIRTH DATE	F S3 S12
		R	0..1	WITHHELD IDENTITY REASON	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			**Rules**
		M	**1..1**	LOCAL PATIENT IDENTIFIER (EXTENDED)	F S3
		M	**1..1**	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	F
M	**1..1**	**Data Element Components**			**Rules**
		M	**1..1**	NHS NUMBER	F S3
		M	**1..1**	NHS NUMBER STATUS INDICATOR CODE	V
		R	0..1	PERSON BIRTH DATE	F S3 S12

OR

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

		M	1..1	NHS NUMBER STATUS INDICATOR CODE	V
R	0..1	Data Element Components			Rules
		M **OR** O and **M** **and** **M** and O and O	**1..1** **OR** 0..1 and **1..1** **and** **1..1** and 0..1 and 0..1	PATIENT FULL NAME **OR** PATIENT TITLE and PATIENT GIVEN NAME **and** PATIENT FAMILY NAME and PATIENT NAME SUFFIX and PATIENT INITIALS	F S3 I4
M	**1..1**	**Data Element Components**			**Rules**
		R	0..1	PERSON BIRTH DATE	F S3 S12

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

M	**1..1**	**Data Element Components**			**Rules**
		R	0..1	HOSPITAL PROVIDER SPELL IDENTIFIER	F
		R	0..1	ADMINISTRATIVE CATEGORY CODE (ON ADMISSION)	V

		R	0..1	PATIENT CLASSIFICATION CODE	V
		R	0..1	METHOD OF ADMISSION (HOSPITAL PROVIDER SPELL)	V
		R	0..1	ADMISSION SOURCE (HOSPITAL PROVIDER SPELL)	V
		M	**1..1**	START DATE (HOSPITAL PROVIDER SPELL)	F S13
		O	0..1	START TIME (HOSPITAL PROVIDER SPELL)	F S14
		M	**1..1**	AGE ON ADMISSION	F

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

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

Notation		DATA GROUP: BIRTH EPISODE- OVERSEAS VISITOR CHARGING CATEGORY			
Group Status R	Group Repeats 0..5	FUNCTION: To carry the details of the Overseas Visitor Charging Categories of the Patient (the Baby) during the Unfinished Birth Care Professional Admitted Care Episode.			
M	**1..1**	**Data Element Components**			**Rules**

		M	**1..1**	OVERSEAS VISITOR CHARGING CATEGORY	V
		M	**1..1**	OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE FROM DATE	F S13
		R	0..1	OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE END DATE	F S13

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

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

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

		M	1..1	SECONDARY DIAGNOSIS (ICD)	F

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

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

					F S13
O	0..1	DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL			**Rules**
		M	**1..1**	PROFESSIONAL REGISTRATION ISSUER CODE	V
		M	**1..1**	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)	F
O	0..1	DATA GROUP: RESPONSIBLE ANAESTHETIST			**Rules**
		M	**1..1**	PROFESSIONAL REGISTRATION ISSUER CODE	V
		M	**1..1**	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)	F

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

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

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

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

		O	0..1	WARD INTENDED AGE GROUP	V
		O	0..1	WARD INTENDED SEX OF PATIENTS	V
		O	0..1	WARD INTENDED DAY PERIOD AVAILABILITY	V
		O	0..1	WARD INTENDED NIGHT PERIOD AVAILABILITY	V
		O	0..1	START DATE (WARD STAY)	F S13
		O	0..1	START TIME (WARD STAY)	F S14
		O	0..1	END DATE (WARD STAY)	F S13
		O	0..1	END TIME (WARD STAY)	F S14
		O	0..1	WARD SECURITY LEVEL	V
		O	0..1	WARD CODE	F

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

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

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

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

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

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

Notation		DATA GROUP: BIRTH 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.			
R	0..9				

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

Notation	DATA GROUP: GP REGISTRATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

One of the following DATA GROUPS must be used:

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

OR

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

		R	0..1	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	F
		R	0..1	PERSON BIRTH DATE (MOTHER)	F S3 S12

OR

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

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

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

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

M	1..*	DATA GROUP: CDS V6-3 Type 004 - Commissioning Data Set Message Trailer 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.

Notation		DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER
Group Status	Group Repeats	FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.
M	1..1	DATA GROUP: CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer 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 190 - ADMITTED PATIENT CARE - UNFINISHED GENERAL EPISODE CDS

Change to Data Set: New Data Set

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

Notation		DATA GROUP: CDS V6-3 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER
Group Status	Group Repeats	FUNCTION: 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..*	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	DATA GROUP: CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol One per Commissioning Data Set record submitted to the Secondary Uses Service.

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

OR

Notation		DATA GROUP: CDS V6-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL
Group Status	Group Repeats	FUNCTION: To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of one of the Net Change Update Mechanism of the Commissioning Data Set Submission Protocol.
M	1..1	DATA GROUP: CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol 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 R	Group Repeats 0..1			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.	
M	1..1			DATA GROUP: PATIENT PATHWAY IDENTITY	Rules
		M *Or* M	1..1 1..1	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) *Or* PATIENT PATHWAY IDENTIFIER	F F I2
		M	1..1	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	F I2
M	1..1			DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS	Rules
		M	1..1	REFERRAL TO TREATMENT PERIOD STATUS	V
		M	1..1	WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)	V
		O	0..1	REFERRAL TO TREATMENT PERIOD START DATE	F S13
		O	0..1	REFERRAL TO TREATMENT PERIOD END DATE	F S13

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

One of the following DATA GROUPS must be used:

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

OR

1..1	DATA GROUP: VERIFIED IDENTITY STRUCTURE Must be used where the NHS NUMBER STATUS INDICATOR CODE National Code = 01 (Number present and verified)	

R	0..1	DATA GROUP: LOCAL IDENTIFIER STRUCTURE			Rules
		M	**1..1**	LOCAL PATIENT IDENTIFIER (EXTENDED)	F S3
		M	**1..1**	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	F
M	**1..1**	**Data Element Components**			**Rules**
		M	**1..1**	NHS NUMBER	F S3
		M	**1..1**	NHS NUMBER STATUS INDICATOR CODE	V
		M	**1..1**	POSTCODE OF USUAL ADDRESS	F S3
		R	0..1	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	F
		R	0..1	PERSON BIRTH DATE	F S3 S12

OR

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

Notation	DATA GROUP: PATIENT CHARACTERISTICS			
Group Status R	Group Repeats 0..1	FUNCTION: To carry the characteristics of the Patient.		

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

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

Notation	DATA GROUP: HOSPITAL PROVIDER SPELL - DISCHARGE CHARACTERISTICS

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

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

Notation	DATA GROUP: CARE EPISODE - ACTIVITY CHARACTERISTICS

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

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

Notation	DATA GROUP: CARE EPISODE - LENGTH OF STAY ADJUSTMENT

Group Status	Group Repeats	FUNCTION:
R	0..1	To carry details of length of stay adjustments to the Unfinished General Care Professional Admitted Care Episode .

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

Notation	DATA GROUP: CARE EPISODE- OVERSEAS VISITOR CHARGING CATEGORY

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

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

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

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

		M	1..1	DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET)	V
M	**1..1**	**DATA GROUP: PRIMARY DIAGNOSIS**			**Rules**
		M	**1..1**	PRIMARY DIAGNOSIS (ICD)	F H4
		O	0..1	PRESENT ON ADMISSION INDICATOR	V
R	0..*	DATA GROUP: SECONDARY DIAGNOSES			**Rules**
		M	**1..1**	SECONDARY DIAGNOSIS (ICD)	F H4
		O	0..1	PRESENT ON ADMISSION INDICATOR	V

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

M	**1..1**	**Data Element Components**			**Rules**
		R	0..1	EMED3 FIT NOTE ASSESSMENT DATE	F S13
		R	0..1	EMED3 FIT NOTE CONDITION (SNOMED CT EXPRESSION)	F
		R	0..1	EMED3 FIT NOTE DIAGNOSIS (ICD)	F
		R	0..1	EMED3 FIT NOTE START DATE	F S13
		R	0..1	EMED3 FIT NOTE END DATE	F S13

		R	0..1	EMED3 FIT NOTE DURATION	F
		R	0..1	EMED3 FIT NOTE RECORDED DATE	F S13
		R	0..1	EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR	V

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

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

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

One of the following DATA GROUPS may be used:

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

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

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

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

Notation		DATA GROUP: LOCATION GROUP (AT END OF CARE EPISODE)			
Group Status	Group Repeats	FUNCTION: To carry the details of the Location at the End of the Unfinished General Care Professional Admitted Care Episode.			
R	0..1				
M	1..1	Data Element Components			Rules
		R	0..1	ORGANISATION SITE IDENTIFIER (OF TREATMENT)	F
		R	0..1	ACTIVITY LOCATION TYPE CODE	F

		O	0..1	WARD INTENDED CLINICAL CARE INTENSITY	V
		O	0..1	WARD INTENDED AGE GROUP	V
		O	0..1	WARD INTENDED SEX OF PATIENTS	V
		O	0..1	WARD INTENDED DAY PERIOD AVAILABILITY	V
		O	0..1	WARD INTENDED NIGHT PERIOD AVAILABILITY	V
		O	0..1	WARD SECURITY LEVEL	V
		O	0..1	WARD CODE	F

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

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

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

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

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

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

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

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

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

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

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

Notation	**DATA GROUP: ELECTIVE ADMISSION LIST ENTRY**

Group Status	Group Repeats	FUNCTION: To carry the details of the Elective Admission List Entry.
R	0..1	

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

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

Notation		DATA GROUP: CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER
Group Status	Group Repeats	FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.
M	1..1	DATA GROUP: CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer 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 200 - ADMITTED PATIENT CARE - UNFINISHED DELIVERY EPISODE CDS

Change to Data Set: New Data Set

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

Notation		DATA GROUP: CDS V6-3 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER
Group Status	Group Repeats	FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.
M	1..1	DATA GROUP: CDS V6-3 Type 001 - Commissioning Data Set Interchange Header 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..*	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	DATA GROUP: CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

OR

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

M	1..1	DATA GROUP: CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol 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			Rules
		M *Or* M	1..1 1..1	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) *Or* PATIENT PATHWAY IDENTIFIER	F F
		M	1..1	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	F I2
M	1..1	DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS			Rules
		M	1..1	REFERRAL TO TREATMENT PERIOD STATUS	V
		M	1..1	WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)	V
		O	0..1	REFERRAL TO TREATMENT PERIOD START DATE	F S13
		O	0..1	REFERRAL TO TREATMENT PERIOD END DATE	

				F S13

Notation		DATA GROUP: PATIENT IDENTITY (MOTHER)
Group Status	Group Repeats	FUNCTION: To carry the Identity of the Patient (the Mother). 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**			**Rules**
		M	**1..1**	NHS NUMBER STATUS INDICATOR CODE	V
		R	0..1	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	F
		R	0..1	WITHHELD IDENTITY REASON	V

OR

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

OR

1..1	**DATA GROUP: UNVERIFIED IDENTITY STRUCTURE** Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE NOT included in the above				
R	0..1	DATA GROUP: LOCAL IDENTIFIER STRUCTURE			**Rules**
		M	**1..1**	LOCAL PATIENT IDENTIFIER (EXTENDED)	F S3
		M	**1..1**	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	F
M	**1..1**	**Data Element Components**			**Rules**
		R	0..1	NHS NUMBER	F S3
		M	**1..1**	NHS NUMBER STATUS INDICATOR CODE	V
R	0..1	Data Element Components			**Rules**
		M **OR** O and	**1..1** **OR** 0..1 and	PATIENT FULL NAME **OR** PATIENT TITLE and	F S3 I4

		M **and** **M** and O and O	**1..1** **and** **1..1** and 0..1 and 0..1	PATIENT GIVEN NAME **and** PATIENT FAMILY NAME and PATIENT NAME SUFFIX and PATIENT INITIALS	
R	0..1	Data Element Components			**Rules**
		M **OR** **M**	**1..1** **OR** **2..5**	PATIENT USUAL ADDRESS (UNSTRUCTURED) **OR** PATIENT USUAL ADDRESS (STRUCTURED)	F S3 I5
M	**1..1**	**Data Element Components**			**Rules**
		R	0..1	POSTCODE OF USUAL ADDRESS	F S3
		R	0..1	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	F
		R	0..1	PERSON BIRTH DATE	F S3 S12

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

Notation		DATA GROUP: DELIVERY CHARACTERISTICS			
Group Status R	Group Repeats 0..1	FUNCTION: To carry the delivery characteristics of the Patient (the Mother).			
M	**1..1**	**Data Element Components**			**Rules**
		R	0..1	NUMBER OF PREVIOUS PREGNANCIES RESULTING IN REGISTRABLE BIRTH	F

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

One of the following DATA GROUPS may be used:

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

OR

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

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

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

Notation		DATA GROUP: DELIVERY EPISODE - ACTIVITY CHARACTERISTICS			
Group Status M	Group Repeats 1..1	FUNCTION: To carry the details of the Unfinished Delivery Care Professional Admitted Care Episode.			
M	1..1	Data Element Components			Rules
		R	0..1	EPISODE NUMBER	F
		R	0..1	LAST EPISODE IN SPELL INDICATOR CODE	V
		R	0..1	PSYCHIATRIC PATIENT STATUS CODE	V
		M	**1..1**	START DATE (EPISODE)	

					Rules
					F S1 S13
		O	0..1	START TIME (EPISODE)	F S14
		R	0..1	END DATE (EPISODE)	F S13
		O	0..1	END TIME (EPISODE)	F S14
		M	**1..1**	AGE AT CDS ACTIVITY DATE	F
		O	0..1	REHABILITATION ASSESSMENT TEAM TYPE	V N3

Notation		DATA GROUP: DELIVERY EPISODE- OVERSEAS VISITOR CHARGING CATEGORY			
Group Status R	Group Repeats 0..5	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.			
M	**1..1**	**Data Element Components**			**Rules**
		M	**1..1**	OVERSEAS VISITOR CHARGING CATEGORY	V
		M	**1..1**	OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE FROM DATE	F S13
		R	0..1	OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE END DATE	F S13

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

Notation		DATA GROUP: CARE EPISODE - PERSON GROUP (CARE PROFESSIONAL)			
Group Status R	Group Repeats 0..*	FUNCTION: To carry the details of the Care Professionals active during the Unfinished Delivery Admitted Patient Care Episode.			
M	**1..1**	**Data Element Components**			**Rules**
		M	**1..1**	PROFESSIONAL REGISTRATION ISSUER CODE	V

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

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

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

One of the following DATA GROUPS may be used:

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

OR

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

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

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

		O	0..1	WARD INTENDED CLINICAL CARE INTENSITY	V
		O	0..1	WARD INTENDED AGE GROUP	V
		O	0..1	WARD INTENDED SEX OF PATIENTS	V
		O	0..1	WARD INTENDED DAY PERIOD AVAILABILITY	V
		O	0..1	WARD INTENDED NIGHT PERIOD AVAILABILITY	V
		O	0..1	WARD SECURITY LEVEL	V
		O	0..1	WARD CODE	F

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

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

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

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

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

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

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

M	1..1			DATA GROUP: ADULT CRITICAL CARE - ADMISSION CHARACTERISTICS	Rules
		M	1..1	CRITICAL CARE LOCAL IDENTIFIER	F
		M	1..1	CRITICAL CARE START DATE	F S13
		O	0..1	CRITICAL CARE START TIME	F S14

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

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

Notation		**DATA GROUP: REFERRER**

Group Status	Group Repeats	FUNCTION:
R	0..1	To carry the details of the Referrer.

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

Notation	DATA GROUP: PREGNANCY - ACTIVITY CHARACTERISTICS

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

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

Notation	DATA GROUP: ANTENATAL CARE - ACTIVITY CHARACTERISTICS

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

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

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

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

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

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

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

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

Notation	DATA GROUP: LABOUR/DELIVERY - ACTIVITY CHARACTERISTICS

Group Status	Group Repeats	FUNCTION:
R	0..1	To carry the details of the Labour/Delivery.

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

		R	0..1	LABOUR OR DELIVERY ONSET METHOD CODE	V
		R	0..1	DELIVERY TIMESTAMP	F

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

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

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

One of the following DATA GROUPS must be used:

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

OR

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

OR

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

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

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

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

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

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

Change to Supporting Information: Changed Description

A Allied Health Professional Referral To Treatment Measurement is a REFERRAL TO TREATMENT PERIOD.

~~In 2008, the Department of Health and Social Care published 'Framing the Contribution of Allied Health Professionals', which sets out three key aspects for improving the SERVICES which CARE PROFESSIONALS in NHS Allied Health Professional Services (Referral To Treatment Measurement) provide:~~In 2008, the Department of Health and Social Care published 'Framing the Contribution of Allied Health Professionals', which sets out three key aspects for improving the SERVICES which ALLIED HEALTH PROFESSIONALS in NHS Allied Health Professional Services (Referral To Treatment Measurement) provide:

- ~~To mandate the collection of Referral To Treatment information for Allied Health Professionals and support SERVICE redesign to improve SERVICES for PATIENTS~~
- To mandate the collection of Referral To Treatment information for ALLIED HEALTH PROFESSIONALS and support SERVICE redesign to improve SERVICES for PATIENTS
- To promote the benefits of self-referral to Physiotherapy SERVICES
- To improve the quality of SERVICES delivered

~~The Department of Health and Social Care introduced voluntary collection of Allied Health Professional REFERRAL TO TREATMENT PERIOD waiting time information from April 2010, and mandatory collection from April 2011. The Community Services Data Set and the Commissioning Data Sets (version 6-2 onwards) include the facility to report the Allied Health Professional REFERRAL TO TREATMENT PERIOD waiting time data elements which are used for waiting time measurement.~~The Department of Health and Social Care introduced voluntary collection of ALLIED HEALTH PROFESSIONAL REFERRAL TO TREATMENT PERIOD waiting time information from April 2010, and mandatory collection from April 2011. The Community Services Data Set and the Commissioning Data Sets (version 6-2 onwards) include the facility to report the ALLIED HEALTH PROFESSIONAL REFERRAL TO TREATMENT PERIOD waiting time data elements which are used for waiting time measurement.

~~The Allied Health Professionals mandated to collect and flow Referral To Treatment data are:~~The ALLIED HEALTH PROFESSIONALS mandated to collect and flow Referral To Treatment data are:

- Art Therapists, Music Therapists and Dramatherapists (Arts Therapists)
- Chiropodists/Podiatrists
- Dietitians
- Occupational Therapists
- Orthoptists
- Physiotherapists
- Prosthetists and Orthotists
- Radiographers (Diagnostic and Therapeutic)
- Speech and Language Therapists

~~There is no maximum waiting time target attached to an Allied Health Professional REFERRAL TO TREATMENT PERIOD, so no adjustments can be applied to the calculated waiting time between the REFERRAL TO TREATMENT PERIOD START DATE and the REFERRAL TO TREATMENT PERIOD END DATE.~~There is no maximum waiting time target attached to an ALLIED HEALTH PROFESSIONAL REFERRAL TO TREATMENT PERIOD, so no adjustments can be applied to the calculated waiting time between the REFERRAL TO TREATMENT PERIOD START DATE and the REFERRAL TO TREATMENT PERIOD END DATE. However, locally the EARLIEST CLINICALLY APPROPRIATE DATE and the EARLIEST REASONABLE OFFER DATE can be used by Health Care Providers and their Commissioners to analyse unexpectedly long waits for First Definitive Treatment.

~~Allied Health Professionals working as part of a Consultant Led Service in secondary care are excluded.~~ALLIED HEALTH PROFESSIONALS working as part of a Consultant Led Service in secondary care are excluded.

Further guidance relating to the Allied Health Professional Referral To Treatment initiative can be found on the Department of Health and Social Care at: Allied Health Professional (AHP) Referral to Treatment (RTT) guide.

CARE PROFESSIONAL ADMITTED CARE EPISODE

Change to Supporting Information: Changed Description

A Care Professional Admitted Care Episode is an ACTIVITY GROUP.

A Care Professional Admitted Care Episode is the period of time within a Hospital Provider Spell during which the PATIENT is under the medical responsibility of a:

- CONSULTANT
- MIDWIFE
- NURSE
- ALLIED HEALTH PROFESSIONAL

A Care Professional Admitted Care Episode can be a:

- Consultant Episode (Hospital Provider)
- Midwife Episode
- Nursing Episode.

CARE PROFESSIONAL OUT-PATIENT ATTENDANCE

Change to Supporting Information: New Supporting Information

A Care Professional Out-Patient Attendance is a CARE CONTACT.

A Care Professional Out-Patient Attendance is an attendance at an Out-Patient Clinic at which a PATIENT is seen by or has contact with (face to face or via another Care Professional Out-Patient Episode) a CARE PROFESSIONAL as part of a Care Professional Out-Patient Episode.

A Care Professional Out-Patient Attendance may involve more than one PERSON (e.g. a family). The number of attendances to be recorded should be the number of PATIENTS for whom the particular CARE PROFESSIONAL has identifiable individual clinical records which will be maintained as a result of the attendance.

If the PATIENT is seen by a CARE PROFESSIONAL, is then sent elsewhere for a Clinical Investigation, and then returns to the Out-Patient Clinic to be seen again by a CARE PROFESSIONAL from the same clinical team, a single Care Professional Out-Patient Attendance is recorded.

A visit by a CARE PROFESSIONAL to the home of a PATIENT which is instigated by the Health Care Provider to review the urgency of a proposed admission to hospital, or to continue to supervise treatment initiated or prescribed at a hospital or clinic, may be recorded as a Care Professional Out-Patient Attendance.

A Care Professional Out-Patient Attendance may also be recorded if a PATIENT is seen by a CONSULTANT with a different MAIN SPECIALTY during a Consultant Episode (Hospital Provider), where there is no transfer of clinical responsibility for the care of the PATIENT. For example, a PATIENT who is admitted to hospital under Gastroenterology MAIN SPECIALTY following an overdose may be seen while still in hospital by a psychiatrist

who has been asked to assess their mental condition. The assessment by the psychiatrist should be recorded as a Care Professional Out-Patient Attendance.

During the Care Professional Out-Patient Attendance, PATIENT DIAGNOSES made and Patient Procedures undertaken should be recorded in clinical records for the PATIENT.

A series of Care Professional Out-Patient Attendances form a Care Professional Out-Patient Episode which is generated from a single REFERRAL REQUEST. A PATIENT may have more than one Care Professional Out-Patient Episodes with the same CARE PROFESSIONAL for different clinical conditions, if separate REFERRAL REQUESTS are made.

A PATIENT attending a WARD for examination or care will be counted as an Care Professional Out-Patient Attendance if they are seen and/or treated by a CONSULTANT or other doctor. If they are seen by a NURSE, the activity is recorded as a Ward Attendance.

This supporting information is also known by these names:

Context	Alias
plural	Care Professional Out-Patient Attendances

CARE PROFESSIONAL OUT-PATIENT EPISODE

Change to Supporting Information: New Supporting Information

A Care Professional Out-Patient Episode is an ACTIVITY GROUP.

A Care Professional Out-Patient Episode is an episode of care for a PATIENT comprising a series of one or more Care Professional Out-Patient Attendances, relating to one REFERRAL REQUEST, managed by the same CARE PROFESSIONAL.

In the case of shared care by two or more CARE PROFESSIONALS equally participating in the care of the PATIENT, one CARE PROFESSIONAL will take overriding responsibility for the PATIENT and only one Care Professional Out-Patient Episode is recorded.

A Care Professional Out-Patient Episode can overlap with other Care Professional Out-Patient Episodes, or with Hospital Provider Spells for a PATIENT using a Hospital Bed. For example, a PATIENT in a long-stay WARD under the care of a CONSULTANT psychiatrist might also be seeing a CONSULTANT surgeon as an out-patient.

A Care Professional Out-Patient Episode starts on the date the PATIENT first sees or is in contact with the CARE PROFESSIONAL at a Care Professional Out-Patient Attendance.

A Care Professional Out-Patient Episode ends when the PATIENT is formally discharged from the care of the CARE PROFESSIONAL. Where the PATIENT is not subject to a Personalised Out-Patient Follow Up Pathway, the PATIENT may be discharged according to local clinical protocols after an agreed period of time.

A Care Professional Out-Patient Episode would not necessarily terminate because a PATIENT was admitted into hospital or placed on an ELECTIVE ADMISSION LIST; if further APPOINTMENTS in respect of the same REFERRAL REQUEST with the CONSULTANT are intended or expected, these would all be included in the same Consultant Out-Patient Episode, with Care Professional Out-Patient Attendances after the end of a Hospital Provider Spell recorded as follow-up attendances.

If after formal discharge the condition of the PATIENT deteriorates and the PATIENT is re-referred to the same CARE PROFESSIONAL, a new Care Professional Out-Patient Episode should be created.

During the Care Professional Out-Patient Episode the PATIENT may be subject to more than one ADMINISTRATIVE CATEGORY PERIODS.

For CONSULTANT-led Care Professional Out-Patient Episodes:

- if the TREATMENT FUNCTION under which the PATIENT is being treated changes, but the CONSULTANT stays the same, this is a continuation of the **same** Care Professional Out-Patient Episode
- if the CONSULTANT changes but the MAIN SPECIALTY and TREATMENT FUNCTION under which the PATIENT is being treated stay the same, this is a **new** Care Professional Out-Patient Episode.
  CARE ACTIVITIES related to the same REFERRAL REQUEST undertaken by other members of the CONSULTANTs team (such as junior doctors or NURSES) should be assigned to the same Care Professional Out-Patient Episode

For non-CONSULTANT-led Care Professional Out-Patient Episodes:

- For REFERRAL REQUESTS to team-led services, such as MIDWIFE care for Maternity PATIENTS, a single Care Professional Out-Patient Episode is recorded regardless of whether the PATIENT sees the same CARE PROFESSIONAL at each Care Professional Out-Patient Attendance

This supporting information is also known by these names:

Context	Alias
plural	Care Professional Out-Patient Episodes

CDS TYPE

Change to Supporting Information: Changed Description

A CDS Type forms part of an ELECTRONIC HEALTH RECORD EXTRACT.

~~CDS Type is a code to identify the specific type of Commissioning Data Set (CDS).~~CDS Type is a code to identify the specific type of Commissioning Data Set (CDS).

Note:

- ~~CDS Type 010 *'Accident and Emergency Attendance'* will no longer be accepted for submission to the Secondary Uses Service from 01 November 2020.~~
- CDS Type 010 *'Accident and Emergency Attendance'* was retired from 1 November 2020 and is no longer accepted for submission to the Secondary Uses Service.
- Commissioning Data Set version 6-3 does not require submission of the following CDS Types:
  - Detained and/or Long Term Psychiatric Census
  - Any Elective Admission List CDS Type
  - Future Outpatient

  The CDS Types are:

~~010~~	~~Accident and Emergency Attendance~~
010	Accident and Emergency Attendance (Retired 1 November 2020)
011	Emergency Care Attendance
~~020~~	

~~Outpatient~~
~~*(Known in the Schema as Care Activity)*~~
~~May also be used to submit a Referral To Treatment Clock Stop Administrative Event~~

~~021~~ ~~Future Outpatient~~
~~*(Known in the Schema as Future Care Activity)*~~

020 Outpatient
May also be used to submit a Referral To Treatment Clock Stop Administrative Event

021 Future Outpatient
030 Elective Admission List End of Period Census (Standard)
040 Elective Admission List End of Period Census (Old)
050 Elective Admission List End of Period Census (New)
060 Elective Admission List Event During Period (Add)
070 Elective Admission List Event During Period (Remove)
080 Elective Admission List Event During Period (Offer)
090 Elective Admission List Event During Period (Available/Unavailable)
100 Elective Admission List Event During Period (Old Service Agreement)
110 Elective Admission List Event During Period (New Service Agreement)
120 Finished Birth Episode
130 Finished General Episode
140 Finished Delivery Episode
150 Other Birth
160 Other Delivery
170 Detained and/or Long-Term Psychiatric Census
180 Unfinished Birth Episode
190 Unfinished General Episode
200 Unfinished Delivery Episode

CDS V6-3 TYPE 001 - CDS INTERCHANGE HEADER OVERVIEW

Change to Supporting Information: New Supporting Information

Introduction

The CDS V6-3 Type 001 - Commissioning Data Set Interchange Header carries mandatory controls for a Commissioning Data Set Interchange and is only used by inclusion in other CDS Types.

Commissioning Data Set Interchanges containing Commissioning Data Set Messages submitted to the Secondary Uses Service must use the required Commissioning Data Set Interchange and Message Header and Trailer Controls to provide the correct addressing and identification for the data flows.

Multiple Commissioning Data Set messages are usually sent in a single Commissioning Data Set Interchange which consists of:

- CDS V6-2-3 Type 001 - Commissioning Data Set Interchange Header - Mandatory - One per Commissioning Data Set Interchange
  CDS V6-2-3 Type 003 - Commissioning Data Set Message Header - Mandatory - One per Commissioning Data Set Message

Dependent upon the Commissioning Data Set Submission Protocol being used, one of the following must be used:

- CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol - Mandatory, one per CDS Type
- CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol - Mandatory, one per CDS Type

Followed by:

- The CDS Type - As required to carry the specific Commissioning Data Set data records

Each Commissioning Data Set message ends with:

- CDS V6-3 Type 004 - Commissioning Data Set Message Trailer - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer - Mandatory - One per Commissioning Data Set Interchange

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

Notation

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

Business Rules

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

XML Schema

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

CDS V6-3 TYPE 002 - CDS INTERCHANGE TRAILER OVERVIEW

Change to Supporting Information: New Supporting Information

Introduction

The CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer carries mandatory controls for a Commissioning Data Set Interchange and is only used by inclusion in other CDS Types.

Commissioning Data Set Interchanges containing Commissioning Data Set Messages submitted to the Secondary Uses Service must use the required Commissioning Data Set Interchange and Message Header and Trailer Controls to provide the correct addressing and identification for the data flows.

Multiple Commissioning Data Set messages are usually sent in a single Commissioning Data Set Interchange which consists of:

- CDS V6-3 Type 001 - Commissioning Data Set Interchange Header - Mandatory - One per Commissioning Data Set Interchange
- CDS V6-3 Type 003 - Commissioning Data Set Message Header- Mandatory - One per Commissioning Data Set Message

Dependent upon the Commissioning Data Set Submission Protocol being used, one of the following must be used:

- CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol - Mandatory, one per CDS Type
- CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol - Mandatory, one per CDS Type

Followed by:

- The CDS Type - As required to carry the specific Commissioning Data Set data records

Each Commissioning Data Set message ends with:

- CDS V6-3 Type 004 - Commissioning Data Set Message Trailer - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer - Mandatory - One per Commissioning Data Set Interchange.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

Notation

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

Business Rules

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

XML Schema

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

CDS V6-3 TYPE 003 - CDS MESSAGE HEADER OVERVIEW

Change to Supporting Information: New Supporting Information

Introduction

The CDS V6-3 Type 003 - Commissioning Data Set Message Header carries mandatory controls for a Commissioning Data Set Message and is only used by inclusion in other CDS Types.

Commissioning Data Set Interchanges containing Commissioning Data Set Messages submitted to the Secondary Uses Service must use the required Commissioning Data Set Interchange and Message Header and Trailer Controls to provide the correct addressing and identification for the data flows.

Multiple Commissioning Data Set messages are usually sent in a single Commissioning Data Set Interchange which consists of:

- CDS V6-3 Type 001 - Commissioning Data Set Interchange Header - Mandatory - One per Commissioning Data Set Interchange
- CDS V6-3 Type 003 - Commissioning Data Set Message Header- Mandatory - One per Commissioning Data Set Message

Dependent upon the Commissioning Data Set Submission Protocol being used, one of the following must be used:

- CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol - Mandatory, one per CDS Type
- CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol - Mandatory, one per CDS Type

Followed by:

- The CDS Type - As required to carry the specific Commissioning Data Set data records

Each Commissioning Data Set message ends with:

- CDS V6-3 Type 004 - Commissioning Data Set Message Trailer - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer - Mandatory - One per Commissioning Data Set Interchange.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

Notation

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

Business Rules

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

XML Schema

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

CDS V6-3 TYPE 004 - CDS MESSAGE TRAILER OVERVIEW

Change to Supporting Information: New Supporting Information

Introduction

The CDS V6-3 Type 004 - Commissioning Data Set Message Trailer carries mandatory controls for a Commissioning Data Set Message and is only used by inclusion in other CDS Types.

Commissioning Data Set Interchanges containing Commissioning Data Set Messages submitted to the Secondary Uses Service must use the required Commissioning Data Set Interchange and Message Header and Trailer Controls to provide the correct addressing and identification for the data flows.

Multiple Commissioning Data Set messages are usually sent in a single Commissioning Data Set Interchange which consists of:

- CDS V6-3 Type 001 - Commissioning Data Set Interchange Header - Mandatory - One per Commissioning Data Set Interchange
- CDS V6-3 Type 003 - Commissioning Data Set Message Header- Mandatory - One per Commissioning Data Set Message

Dependent upon the Commissioning Data Set Submission Protocol being used, one of the following must be used:

- CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol - Mandatory, one per CDS Type
- CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol - Mandatory, one per CDS Type

Followed by:

- The CDS Type - As required to carry the specific Commissioning Data Set data records

Each Commissioning Data Set message ends with:

- CDS V6-3 Type 004 - Commissioning Data Set Message Trailer - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer - Mandatory - One per Commissioning Data Set Interchange.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

Notation

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

Business Rules

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

XML Schema

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

Change to Supporting Information: New Supporting Information

Introduction

The CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol carries mandatory controls for a Commissioning Data Set Type and is only used by inclusion in other CDS Types.

Commissioning Data Set Interchanges containing Commissioning Data Set Messages submitted to the Secondary Uses Service must use the required Commissioning Data Set Interchange and Message Header and Trailer Controls to provide the correct addressing and identification for the data flows. All CDS Types using the Commissioning Data Set Bulk Replacement Update Mechanism of the Commissioning Data Set Submission Protocol must begin with this Mandatory Data Group.

Multiple Commissioning Data Set messages are usually sent in a single Commissioning Data Set Interchange which consists of:

- CDS V6-3 Type 001 - Commissioning Data Set Interchange Header - Mandatory - One per Commissioning Data Set Interchange
- CDS V6-3 Type 003 - Commissioning Data Set Message Header- Mandatory - One per Commissioning Data Set Message - Mandatory - One per Commissioning Data Set Interchange

Dependent upon the Commissioning Data Set Submission Protocol being used, one of the following must be used:

- CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol - Mandatory, one per CDS Type
- CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol - Mandatory, one per CDS Type

Followed by:

- The CDS Type - As required to carry the specific Commissioning Data Set data records

Each Commissioning Data Set message ends with:

- CDS V6-3 Type 004 - Commissioning Data Set Message Trailer - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer - Mandatory - One per Commissioning Data Set Interchange.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

Notation

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

Business Rules

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

XML Schema

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

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

Change to Supporting Information: New Supporting Information

Introduction

The CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol carries mandatory controls for a Commissioning Data Set Type and is only used by inclusion in other CDS Types.

Commissioning Data Set Interchanges containing Commissioning Data Set Messages submitted to the Secondary Uses Service must use the required Commissioning Data Set interchange and Message Header and Trailer Controls to provide the correct addressing and identification for the data flows. All CDS Types using the Commissioning Data Set Net Change Update Mechanism of the Commissioning Data Set Submission Protocol must begin with this Mandatory Data Group.

Multiple Commissioning Data Set messages are usually sent in a single Commissioning Data Set Interchange which consists of:

- CDS V6-3 Type 001 - Commissioning Data Set Interchange Header - Mandatory - One per Commissioning Data Set Interchange
- CDS V6-3 Type 003 - Commissioning Data Set Message Header- Mandatory - One per Commissioning Data Set Message

Dependent upon the Commissioning Data Set Submission Protocol being used, one of the following must be used:

- CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol - Mandatory, one per CDS Type
- CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol - Mandatory, one per CDS Type

Followed by:

- The CDS Type - As required to carry the specific Commissioning Data Set data records

Each Commissioning Data Set message ends with:

- CDS V6-3 Type 004 - Commissioning Data Set Message Trailer - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- CDS V6-3 Type 002 - Commissioning Data Set Interchange Trailer - Mandatory - One per Commissioning Data Set Interchange.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

Notation

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

Business Rules

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

XML Schema

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

CDS V6-3 TYPE 020 - OUTPATIENT CDS OVERVIEW

Change to Supporting Information: New Supporting Information

Introduction

The CDS V6-3 Type 020 - Outpatient Commissioning Data Set carries the data for a Care Professional Out-Patient Attendance or a cancelled/missed APPOINTMENT.

It covers all NHS and private Out-patient ACTIVITY taking place in any:

- acute, community, mental health NHS Trust or NHS Foundation Trust
- other NHS hospital
- non-NHS hospitals or institutions where the care delivered is NHS-funded.

under the care of a CONSULTANT, MIDWIFE, NURSE or ALLIED HEALTH PROFESSIONAL, where an appropriate MAIN SPECIALTY CODE and TREATMENT FUNCTION CODE exists.

ACTIVITY taking place under the care of ALLIED HEALTH PROFESSIONALS, other Biomedical Scientists and Clinical Scientists may also be carried (where an appropriate MAIN SPECIALTY CODE and TREATMENT FUNCTION CODE exists) if required although this is not a Commissioning Data Set Mandated Data Flow, unless the ACTIVITY falls under the Allied Health Professional Referral To Treatment Measurement standard. In this case, a Care Professional Out-Patient Attendance record for the ALLIED HEALTH PROFESSIONAL ACTIVITY must be submitted, with the CDS DATA GROUP : PATIENT PATHWAY data elements completed as necessary.

Where the Out-patient data relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, the CDS DATA GROUP : PATIENT PATHWAY data elements must be completed where appropriate.

This CDS Type may also be used to submit Referral To Treatment Clock Stop Administrative Events.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

Notation

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

Business Rules

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

XML Schema

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

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

Change to Supporting Information: New Supporting Information

Introduction

CDS V6-3 Type 120 - Admitted Patient Care - Finished Birth Episode Commissioning Data Set carries the data for a Finished Birth Care Professional Admitted Care Episode.

This is required when a delivery has resulted in a REGISTRABLE BIRTH which has taken place in either an NHS Hospital or in a non-NHS ORGANISATION funded by the NHS.

The information is taken from the birth notification for each baby born.

In addition to Finished Birth Care Professional Admitted Care Episodes, Unfinished Birth Care Professional Admitted Care Episode Commissioning Data Set records are required as at midnight on 31st March each year.

CDS V6-3 Type 180 - Admitted Patient Care - Unfinished Birth Episode Commissioning Data Set should be used for the submission of this Unfinished Birth Episode Commissioning Data Set.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

Notation

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

Business Rules

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

XML Schema

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

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

Change to Supporting Information: New Supporting Information

Introduction

CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set carries the data for a Finished General Care Professional Admitted Care Episode.

It covers all NHS and private Care Professional Admitted Care Episode (day case and inpatient) ACTIVITY taking place in any:

- acute, community, mental health NHS Trust or NHS Foundation Trust
- other NHS hospital
- non-NHS hospitals or institutions where the care delivered is NHS-funded.

under the care of a CONSULTANT, MIDWIFE or NURSE, where an appropriate MAIN SPECIALTY CODE and TREATMENT FUNCTION CODE exists.

ACTIVITY taking place under the care of ALLIED HEALTH PROFESSIONALS, other Biomedical Scientists and Clinical Scientists may also be carried (where an appropriate MAIN SPECIALTY CODE and TREATMENT FUNCTION CODE exists) if required although this is not a Commissioning Data Set Mandated Data Flow.

Where the Care Professional Admitted Care Episode data relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, the CDS DATA GROUP : PATIENT PATHWAY data elements must be completed where appropriate.

An Unfinished General Care Professional Admitted Care Episode Commissioning Data Set record is required as at midnight on 31 March each year and for all unfinished short-stay informal psychiatric PATIENTS who are resident in hospital or on leave of absence (Home Leave) on 31 March and who have been in hospital for less than 12 months.

CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set should be used for the submission of this Unfinished General Episode Care Professional Admitted Care Episode data.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

Notation

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

Business Rules

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

XML Schema

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

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

Change to Supporting Information: New Supporting Information

Introduction

CDS V6-3 Type 140 - Admitted Patient Care - Finished Delivery Episode Commissioning Data Set carries the data for a Finished Delivery Care Professional Admitted Care Episode.

This is required when a delivery has resulted in a REGISTRABLE BIRTH which has taken place in either an NHS Hospital or in a non-NHS ORGANISATION funded by the NHS.

The information is taken from the birth notification for each baby born.

In addition to Finished Delivery Care Professional Admitted Care Episodes, Unfinished Delivery Care Professional Admitted Care Episode Commissioning Data Set records are required for all Unfinished Delivery Episodes as at midnight on 31 March each year.

CDS V6-3 Type 200 - Admitted Patient Care - Unfinished Delivery Episode Commissioning Data Set should be used for the submission of this Unfinished Delivery Episode Commissioning Data Set.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

Notation

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

Business Rules

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

XML Schema

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

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

Change to Supporting Information: New Supporting Information

Introduction

CDS V6-3 Type 150 - Admitted Patient Care - Other Birth Event Commissioning Data Set carries the data for an Other Birth.

This CDS Type applies to:

- NHS-funded home births and
- all other birth events which are not NHS-funded, either directly or under an NHS SERVICE AGREEMENT.

The data in these records originates from birth notification records and requires only a limited data set to be completed.

Maternity Care Professional Admitted Care Episodes taking place in either NHS hospitals or in non-NHS ORGANISATIONS funded by the NHS, will be recorded using the CDS V6-3 Type 120 - Admitted Patient Care -

Finished Birth Episode Commissioning Data Set and CDS V6-3 Type 140 - Admitted Patient Care - Finished Delivery Episode Commissioning Data Set.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

Notation

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

Business Rules

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

XML Schema

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

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

Change to Supporting Information: New Supporting Information

Introduction

CDS V6-3 Type 160 - Admitted Patient Care - Other Delivery Event Commissioning Data Set carries the data for an Other Delivery.

This CDS Type applies to:

- NHS-funded home deliveries and
- all other delivery events which are not NHS-funded, either directly or under an NHS SERVICE AGREEMENT.

The data in these records originates from birth notification records and requires only a limited data set to be completed.

Maternity Care Professional Admitted Care Episodes taking place in either NHS hospitals or in non-NHS ORGANISATIONS funded by the NHS, will be recorded using the CDS V6-3 Type 120 - Admitted Patient Care - Finished Birth Episode Commissioning Data Set and CDS V6-3 Type 140 - Admitted Patient Care - Finished Delivery Episode Commissioning Data Set.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

Notation

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

Business Rules

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

XML Schema

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

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

Change to Supporting Information: New Supporting Information

Introduction

CDS V6-3 Type 180 - Admitted Patient Care - Unfinished Birth Episode Commissioning Data Set carries the data for an Unfinished Birth Care Professional Admitted Care Episode.

This is required when a delivery has resulted in a REGISTRABLE BIRTH which has taken place in either an NHS Hospital or in an non-NHS ORGANISATION funded by the NHS.

The information is taken from the birth notification for each baby born.

Unfinished Birth Care Professional Admitted Care Episode Commissioning Data Set records are required for all Unfinished Birth Care Professional Admitted Care Episode as at midnight on 31st March each year.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

Notation

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

Business Rules

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

XML Schema

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

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

Change to Supporting Information: New Supporting Information

Introduction

CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set carries the data for an Unfinished General Care Professional Admitted Care Episode.

It covers all NHS and private Care Professional Admitted Care Episode (day case and inpatient) ACTIVITY taking place in any:

- acute, community, mental health NHS Trust or NHS Foundation Trust
- other NHS hospital
- non-NHS hospitals or institutions where the care delivered is NHS-funded.

under the care of a CONSULTANT, MIDWIFE or NURSE, where an appropriate MAIN SPECIALTY CODE and TREATMENT FUNCTION CODE exists.

ACTIVITY taking place under the care of ALLIED HEALTH PROFESSIONALS, other Biomedical Scientists and Clinical Scientists may also be carried (where an appropriate MAIN SPECIALTY CODE and TREATMENT FUNCTION CODE exists) if required although this is not a Commissioning Data Set Mandated Data Flow.

Where the Care Professional Admitted Care Episode data relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, the CDS DATA GROUP : PATIENT PATHWAY data elements must be completed where appropriate.

An Unfinished General Care Professional Admitted Care Episode Commissioning Data Set record is required for all Unfinished General Care Professional Admitted Care Episodes as at midnight on 31 March each year and for all unfinished short-stay informal psychiatric PATIENTS who are resident in hospital or on leave of absence (Home Leave) on 31 March and who have been in hospital for less than 12 months.

CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set may optionally be sent more regularly, usually monthly.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

Notation

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

Business Rules

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

XML Schema

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

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

Change to Supporting Information: New Supporting Information

Introduction

CDS V6-3 Type 200 - Admitted Patient Care - Unfinished Delivery Episode Commissioning Data Set carries the data for an Unfinished Delivery Care Professional Admitted Care Episode.

This may take place in either NHS Hospitals or in non-NHS ORGANISATIONS funded by the NHS. The information is taken from the birth notification for each baby born.

Unfinished Birth and Delivery Care Professional Admitted Care Episode Commissioning Data Set records are required for all Unfinished Birth and Delivery Care Professional Admitted Care Episodes as at midnight on 31 March each year.

To access more detailed information on the Commissioning Data Sets, see the Commissioning Data Sets Introduction.

Notation

See Commissioning Data Set Notation for an explanation of Group Status and Group Repeats.

Business Rules

See Commissioning Data Set Business Rules for an explanation of the business and/or processing rules which apply to individual Data Elements.

XML Schema

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-3 XML Schema Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

CDS VERSION 6-3 MENU

Change to Supporting Information: New Supporting Information

Commissioning Data Set Business Rules
Commissioning Data Set Notation

CDS Data Flow Controls - (Mandatory for every CDS Interchange):
CDS V6-3 Type 001 - CDS Interchange Header
CDS V6-3 Type 002 - CDS Interchange Trailer
CDS V6-3 Type 003 - CDS Message Header
CDS V6-3 Type 004 - CDS Message Trailer

CDS Transaction Header Group - (Mandatory for every CDS TYPE):
CDS V6-3 Type 005B - CDS Transaction Header Group - Bulk Update Protocol **or**
CDS V6-3 Type 005N - CDS Transaction Header Group - Net Change Protocol

CDS TYPES:

Outpatient Care:
CDS V6-3 Type 020 - Outpatient CDS

Admitted Patient Care:
CDS V6-3 Type 120 - Admitted Patient Care - Finished Birth Episode CDS
CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode CDS
CDS V6-3 Type 140 - Admitted Patient Care - Finished Delivery Episode CDS
CDS V6-3 Type 150 - Admitted Patient Care - Other Birth Event CDS
CDS V6-3 Type 160 - Admitted Patient Care - Other Delivery Event CDS
CDS V6-3 Type 180 - Admitted Patient Care - Unfinished Birth Episode CDS

CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode CDS
CDS V6-3 Type 200 - Admitted Patient Care - Unfinished Delivery Episode CDS

COMMISSIONING DATA SET ADDRESSING GRID

Change to Supporting Information: Changed Description

This page has been updated in DDCN 1645 (Specialised Commissioning: Removal of Default Code YDD82) to remove the National Commissioning Group, as NHS England became responsible for commissioning all specialised services in April 2013.
The page will be updated as part of an Information Standard to reflect the current arrangements for the Commissioning Data Sets.

Note that the Commissioning Data Set Addressing Grid is only applicable for Commissioning Data Set version 6-2, as CDS PRIME RECIPIENT IDENTITY and CDS COPY RECIPIENT IDENTITY have been replaced with ORGANISATION IDENTIFIER (CDS RECIPIENT) in Commissioning Data Set version 6-3.

The Commissioning Data Set Addressing Grid below illustrates which ORGANISATION CODES should be used to populate the CDS PRIME RECIPIENT IDENTITY and CDS COPY RECIPIENT IDENTITY for each PATIENT / NHS SERVICE AGREEMENT. See the specific ORGANISATION CODE Data Elements for further information on their usage and Organisation Data Service Default Codes etc.

Health Care Providers need to specify the ORGANISATIONS that have a right to the commissioning data set data as a CDS PRIME RECIPIENT IDENTITY or CDS COPY RECIPIENT IDENTITY. This is so that they can access the data once it has been stored in the Secondary Uses Service.

Please note that payment via the National Tariff Payment System is not determined by the CDS PRIME RECIPIENT IDENTITY or CDS COPY RECIPIENT IDENTITY.

Important Notes:

- The CDS PRIME RECIPIENT IDENTITY must be allocated on the first creation and submission of a CDS Type for a PATIENT and **must not change even if the ADDRESS or ORGANISATION CODE (RESIDENCE RESPONSIBILITY) of the PATIENT changes during the lifetime of the Commissioning Data Set record** otherwise duplicate Commissioning Data Set data may be lodged in the Secondary Uses Service database.
  See the supporting information in Commissioning Data Set Submission Protocol for a detailed explanation.
- Note that if two recipients are identical for example, the ORGANISATION CODE (RESIDENCE RESPONSIBILITY) may be the same as the ORGANISATION CODE (CODE OF COMMISSIONER), only one entry for that ORGANISATION should be made for that recipient.
- Specialised service ACTIVITY commissioned by a regional Specialised Commissioning Group should include their ORGANISATION CODE as a CDS COPY RECIPIENT IDENTITY. ACTIVITY commissioned by a shared service ORGANISATION or other consortium of Primary Care Trusts, should similarly include the ORGANISATION CODE of the shared service or the lead Primary Care Trust, if this does not already appear as a CDS COPY RECIPIENT IDENTITY or CDS PRIME RECIPIENT IDENTITY.

~~Commissioning Data Set Addressing Grid for users of Commissioning Data Set version 6-2 onwards~~Commissioning Data Set Addressing Grid for users of Commissioning Data Set version 6-2

PATIENT / NHS SERVICE AGREEMENT	**Data Elements in the Commissioning Data Sets Version 6-2 onwards**	
		CDS COPY RECIPIENT IDENTITY **O***

	CDS PRIME RECIPIENT IDENTITY M*		
Private PATIENT	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	VPP00	ORGANISATION CODE (RESPONSIBLE PCT) or ORGANISATION CODE of the responsible Clinical Commissioning Group
Overseas Visitor liable for NHS charges and not registered with a General Medical Practitioner Practice	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	VPP00	
Overseas Visitor liable for NHS charges and registered with a General Medical Practitioner Practice	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	VPP00	ORGANISATION CODE (RESPONSIBLE PCT) or ORGANISATION CODE of the responsible Clinical Commissioning Group
Overseas Visitor exempt from charges, current permanent residence overseas and not registered with a General Medical Practitioner Practice	TDH00	ORGANISATION CODE (CODE OF COMMISSIONER)	
Overseas Visitor exempt from charges, current permanent overseas and registered with a General Medical Practitioner Practice	TDH00	ORGANISATION CODE (CODE OF COMMISSIONER)	ORGANISATION CODE (RESPONSIBLE PCT) or ORGANISATION CODE of the responsible Clinical Commissioning Group
Overseas Visitor exempt from charges, current permanent residence is the UK and not registered with a General Medical Practitioner Practice	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	ORGANISATION CODE (CODE OF COMMISSIONER)	
Overseas Visitor exempt from charges, current permanent residence is the UK and registered with a General Medical Practitioner Practice	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	ORGANISATION CODE (CODE OF COMMISSIONER)	ORGANISATION CODE (RESPONSIBLE PCT) or ORGANISATION CODE of the responsible Clinical Commissioning Group
PATIENT registered with a General Medical Practitioner Practice treated as a Non-Contract Activity	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	ORGANISATION CODE (RESPONSIBLE PCT) or ORGANISATION CODE of the responsible Clinical Commissioning Group	ORGANISATION CODE (CODE OF COMMISSIONER)
PATIENT not registered with a General Medical Practitioner Practice treated as a Non-Contract Activity	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	ORGANISATION CODE (CODE OF COMMISSIONER)	
** PATIENT registered with General Medical Practitioner Practice with a Specialised Services and Other Commissioning Consortia Service Agreement	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	ORGANISATION CODE (RESPONSIBLE PCT) or ORGANISATION CODE of the responsible Clinical Commissioning Group	ORGANISATION CODE of ORGANISATION to which costs of treatment accrue

** PATIENT not registered with General Medical Practitioner Practice with a Specialised Services and Other Commissioning Consortia Service Agreement	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	ORGANISATION CODE of ORGANISATION to which costs of treatment accrue	
PATIENT registered with General Medical Practitioner Practice with Primary Care Trust NHS SERVICE AGREEMENT (excluding Overseas Visitors)	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	ORGANISATION CODE (RESPONSIBLE PCT) or ORGANISATION CODE of the responsible Clinical Commissioning Group	
PATIENT not registered with a General Medical Practitioner Practice but resident in an area covered by a Primary Care Trust with a Primary Care Trust NHS SERVICE AGREEMENT (excluding Overseas Visitors)	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)		

Notes:

Key to population codes:

> **M***: This Data Element is mandatory in the CDS-XML schema. Submissions will not flow if this Data Element is absent
> **O***: This Data Element is optional
>
> ** Specialised Services and Other Commissioning Consortia Service Agreements include SERVICES that are commissioned by regional Specialised Commissioning Groups and local arrangements for commissioning ACTIVITY through shared service ORGANISATIONS.

COMMISSIONING DATA SET BUSINESS RULES

Change to Supporting Information: Changed Description

The Commissioning Data Sets have notation to identify the business and/or processing rules which apply to individual Data Elements. This notation appears in the Rules column of the Commissioning Data Sets details page.

Population Validation

All Data Elements are subject to **length** validation. Some Data Elements are also subject to **format** and **content** validation against a list of permitted values defined in the NHS Data Model and Dictionary. The value lists are held on the Attribute which the Data Element is based on, plus default codes which are held on the Data Element itself.

RULE	POPULATION VALIDATION
F	The format is validated, for example the format of a date must comply with the XML standard.
V	The Data Element is validated against an explicit list of permitted values as defined in the NHS Data Model and Dictionary. Note the permitted values differ between CDS-XML schema version 6-2 and CDS-XML version 6-2-0 for CARE PROFESSIONAL MAIN SPECIALTY CODE and ACTIVITY TREATMENT FUNCTION CODE.

Business Rules

Some Data Elements are subject to additional Business Rules as indicated below:

- **Prefix H** = Healthcare Resource Group Business Rules.
- ~~**Prefix I** = CDS-XML Schema anomalies and issues.~~
- **Prefix I** = CDS-XML Schema notes, anomalies and issues.
- **Prefix N** = NHS Data Standards and Policy Rules
- **Prefix S** = Secondary Uses Service Business Rules

PREFIX	BUSINESS RULES: H - Healthcare Resource Group Business Rules
H4	This Data Element is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4.** Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource. For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

~~PREFIX~~	~~BUSINESS RULES: I - CDS-XML Schema Anomalies and Issues~~
PREFIX	**BUSINESS RULES: I - CDS-XML Schema Notes, Anomalies and Issues**
I1	This is a known schema anomaly and has been registered for future resolution.
I2	See the specifications in the NHS Data Model and Dictionary for the specific format characteristics of this Data Element.
I3	There is no national requirement to flow Healthcare Resource Group 4 (HRG4) through the Commissioning Data Sets, see DSCN 17/2008.
I4	From Commissioning Data Set version 6-3 onwards, the NHS Data Model and Dictionary data set layout has been updated to correctly represent the existing requirements of the CDS-XML Schema for PERSON NAME STRUCTURED and PERSON NAME UNSTRUCTURED
I5	From Commissioning Data Set version 6-3 onwards, the NHS Data Model and Dictionary data set layout has been updated to correctly represent the existing requirements of the CDS-XML Schema for ADDRESS STRUCTURED and ADDRESS UNSTRUCTURED

PREFIX	BUSINESS RULES: N - NHS Data Standards and Policy Rules
N1	Psychiatric PATIENTS only (Retired January 2021).
N2	Not defined or approved by the Data Alliance Partnership Board or its predecessors the Data Coordination Board, Standardisation Committee for Care Information and Information Standards Board for Health and Social Care.
N3	The definition and value list for this data is under review.
N4	Up to 20 codes per daily activity occurrence may be recorded.
N5	This data should only flow in Commissioning Data Set version 6-1 for PATIENTS detained under the Mental Health Act prior to the Mental Health Act 2007 (Retired June 2015).
N6	This data should only flow in Commissioning Data Set version 6-2 for PATIENTS detained under the Mental Health Act 2007.
N7	From Commissioning Data Set version 6-0 onwards, the use of the DETAINED AND (OR) LONG TERM PSYCHIATRIC CENSUS DATE in the location group is **optional** as it **must** be carried in the Episode Characteristics.

PREFIX	BUSINESS RULES: S - Secondary Uses Service Business Rules
S1	This mandatory Commissioning Data Set date is used as the originating date to determine the mandatory CDS ACTIVITY DATE.

S2	The Secondary Uses Service **DOES NOT** support the use of the CDS TEST INDICATOR. Therefore this Data Element must not be used (Retired June 2015).
S3	See Security Issues and Patient Confidentiality, for further information.
S4	Used to ensure the correct sequencing of multiple and/or subsequent Commissioning Data Set submissions.
~~S5~~	~~These ORGANISATION CODES must be present and registered with the Secondary Uses Service. The Commissioning Data Set Schema does not validate the content value of this data~~
S5	These ORGANISATION CODES/ORGANISATION IDENTIFIERS must be present and registered with the Secondary Uses Service. The Commissioning Data Set Schema does not validate the content value of this data
S6	All CDS REPORT PERIOD START DATES and CDS REPORT PERIOD END DATES must be consistent in all Commissioning Data Set records contained in a BULK Interchange submission. The CDS REPORT PERIOD START DATE must be on or before the CDS REPORT PERIOD END DATE. The CDS ACTIVITY DATE is a mandatory data element and must fall within the period defined. See the Commissioning Data Set Submission Protocol.
S7	See the Commissioning Data Set Addressing Grid.
S8	These Data Elements are required for correct processing by the Secondary Uses Service. If omitted, the Secondary Uses Service will reject the Commissioning Data Set data.
S9	The CDS UNIQUE IDENTIFIER is a mandatory data item when using the Net Change Protocol. When using the Bulk Update Protocol this data item is optional but it is strongly advised that where it can be correctly generated and maintained it should be used. See the Commissioning Data Set Submission Protocol.
S10	For CDS V6-2 Type 170 - Admitted Patient Care - Detained and or Long Term Psychiatric Census Commissioning Data Set, the CDS ACTIVITY DATE contains the CDS CENSUS DATE which is also the DETAINED AND (OR) LONG TERM PSYCHIATRIC CENSUS DATE.
S11	For the following CDS Types, the CDS ACTIVITY DATE must contain the Date of the Elective Admission List Census which is usually the end of the Period being reported: CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set CDS V6-2 Type 040 - Elective Admission List - End of Period Census (Old) Commissioning Data Set CDS V6-2 Type 050 - Elective Admission List - End of Period Census (New) Commissioning Data Set
S12	These PERSON BIRTH DATE Data Elements must use dates between 01/01/1880 and 31/12/2999 in order to pass validation
S13	Data Elements reporting a date (which is not a PERSON BIRTH DATE Data Element) must use dates between 01/01/1900 and 31/12/2999 in order to pass validation
S14	For Data Elements reporting a time, the hour portion must be between 00 and 23 inclusive in order to pass validation

---

COMMISSIONING DATA SET MANDATED DATA FLOWS

Change to Supporting Information: Changed Description

The minimum Commissioning Data Sets information flow requirement to enable Hospital Episode Statistics, 18 Weeks ACTIVITY reporting, and the National Tariff Payment System to be supported by the Secondary Uses Service is shown in the table below.

The Secondary Uses Service supports every CDS Type but only a subset is mandated to flow.

Commissioning Data Sets may flow to the Secondary Uses Service using either Net Change or Bulk Replacement Commissioning Data Set Submission Protocols. Many Standard NHS Contracts between Health Care Providers and the commissioners of their SERVICES, now specify weekly submission of initially-coded data sets to the

Secondary Uses Service. The use of Net Change Commissioning Data Set Submission Protocols is recommended for submissions of this frequency.

CDS TYPE	DESCRIPTION	MIN FREQUENCY	DIRECTIVE	DATA FLOW
CDS010	Accident and Emergency (Retired 01 November 2020)			
CDS 011	Emergency Care	Weekly	Emergency Care Attendances for EMERGENCY CARE DEPARTMENT TYPE 01 and 02 were mandated to flow nationally from 1st October 2017. See SCCI0092-2062 Emergency Care Attendances for EMERGENCY CARE DEPARTMENT TYPES 03 and 04 were mandated to flow from October 2018. See SCCI0092-2062	Data is expected to flow on a daily basis where possible, but a weekly frequency is the minimum requirement.
CDS 020	Out-Patient	Weekly	Out-Patient Attendance Commissioning Data Sets (including Ward Attenders) were mandated to be submitted to the Secondary Uses Service from 1st October 2001, see DSCN 05/2001. Out-Patient Attendance Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009. NURSE and MIDWIFE attendances and Attendances for nursing care were enabled to be carried in the Out-Patient Attendance Commissioning Data Set from 1 April 2005, DSCN 32/2004 Other Care Professional Attendances where an appropriate Treatment Function exists may also be submitted.	NHS Acute Health Care Providers must submit data weekly. NHS Community Health Care Providers, NHS Mental Health Care Providers and Independent Sector Healthcare Providers undertaking acute care, must submit data weekly as soon as possible and no later than 31 March 2021.

			Out-patient records where the activity relates to the Allied Health Professional Referral To Treatment Measurement standard must be submitted to the Secondary Uses Service (in accordance with ISN ISB0092 Amd 7/2013, and must include the PATIENT PATHWAY data group data items. Note that this is only supported in Commissioning Data Set version 6-2 onwards, with the introduction of data element WAITING TIME MEASUREMENT TYPE.	
~~CDS 021~~	~~Future Out-Patients~~	~~As Required for piloting~~	~~From 01/01/2008, submissions to support local activities and commissioning will be supported for piloting purposes only.~~	
~~CDS 030~~	~~Elective Admission List End of Period (Standard)~~	~~Monthly if used~~	~~All Providers should endeavour to support this data flow.~~ ~~Elective Admission List End of Period Census (Standard) Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.~~	~~All entries where at the end of the time period being reported and defined by the Commissioning Data Set Submission Protocol, the PATIENT remains on the ELECTIVE ADMISSION LIST. Optionally and by local agreement with commissioners, entries relating to the PATIENTS that have been removed from the ELECTIVE ADMISSION LIST may be included.~~
~~CDS 040~~	~~Elective Admission List End of Period (New)~~	~~Monthly if used~~	~~Optional~~	~~May be submitted where the Commissioner has been changed during the time period reported.~~
~~CDS 050~~	~~Elective Admission List End of Period (Old)~~	~~Monthly if used~~	~~Optional~~	~~May be submitted where the Commissioner has been changed during the time period reported.~~
~~CDS 060~~	~~Elective Admission List Event During Period (Add)~~	~~Monthly if used~~	~~Optional~~ ~~Elective Admission List Event During Period (Add) Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times~~	~~May be submitted where an entry has been added to the ELECTIVE ADMISSION LIST during the time period reported.~~

			Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	
CDS 070	Elective Admission List Event During Period (Remove)	Monthly if used	Optional Elective Admission List Event During Period (Remove) Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	May be submitted where an entry has been removed from the ELECTIVE ADMISSION LIST during the time period reported.
CDS 080	Elective Admission List Event During Period (Offer)	Monthly if used	Optional Elective Admission List Event During Period (Offer) CDS records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	May be submitted where an offer has been made during the time period reported.
CDS 090	Elective Admission List Event During Period (Available / Unavailable)	Monthly if used	Optional	May be submitted where a patient becomes Available or Unavailable during the time period reported.
CDS 100	Elective Admission List Event During Period (Old Service Agreement)	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
CDS 110	Elective Admission List Event During Period (New Service Agreement)	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
CDS 021	Future Out-Patients - **Commissioning Data Set version 6-2 only**	As Required for piloting	From 01/01/2008, submissions to support local activities and commissioning will be supported for piloting purposes only.	
CDS 030	Elective Admission List End of Period (Standard) - **Commissioning Data Set version 6-2 only**	Monthly if used	All Providers should endeavour to support this data flow.	All entries where at the end of the time period being reported and defined by the Commissioning Data Set

			Elective Admission List End of Period Census (Standard) Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	Submission Protocol, the PATIENT remains on the ELECTIVE ADMISSION LIST. Optionally and by local agreement with commissioners, entries relating to the PATIENTS that have been removed from the ELECTIVE ADMISSION LIST may be included.
CDS 040	Elective Admission List End of Period (New) - **Commissioning Data Set version 6-2 only**	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
CDS 050	Elective Admission List End of Period (Old) - **Commissioning Data Set version 6-2 only**	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
CDS 060	Elective Admission List Event During Period (Add) **Commissioning Data Set version 6-2 only**	Monthly if used	Optional Elective Admission List Event During Period (Add) Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	May be submitted where an entry has been added to the ELECTIVE ADMISSION LIST during the time period reported.
CDS 070	Elective Admission List Event During Period (Remove)**Commissioning Data Set version 6-2 only**	Monthly if used	Optional Elective Admission List Event During Period (Remove) Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	May be submitted where an entry has been removed from the ELECTIVE ADMISSION LIST during the time period reported.
CDS 080	Elective Admission List Event During Period (Offer) **Commissioning Data Set version 6-2 only**	Monthly if used	Optional Elective Admission List Event During Period (Offer) CDS	May be submitted where an offer has been made during the time period reported.

			records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	
CDS 090	Elective Admission List Event During Period (Available / Unavailable) - **Commissioning Data Set version 6-2 only**	Monthly if used	Optional	May be submitted where a patient becomes Available or Unavailable during the time period reported.
CDS 100	Elective Admission List Event During Period (Old Service Agreement) **Commissioning Data Set version 6-2 only**	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
CDS 110	Elective Admission List Event During Period (New Service Agreement) **Commissioning Data Set version 6-2 only**	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
CDS 120	Finished Birth Episode	Weekly	All finished Admitted Patient Care data must be submitted "at least monthly" (EL - Dec 1995). This includes Non-Contract Activity.	NHS Acute Health Care Providers must submit data weekly. NHS Community Health Care Providers, NHS Mental Health Care Providers and Independent Sector Healthcare Providers undertaking acute care, must submit data weekly as soon as possible and no later than 31 March 2021.
CDS 130	Finished General Episode	Weekly	All finished Admitted Patient Care data must be submitted "at least monthly" (EL - Dec 1995). This includes Non-Contract Activity. Finished General Episode Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data	NHS Acute Health Care Providers must submit data weekly. NHS Community Health Care Providers, NHS Mental Health Care Providers and Independent Sector Healthcare Providers undertaking acute care, must submit data weekly as soon as possible and no later than 31 March 2021.

			group items, from 1st October 2009.	
CDS 140	Finished Delivery Episode	Weekly	All finished Admitted Patient Care data must be submitted "at least monthly" (EL - Dec 1995). This includes Non-Contract Activity.	NHS Acute Health Care Providers must submit data weekly. NHS Community Health Care Providers, NHS Mental Health Care Providers and Independent Sector Healthcare Providers undertaking acute care, must submit data weekly as soon as possible and no later than 31 March 2021.
CDS 150	Other Birth	Monthly	This includes Home Birth.	All Episodes that have finished relevant to the time period defined by the Commissioning Data Set Submission Protocol being used.
CDS 160	Other Delivery	Monthly	This includes Home Delivery.	All Episodes that have finished relevant to the time period defined by the Commissioning Data Set Submission Protocol being used.
~~CDS 170~~	~~The Detained and/or Long Term Psychiatric Census~~	~~Annually~~	~~Required by the NHS Digital.~~ ~~May optionally be sent more regularly, usually monthly.~~	~~Reflects data as at the 31st March each year.~~ ~~All Episodes that are relevant to the time period defined by the Commissioning Data Set Submission Protocol being used.~~
CDS 170	The Detained and/or Long Term Psychiatric Census - **Commissioning Data Set version 6-2 only**	Annually	Required by the NHS Digital. May optionally be sent more regularly, usually monthly.	Reflects data as at the 31st March each year. All Episodes that are relevant to the time period defined by the Commissioning Data Set Submission Protocol being used.
CDS 180	Unfinished Birth Episode	Annually	The Annual Census / Unfinished Census. Required by the NHS Digital. May optionally be sent more regularly, usually monthly.	Data relating to episodes that were unfinished as at midnight on 31st March and have not been included in the Detained and/or Long Term Psychiatric Census, and have not been submitted to the Secondary Uses Service in either Finished or Unfinished Commissioning Data Set data, must be submitted to the Secondary Uses Service.
CDS 190	Unfinished General Episode	Annually	The Annual Census / Unfinished Census. Required by the NHS Digital	Data relating to episodes that were unfinished as at midnight on 31st March and have not

			May optionally be sent more regularly, usually monthly. Unfinished General Episode Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	been included in the Detained and/or Long Term Psychiatric Census, and have not been submitted to the Secondary Uses Service in either Finished or Unfinished Commissioning Data Set data, must be submitted to the Secondary Uses Service.
CDS 200	Unfinished Delivery Episode	Annually	The Annual Census / Unfinished Census. Required by the NHS Digital May optionally be sent more regularly, usually monthly.	Data relating to episodes that were unfinished as at midnight on 31st March and have not been included in the Detained and/or Long Term Psychiatric Census, and have not been submitted to the Secondary Uses Service in either Finished or Unfinished Commissioning Data Set data, must be submitted to the Secondary Uses Service.

COMMISSIONING DATA SET NOTATION

Change to Supporting Information: Changed Description

~~The Commissioning Data Set is the basic structure used for the submission of commissioning data to the Secondary Uses Service and is designed to be capable of individually conveying many different Commissioning Data Set structures, encompassing Emergency Care Attendances, Out-Patient Attendances, Admitted Patient Care and Elective Admission List.~~The Commissioning Data Set is the basic structure used for the submission of commissioning data to the Secondary Uses Service and is designed to be capable of individually conveying many different Commissioning Data Set structures, encompassing Emergency Care Attendances, Out-Patient Attendances, Admitted Patient Care. (Elective Admission List is also defined in Commissioning Data Set version 6-2 only).

The Commissioning Data Sets have been defined in specific components known as a CDS Type.

Specific notation is used to indicate the requirements of the Commissioning Data Set XML Schema Design conditions for submission of data in the Commissioning Data Sets.

The structure of the Commissioning Data Set XML Schema is shown by the use of Data Groups and Sub Groups within those Data Groups. For each Data Group, Sub Group and individual Data Element, the allowed cardinality at each level is also shown in the "Status" and "Repeats" columns.

The CDS Type specifications must therefore be read in this hierarchy, using the Status and Repeat conditions within the Data Groups and Sub Groups, to determine the requirements for the individual Data Elements.

Status Column Notation

The Notation used for the **"STATUS"** column is as follows:

STATUS	MEANING	DESCRIPTION
M	**MANDATORY**	This signifies that the collection and submission of this Commissioning Data Set data is deemed **MANDATORY** and its presence is necessary for the CDS Type to be correctly validated and accepted for processing by the Secondary Uses Service. If a data item is shown as **MANDATORY**, this should also be regarded as **REQUIRED** by the Department of Health and Social Care. In most instances, data marked as **MANDATORY** in a Sub Group will result in its parent Data Group also being marked as mandatory, but this is not always the case. For instance, although the Consultant Episode - Clinical Diagnosis Group (ICD) is marked as **R=REQUIRED** (and therefore need not actually be populated), if it is used then both the DIAGNOSIS SCHEME IN USE and the PRIMARY DIAGNOSIS (ICD) are marked as **M=MANDATORY** and must both be present.
R	**REQUIRED**	This signifies that the collection and submission of this Commissioning Data Set data is deemed **REQUIRED** by the Department of Health and Social Care to comply with authorised NHS Standards, Policies and Directives. Therefore whenever a Commissioning Data Set is collected and subsequently submitted to the Secondary Uses Service, this data must be supported and populated into the relevant data sets if the data is available. Note that "temporal" conditions may mean that there are instances where this directive cannot be fulfilled. For instance in a CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set, ICD and OPCS data elements are marked as "Required" indicating that this data should be included. However, if at the time of submission to the Secondary Uses Service this data remains incomplete (perhaps awaiting coding in the ORGANISATION), the remaining data in the CDS record should still be submitted. Once the ORGANISATION has updated its systems with the data, the CDS Type relating to that ACTIVITY should then be resubmitted to the Secondary Uses Service.
M	**MANDATORY**	This signifies that the collection and submission of this Commissioning Data Set data is deemed **MANDATORY** and its presence is necessary for the CDS Type to be correctly validated and accepted for processing by the Secondary Uses Service. If a data item is shown as **MANDATORY**, this should also be regarded as **REQUIRED** by the Department of Health and Social Care. In most instances, data marked as **MANDATORY** in a Sub Group will result in its parent Data Group also being marked as mandatory, but this is not always the case. For instance, although the Care Episode - Clinical Diagnosis Group (ICD) is marked as **R=REQUIRED** (and therefore need not actually be populated), if it is used then both the DIAGNOSIS SCHEME IN USE and the PRIMARY DIAGNOSIS (ICD) are marked as **M=MANDATORY** and must both be present.
R	**REQUIRED**	

		This signifies that the collection and submission of this Commissioning Data Set data is deemed **REQUIRED** by the Department of Health and Social Care to comply with authorised NHS Standards, Policies and Directives. Therefore whenever a Commissioning Data Set is collected and subsequently submitted to the Secondary Uses Service, this data must be supported and populated into the relevant data sets if the data is available. Note that "temporal" conditions may mean that there are instances where this directive cannot be fulfilled. For instance in a CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set, ICD and OPCS data groups are marked as "Required" indicating that this data should be included. However, if at the time of submission to the Secondary Uses Service this data remains incomplete (perhaps awaiting coding in the ORGANISATION), the remaining data in the CDS record should still be submitted. Once the ORGANISATION has updated its systems with the data, the CDS Type relating to that ACTIVITY should then be resubmitted to the Secondary Uses Service.
O	**OPTIONAL**	This signifies that the collection and submission of this Commissioning Data Set data is **OPTIONAL**. Its inclusion in the Commissioning Data Set is therefore determined by "local agreement" between the ORGANISATIONS exchanging the data. Note that even if marked **O=OPTIONAL**, any data included in a Commissioning Data Set submission to the Secondary Uses Service must comply with its specification published in the NHS Data Model and Dictionary otherwise the data may be deemed invalid and rejected.
~~**X**~~	~~**X**~~	~~This is used where the Data Element name has been included in the Commissioning Data Set design, usually for pilot use, but is not yet authorised for transmission by the wider NHS. The Data Element will be in italics and not linked to the Data Element where one exists.~~
X	**Not yet authorised**	This is used where the Data Element name has been included in the Commissioning Data Set design, usually for pilot use, but is not yet authorised for transmission by the wider NHS.

Repeats Column Notation

~~The Notation used for the **"REPEATS"** column is as follows:~~Examples of the Notation used for the **"REPEATS"** column are as follows:

REPEATS	DESCRIPTION
0..1	This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 0 to a maximum of 1.
0..9	This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 0 to a maximum of 9.
0..*	This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 0 to an unlimited maximum.
1..1	This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 1 to a maximum of 1.
1..97	This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 1 to a maximum of 97.
1..*	

	This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 1 to an unlimited maximum.

Rules Column Notation

An entry in the **"Rules"** column shows that a specific Rule applies to submission of an individual Data Element.

The meaning of these Rules can be found in Commissioning Data Set Business Rules.

Notation Examples

~~The following are examples of some common scenarios.~~The following are examples of some common scenarios:

EXAMPLE 1:
A MANDATORY Data Group with differing Sub-Groups and component data status conditions.

The following example shows a **MANDATORY** Data Group - therefore the Data Group must be present for the CDS Type to be validated and accepted for processing by the Secondary Uses Service.

When a Data Group is used:

1. All **MANDATORY** Sub Groups and/or Data Elements must be present
2. Any **REQUIRED** Sub Groups and/or Data Elements must be present if the data is available
3. Any **OPTIONAL** Sub Groups and/or Data Elements may be omitted

The following data structure is one of three options when completing the Patient Identity Data Group:

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

		M	**1..1**	NHS NUMBER	F S3
		M	**1..1**	NHS NUMBER STATUS INDICATOR CODE	V
		M	**1..1**	POSTCODE OF USUAL ADDRESS	F S3
		R	0..1	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	F
		R	0..1	PERSON BIRTH DATE	F S3 S12

~~**EXPLANATION:**~~

~~The parent Data Group has a **"Status"** of **M=MANDATORY** which indicates that this Data Group must be present in the Commissioning Data Set to ensure correct validation and acceptance when submitted to the Secondary Uses Service. The parent Data Group **"Repeats"** = 1..1 indicates that only one occurrence of this Data Group must flow in this particular Commissioning Data Set record.~~

~~The Sub Group of "Local Identifier Structure" is marked as **R=REQUIRED** and therefore must be populated if the data is available. The **"Repeats"** notation of 0..1 indicates that population of this Sub Group is not necessary to enable the Commissioning Data Set record to be sent to the Secondary Uses Service. If it is sent, then only one occurrence of this Sub Group may flow in this particular Commissioning Data Set record.~~
~~Both Data Elements in the Sub Group are marked **M=MANDATORY** and must both be correctly populated.~~

~~The Sub Group of "Data Element Components" is a "generic" structure and is marked as **M=MANDATORY** and therefore must be populated. The "Repeats" notation of 1..1 indicates that only one occurrence of this Data Group may flow in this particular Commissioning Data Set record. All the Data Elements marked with **M=MANDATORY** must be populated. PERSON BIRTH DATE however is marked with **R=REQUIRED**, so must also be completed if the data is available.~~

EXPLANATION:

The parent DATA GROUP: VERIFIED IDENTITY STRUCTURE has a **"Status"** of **M=MANDATORY** which indicates that this Data Group must be present in the Commissioning Data Set to ensure correct validation and acceptance when submitted to the Secondary Uses Service. The parent Data Group **"Repeats"** = 1..1 indicates that only one occurrence of this Data Group must flow in this particular Commissioning Data Set record.

The Sub Group of "DATA GROUP: LOCAL IDENTIFIER STRUCTURE" is marked as **R=REQUIRED** and therefore must be populated if the data is available. The **"Repeats"** notation of 0..1 indicates that population of this Sub Group is not necessary to enable the Commissioning Data Set record to be sent to the Secondary Uses Service. If it is sent, then only one occurrence of this Sub Group may flow in this particular Commissioning Data Set record.
Both Data Elements in the Sub Group are marked **M=MANDATORY** and must both be correctly populated.

The Sub Group of "Data Element Components" is a "generic" structure and is marked as **M=MANDATORY** and therefore must be populated. The "**Repeats**" notation of 1..1 indicates that only one occurrence of this Data Group may flow in this particular Commissioning Data Set record. All the Data Elements marked with **M=MANDATORY** must be populated. PERSON BIRTH DATE however is marked with **R=REQUIRED**, so must also be completed if the data is available.

EXAMPLE 2:
A REQUIRED Data Group with differing component data status conditions.

The following example shows a **REQUIRED** Data Group. This data must be present in the relevant Commissioning Data Set if available. However, if submitted to the Secondary Uses Service, omission of this **REQUIRED** Data Group will not cause rejection.

When the Data Group is used:

1. All **MANDATORY** Sub Groups and/or Data Elements must be utilised
2. Any **REQUIRED** Sub Groups and/or Data Elements must be present if the data is available
3. Any **OPTIONAL** Sub Groups and/or Data Elements may be omitted

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

Status	Repeats	Item				Rules
M	**1..1**	**Data Element Components**				**Rules**
		M	**1..1**	DIAGNOSIS SCHEME IN USE		V
~~**M**~~	~~**1..1**~~	~~**DATA GROUP: PRIMARY DIAGNOSIS**~~				~~**Rules**~~
		M	**1..1**	**DATA GROUP: PRIMARY DIAGNOSIS**		**Rules**
				M	**1..1** PRIMARY DIAGNOSIS (ICD)	F H4
~~O~~	~~0..1~~	~~PRESENT ON ADMISSION INDICATOR~~	~~F~~			
~~O~~	~~0..*~~	~~**DATA GROUP: SECONDARY DIAGNOSIS**~~				~~**Rules**~~
		R	0..*	**DATA GROUP: SECONDARY DIAGNOSIS**		**Rules**
				M	**1..1** SECONDARY DIAGNOSIS (ICD)	F H4
~~O~~	~~0..1~~	~~PRESENT ON ADMISSION INDICATOR~~	~~F~~			

~~**EXPLANATION:**~~

~~The Data Group **"Status"** of **R=Required** indicates that this Data Group must be populated in the relevant Commissioning Data Set if the data is available. The Data Group **"Repeats" = 0..1** indicates that population of this Data Group is not necessary to enable the Commissioning Data Set to be sent to the Secondary Uses Service. If it is sent, then only one occurrence of this Data Group may flow in this particular Commissioning Data Set record.~~

~~If the Data Group is completed then the Data Element PROCEDURE SCHEME IN USE, marked as **M=MANDATORY**, must be populated. The **"Repeats"** notation of 1..1 indicates that only one occurrence of this Data Element is valid.~~

~~If the Data Group is completed then the Data Element PRIMARY DIAGNOSIS (ICD), marked as **M=MANDATORY**, must be populated. The **"Repeats"** notation of 1..1 indicates that only one occurrence of this Data Element is valid.~~

If the Data Group is completed then the Sub Group "Secondary Diagnoses", marked as **O=OPTIONAL**, may be omitted, but if populated it must be in the correct format. The **"Repeats"** notation of 0..* indicates that unlimited occurrences of this Data Element are valid. Each occurrence must contain a valid SECONDARY DIAGNOSIS (ICD).

EXPLANATION:

The DATA GROUP: CONSULTANT EPISODE - CLINICAL DIAGNOSIS GROUP (ICD) **"Status"** of **R=Required** indicates that this Data Group must be populated in the relevant Commissioning Data Set if the data is available. The Data Group **"Repeats" = 0..1** indicates that population of this Data Group is not necessary to enable the Commissioning Data Set to be sent to the Secondary Uses Service. If it is sent, then only one occurrence of this Data Group may flow in this particular Commissioning Data Set record.

If the Data Group is completed then the Data Element PROCEDURE SCHEME IN USE, marked as **M=MANDATORY**, must be populated. The **"Repeats"** notation of 1..1 indicates that only one occurrence of this Data Element is valid.

If the Data Group is completed then the Data Element PRIMARY DIAGNOSIS (ICD), marked as **M=MANDATORY**, must be populated. The **"Repeats"** notation of 1..1 indicates that only one occurrence of this Data Element is valid.

If the Data Group is completed then the Sub Group "Secondary Diagnoses", marked as **R=REQUIRED**, must be completed if the data is available, and if populated it must be in the correct format. The **"Repeats"** notation of 0..* indicates that unlimited occurrences of this Data Element are valid. Each occurrence must contain a valid SECONDARY DIAGNOSIS (ICD).

EXAMPLE 3:
An OPTIONAL Data Group with differing component data status conditions.

The following example shows an **OPTIONAL** Data Group. Its inclusion in the Commissioning Data Sets is therefore determined by "local agreement" between ORGANISATIONS exchanging the data.

When the Data Group is used:

1. All **MANDATORY** Sub Groups and/or Data Elements must be utilised
2. Any **REQUIRED** Sub Groups and/or Data Elements must be present if the data is available
3. Any **OPTIONAL** Sub Groups and/or Data Elements may be omitted

Notation		DATA GROUP: CONSULTANT EPISODE - CLINICAL DIAGNOSIS GROUP (ICD)
Group Status O	Group Repeats 0..1	FUNCTION: To carry the details of the ICD coded Clinical Diagnoses.

Notation		DATA GROUP: PATIENT PATHWAY
Group Status O	Group Repeats 0..1	FUNCTION: To carry the details of the Patient Pathway.

M	1..1	Data Element Components			Rules
		M	1..1	DIAGNOSIS SCHEME IN USE	V
M	1..1	DATA GROUP: PRIMARY DIAGNOSIS			Rules
		M	1..1	PRIMARY DIAGNOSIS (ICD)	F H4
		O	0..1	PRESENT ON ADMISSION INDICATOR	F

O	0..*	DATA GROUP: SECONDARY DIAGNOSIS			Rules
		M	1..1	SECONDARY DIAGNOSIS (ICD)	F H4
		O	0..1	PRESENT ON ADMISSION INDICATOR	F
M	1..1	DATA GROUP: PATIENT PATHWAY IDENTITY			Rules
	M *Or* M	1..1 1..1	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) *Or* PATIENT PATHWAY IDENTIFIER		F F I2
	M	1..1	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)		F I2
M	1..1	DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS			Rules
	M	1..1	REFERRAL TO TREATMENT PERIOD STATUS		V
	M	1..1	WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)		V
	O	0..1	REFERRAL TO TREATMENT PERIOD START DATE		F S13
	O	0..1	REFERRAL TO TREATMENT PERIOD END DATE		F S13

EXPLANATION:

The Data Group **"Status"** of **O=OPTIONAL** indicates that this Data Group may be omitted at its inclusion in the Commissioning Data Set is determined by "local agreement" between the ORGANISATIONS exchanging the data.

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

The Data Group **"Repeats" = 0..1** indicates that population of this Data Group is not necessary to enable the Commissioning Data Set to be sent to the Secondary Uses Service. If it is sent, then only one occurrence of this Data Group may flow in this particular Commissioning Data Set record.

If the Data Group is completed then the Data Element DIAGNOSIS SCHEME IN USE, marked as **M=MANDATORY**, must be populated. The **"Repeats"** notation of 1..1 indicates that only one occurrence of this Data Element is valid.

If the Data Group is completed then the Data Element PRIMARY DIAGNOSIS (ICD), marked as **M=MANDATORY**, must be populated. The **"Repeats"** notation of 1..1 indicates that only one occurrence of this Data Element is valid.

If the Data Group is completed then the Sub Group "Secondary Diagnoses", marked as **O=OPTIONAL**, may be omitted, but if populated it must be in the correct format. The **"Repeats"** notation of 0..* indicates that unlimited occurrences of this Data Element are valid. Each occurrence must contain a valid SECONDARY DIAGNOSIS (ICD).

EXPLANATION:

The DATA GROUP: PATIENT PATHWAY **"Status"** of **O=OPTIONAL** indicates that this Data Group may be omitted and its inclusion in the Commissioning Data Set is determined by "local agreement" between the ORGANISATIONS exchanging the data.

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

The Data Group **"Repeats" = 0..1** indicates that population of this Data Group is not necessary to enable the Commissioning Data Set to be sent to the Secondary Uses Service. If it is sent, then only one occurrence of this Data Group may flow in this particular Commissioning Data Set record.

If the DATA GROUP: PATIENT PATHWAY is submitted, then both of the sub-groups (DATA GROUP: PATIENT PATHWAY IDENTITY, and DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS) must be submitted. Data Elements marked as **M=MANDATORY**, must be populated. The **"Repeats"** notation of 1..1 indicates that only one occurrence of each of these Data Elements are valid.

In the DATA GROUP: PATIENT PATHWAY sub-group, **either** UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) **or** PATIENT PATHWAY IDENTIFIER must be submitted (but not both).

COMMISSIONING DATA SETS INTRODUCTION

Change to Supporting Information: Changed Description

The Commissioning Data Sets (CDS) are maintained and developed by the NHS Digital, in accordance with the needs of the NHS and the Department of Health and Social Care.

Commissioning Data Sets form the basis of data on ACTIVITY carried out by ORGANISATIONS reported centrally for monitoring and payment purposes. They support the current Healthcare Resource Group (HRG) version for calculation of payment to trusts and monitoring of other initiatives.

Requests for changes to the Commissioning Data Sets should be submitted via email to enquiries@nhsdigital.nhs.uk, stating "Commissioning Data Sets" in the subject line.

For further information on Commissioning Data Sets, see:

- Commissioning Data Sets Overview
- Commissioning Data Set Version 6-2 Type List
- Commissioning Data Set Version 6-3 Type List
- Commissioning Data Set Versions

- Commissioning Data Set Addressing Grid
- Commissioning Data Set Business Rules
- Commissioning Data Set Data Duplication
- Commissioning Data Set Mandated Data Flows
- Commissioning Data Set Notation
- Commissioning Data Set Submission and Organisation Mergers
- Commissioning Data Set Submission Protocol
- Referral To Treatment Clock Stop Administrative Event
- Security Issues and Patient Confidentiality

- **CDS XML Schema:**
- Commissioning Data Set XML Schema Overview
- Commissioning Data Set XML Schema Design
- Commissioning Data Set XML Schema Version Numbering
- Commissioning Data Set XML Schema Documentation
- XML Schema TRUD Download

- **XML Schema Constraints:**
- Commissioning Data Set Version 6-2 XML Schema Constraints
- Commissioning Data Set Version 6-2-1 XML Schema Constraints
- Commissioning Data Set Version 6-2-2 XML Schema Constraints
- Commissioning Data Set Version 6-2-3 XML Schema Constraints
- Commissioning Data Set Version 6-3 XML Schema Constraints

COMMISSIONING DATA SETS MENU

Change to Supporting Information: Changed Description

- CDS Overview
- CDS Version 6-2 Type List
- CDS Version 6-3 Type List
- CDS Versions

- CDS Addressing Grid
- CDS Business Rules
- CDS Data Duplication
- CDS Mandated Data Flows
- CDS Notation
- CDS Submission and Organisation Mergers
- CDS Submission Protocol
- Referral To Treatment Clock Stop Administrative Event
- Security Issues and Patient Confidentiality

- **CDS XML Schema:**
- CDS XML Schema Overview
- CDS XML Schema Design
- CDS XML Schema Version Numbering
- CDS XML Schema Documentation
- XML Schema TRUD Download

XML Schema Constraints:
- CDS Version 6-2 XML Schema Constraints
- CDS Version 6-2-1 XML Schema Constraints
- CDS Version 6-2-2 XML Schema Constraints
- CDS Version 6-2-3 XML Schema Constraints
- CDS Version 6-3 XML Schema Constraints

COMMISSIONING DATA SETS OVERVIEW

Change to Supporting Information: Changed Description

The purpose of the Commissioning Data Sets is to enable conformant health ACTIVITY information to be generated, independent of the ORGANISATION or system that maintains it. This enables health CARE PROFESSIONALS to measure and compare the delivery and quality of care provided and to support them in sharing information with other health professionals and ORGANISATIONS.

Commissioning Data Sets currently support the following ACTIVITIES:

- monitoring and managing NHS SERVICE AGREEMENTS
- developing commissioning plans

- supporting the National Tariff Payment System
- underpinning clinical governance
- understanding the health needs of the population
- reporting waiting time measurement

Information on care provided for all PATIENTS by Health Care Providers (both NHS and Independent Sector Healthcare Providers for NHS PATIENTS only) must be submitted to the Secondary Uses Service according to the Commissioning Data Set Mandated Data Flows guidelines.

Commissioning ORGANISATIONS need access to data to monitor Non-Contract Activity as part of the management of their NHS SERVICE AGREEMENTS, and to monitor in-year REFERRAL REQUESTS to investigate the sources and reasons for Non-Contract Activity.

The Department of Health and Social Care requires accurate data for all PATIENTS admitted, treated as out-patients or treated as an Emergency Care Attendance by Health Care Providers, including PATIENTS receiving private treatment. The Commissioning Data Sets also includes NHS PATIENTS treated electively in the independent sector and overseas.

~~Referral To Treatment Clock Stop Administrative Events may also flow using the CDS V6-2 Type 020 - Outpatient Commissioning Data Set.~~Referral To Treatment Clock Stop Administrative Events may also flow using the CDS V6-2 Type 020 - Outpatient Commissioning Data Set or CDS V6-3 Type 020 - Outpatient Commissioning Data Set. This allows the Secondary Uses Service to build accurate PATIENT PATHWAYS for the reporting of waiting time measurement.

CDS Types

~~The Commissioning Data Sets are the basic structure used for the submission of commissioning data to the Secondary Uses Service and is designed to be capable of individually conveying many different Commissioning Data Set structures encompassing Emergency Care Attendances, Out-Patient Attendances, Future Attendances, Admitted Patient Care and Elective Admission List data.~~The Commissioning Data Sets are the basic structure used for the submission of commissioning data to the Secondary Uses Service and is designed to be capable of individually conveying many different Commissioning Data Set structures encompassing Emergency Care Attendances, Care Professional Out-Patient Attendances, and Care Professional Admitted Care Episodes for both CDS version 6-2 and CDS version 6-3. CDS version 6-2 also supports the submission of Future Out-Patient Attendances and Elective Admission List data.

Further Information

Further guidance material for submission of data to the Secondary Uses Service can be found at: Secondary Uses Service (SUS Guidance).

COMMISSIONING DATA SET SUBMISSION PROTOCOL

Change to Supporting Information: Changed Description

The Commissioning Data Sets submitted by providers carry information to determine the update method to be used by the Secondary Uses Service in order to update the national database.

These update rules are known as the Commissioning Data Set Submission Protocol and the set of data controls used to indicate this are carried in the Commissioning Data Set Transaction Header Group which must be present and correct in every CDS Type submitted to the Secondary Uses Service.

Net Change:
~~Net Change processes are managed by specific data settings as defined in the CDS V6-2 Type 005N -~~

~~Commissioning Data Set Transaction Header Group - Net Change Protocol option of the CDS Transaction Header Group.~~Net Change processes are managed by specific data settings as defined in the CDS V6-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol / CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol option of the CDS Transaction Header Group. The Secondary Uses Service uses the following data to manage the database:

- CDS SENDER IDENTITY/ORGANISATION IDENTIFIER (CDS SENDER)
- CDS UNIQUE IDENTIFIER
- CDS APPLICABLE DATE
- CDS APPLICABLE TIME

Note that CDS SENDER IDENTITY is used for CDS V6-2, CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set and CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set. ~~ORGANISATION IDENTIFIER (CDS SENDER) is used for CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set and all other Commissioning Data Set versions after CDS V6-2.~~ ORGANISATION IDENTIFIER (CDS SENDER) is used for CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set and CDS Version 6-3 onwards.

~~Each CDS Type must have a CDS UNIQUE IDENTIFIER which must be uniquely maintained for the life of that Commissioning Data Set record.~~Each CDS Type must have a CDS UNIQUE IDENTIFIER which must be uniquely maintained throughout the life of that Commissioning Data Set record. This is a particular consideration where mergers and/or healthcare systems are changed or upgraded, see Commissioning Data Set Submission and Organisation Mergers. Any change to the CDS UNIQUE IDENTIFIER during the "lifetime" of a Commissioning Data Set record will almost certainly result in a duplicate record being lodged in the Secondary Uses Service database.

A Commissioning Data Set record delete transaction must be sent to the Secondary Uses Service database when any previously sent Commissioning Data Set record requires deletion/removal, for example to reflect Commissioner changes etc.

~~Where CDS UPDATE TYPE 1 is required (delete/cancellation), an empty XML element called 'Delete Transaction' can be used instead of submitting he original CDS Type record, after the CDS V6-2 Type 005N - CDS Transaction Header Group - Net Change Protocol. See the CDS V6-2- XML Schema Release Notes which can be downloaded via the XML Schema TRUD Download page.~~Where CDS UPDATE TYPE 1 is required (delete/cancellation), an empty XML element called 'Delete Transaction' can be used instead of submitting he original CDS Type record, after the CDS V6-2 Type 005N - CDS Transaction Header Group - Net Change Protocol/ CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol. See the CDS V6-2 or CDS V6-3 XML Schema Release Notes which can be downloaded via the XML Schema TRUD Download page.

The CDS APPLICABLE DATE and CDS APPLICABLE TIME must be used to ensure that all Commissioning data is updated in the Secondary Uses Service database in the correct chronological order.

The CDS SENDER IDENTITY/ORGANISATION IDENTIFIER (CDS SENDER) **must not change during the lifetime of the CDS data**.
~~This is particularly significant for multiple and/or merged ORGANISATIONS, and for those services who submit data on behalf of another NHS Trust, NHS Foundation Trust or Independent Sector Healthcare Provider.~~ This is particularly significant for multiple and/or merged ORGANISATIONS, and for those services who submit data on behalf of another NHS Trust, NHS Foundation Trust or Independent Sector Healthcare Provider.

Bulk Replacement
~~Bulk Replacement processes are managed by specific data settings as defined in the CDS V6-2 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol option of the CDS Transaction Header Group.~~Bulk Replacement processes are managed by specific data settings as defined in the CDS V6-2 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol/CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol option of the CDS Transaction Header Group. The Secondary Uses Service uses the following data to manage the database:

- CDS SENDER IDENTITY/ORGANISATION IDENTIFIER (CDS SENDER)

- CDS BULK REPLACEMENT GROUP CODE
- CDS EXTRACT DATE
- CDS EXTRACT TIME
- CDS REPORT PERIOD START DATE
- CDS REPORT PERIOD END DATE

Note that CDS SENDER IDENTITY is used for CDS V6-2, CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set and CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set. ~~ORGANISATION IDENTIFIER (CDS SENDER) is used for CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set and all other Commissioning Data Set versions after CDS V6-2.~~ ORGANISATION IDENTIFIER (CDS SENDER) is used for CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set and CDS V6-3 onwards.

Every CDS Type must be submitted using the correct CDS BULK REPLACEMENT GROUP CODE.

The CDS REPORT PERIOD START DATE and the CDS REPORT PERIOD END DATE, (i.e. the effective date period), must be valid and consistent, and reflect the dates relevant to the Commissioning data contained in the interchange.

The CDS SENDER IDENTITY/ORGANISATION IDENTIFIER (CDS SENDER) must not change during the lifetime of the Commissioning Data Set record. This is particularly significant for multiple and/or merged ORGANISATIONS, and for those services who submit data on behalf of another ORGANISATION.

~~For submissions of CDS V6-2, CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set Type 011 and CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set, the CDS PRIME RECIPIENT IDENTITY is Mandatory for submission in the CDS Type 005B - CDS Transaction Header Group - Bulk Update Protocol and CDS Type 005N - CDS Transaction Header Group - Net Change Protocol.~~For submissions of CDS V6-2, CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set Type 011 and CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set, the CDS PRIME RECIPIENT IDENTITY is Mandatory for submission in the CDS Type 005B (CDS Transaction Header Group - Bulk Update Protocol) and CDS Type 005N (CDS Transaction Header Group - Net Change Protocol). However, it no longer forms part of the key for the process of determining duplicate records within the Secondary Uses Service. ~~Note that the CDS PRIME RECIPIENT IDENTITY continues to be used to determine data access requirements within the Secondary Uses Service.~~ Note that the CDS PRIME RECIPIENT IDENTITY continues to be used to determine data access requirements within the Secondary Uses Service for Commissioning Data Set version 6-2 submissions. For Commissioning Data Set version 6-3 and CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set, data element ORGANISATION IDENTIFIER (CDS RECIPIENT) is used for this purpose.

~~Versions of the CDS Type 005B - CDS Transaction Header Group - Bulk Update Protocol and CDS Type 005N - CDS Transaction Header Group - Net Change Protocol from CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set onwards use ORGANISATION IDENTIFIER (CDS RECIPIENT) which is no longer Mandatory for submission; however the requirement for this data element to support access to data remains.~~

If it is necessary to change any of this data during the lifetime of a Commissioning Data Set record, then the Secondary Uses Service (SUS) Service Desk should be contacted for advice. See the NHS Digital website at: Secondary Uses Service (SUS).

It is strongly advised that users of the Bulk Replacement Mechanism maintain a correctly generated CDS UNIQUE IDENTIFIER within the Commissioning data. This will establish a migration path towards the use of the Net Change Mechanism and will also then minimise the risk of creating duplicate Commissioning Data Set data.

Sub contracting

If a Health Care Provider sub-contracts healthcare provision and its associated Commissioning Data Set submission to a second ORGANISATION (eg a different Health Care Provider or a Shared Services Organisation), arrangements to submit the Commissioning Data Set data must be made locally to ensure that only one ORGANISATION sends the Commissioning Data Set data to the Secondary Uses Service.

If the second ORGANISATION wishes to add other Commissioning data to the Secondary Uses Service database to that already submitted by the first ORGANISATION, both parties need to ensure that a different CDS SENDER IDENTITY/ORGANISATION IDENTIFIER (CDS SENDER) is used.

Note: Data sent using the same CDS SENDER IDENTITY/ORGANISATION IDENTIFIER (CDS SENDER) by two different parties will most likely overwrite each other's data in the Secondary Uses Service database. Further advice can be obtained from the Secondary Uses Service (SUS) Service Desk, see the NHS Digital website at: SUS Guidance.

Users should be aware of how the 15 character code of their CDS INTERCHANGE SENDER IDENTITY (also known as the EDI Address) is created. This may depend on how their XML interface solution has been set up. It may not be possible to rely on a change to the ORGANISATION CODE (CODE OF PROVIDER)/ORGANISATION IDENTIFIER (CODE OF PROVIDER) in order to change the CDS INTERCHANGE SENDER IDENTITY should this become necessary.

COMMISSIONING DATA SET VERSION 6-3 TYPE LIST

Change to Supporting Information: New Supporting Information

CDS TYPE
Outpatient Care:
CDS V6-3 Type 020 - Outpatient CDS
Admitted Patient Care:
CDS V6-3 Type 120 - Admitted Patient Care - Finished Birth Episode CDS
CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode CDS
CDS V6-3 Type 140 - Admitted Patient Care - Finished Delivery Episode CDS
CDS V6-3 Type 150 - Admitted Patient Care - Other Birth Event CDS
CDS V6-3 Type 160 - Admitted Patient Care - Other Delivery Event CDS
CDS V6-3 Type 180 - Admitted Patient Care - Unfinished Birth Episode CDS
CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode CDS
CDS V6-3 Type 200 - Admitted Patient Care - Unfinished Delivery Episode CDS
Commissioning Data Set Interchange and Message Controls - Mandatory for every Interchange:
CDS V6-3 Type 001 - CDS Interchange Header
CDS V6-3 Type 002 - CDS Interchange Trailer
CDS V6-3 Type 003 - CDS Message Header
CDS V6-3 Type 004 - CDS Message Trailer
Commissioning Data Set Transaction Header Group - Mandatory for every Commissioning Data Set:
CDS V6-3 Type 005B - CDS Transaction Header Group - Bulk Update Protocol
or
CDS V6-3 Type 005N - CDS Transaction Header Group - Net Change Protocol

---

COMMISSIONING DATA SET VERSIONS

Change to Supporting Information: Changed Description

Listed below are the Commissioning Data Set versions since 2001.

Current versions:

- November 2012: CDS Version 6-2 Type List (updated October 2017 to support CDS Version 6-2-1, April 2019 to support CDS Version 6-2-2, April 2021 to support CDS Version 6-2-3 and April 2021 to support CDS Version 6-2-0)
- April 2022: CDS Version 6-3 Type List

Retired versions:

- November 2008: CDS Version 6-1 Type List
- December 2007 to November 2012: CDS Version 6-0
- April 2005 to March 2008: CDS Version NHS005 Type List
- April 2001 to March 2005: CDS Version NHS003 and 4 Type List

The XML Schemas and supporting information can be downloaded from Technology Reference Data Update Distribution (TRUD) at: NHS Data Model and Dictionary: DD XML Schemas.

COMMISSIONING DATA SET XML SCHEMA DESIGN

Change to Supporting Information: Changed Description

~~The use of XML was mandated by the e-Government Interoperability Framework (e-GIF) programme as the standard to be used for messaging by government organisations and has accordingly been adopted by the NHS.~~The use of XML was mandated by the e-Government Interoperability Framework (e-GIF) programme as the standard to be used for messaging by government organisations and was adopted by the NHS for the submission of Commissioning Data Set data to the Secondary Uses Service.

~~For the submission of Commissioning Data Set data to the Secondary Uses Service, XML based messaging has been developed to be fully adopted by the end of 2007, replacing all previously published Commissioning Data Set Message formats.~~

XML Schema Standards
The overall standards applied and supported by the schema are:

- W3C schema standards
- e-Government Interoperability Framework (e-GIF)
- e-GOV Best Practice guidelines for XML Schema
- The NHS Data Model and Dictionary

Note:
e-GIF and the Government Data Standards Catalogue **have been archived** and are available for reference only.

XML Schema Naming Conventions
These are in CamelCase reflecting recommended e-GOV guidelines for best practice. Wherever possible, schema data item names are compliant (or intuitively identifiable) with the NHS Data Model and Dictionary data naming conventions.

XML Schema Components
The schema consists of the following components:

- The CDS XML Message Root
- The CDS XML Standard Data Structures
- The CDS XML Standard Data Elements
- CDS Type Sub-Schemas

These are described below.

The XML Schema Root
The schema root is the control section of the schema and uses the "XML Include" technique to call schema sub-components:

- The Standard Data Structures
- The Standard Data Elements
- All CDS Type sub-component schemas, including the Commissioning Data Set Headers and Trailers

In addition, the schema root is the only schema entry point and on entry the schema validates the XML Attributes for:

- SchemaVersion
- SchemaDate

XML Schema Component: Standard Data Structures
XML Schema Version 6-0 introduced standard data structures which are invoked from the CDS Type sub-component schemas. This simplifies the management and definition of data structures and eliminates (as far as is possible) the multiple definitions of the many common structures used across the CDS Type components. It also helps to eliminate naming and spelling inconsistencies.

This implementation of the schema does not enforce the sequence of data elements within its data structures (nor its data structures within the schema), nor is it foreseen that this will be enforced in future. For ease of understanding, users are advised to implement the structure sequences as published.

In general, the restraints on the permitted occurrences of data groups have been removed and in most cases, unbounded occurrences of iterating data structures are supported. The NHS Data Model and Dictionary defines the actual requirements for the use of NHS data.

XML Schema Component: Standard Data Elements
XML Schema data items are defined with ***_Type*** suffixes and usually refer to a standard list of XML data types which are usually qualified with an enumeration list to reflect the NHS Data Standards as published in the NHS Data Model and Dictionary.

Schema Component: XML Attributes
XML Attributes are used (sparingly) to enforce certain logical data and structure relationships, an example being to determine the type of Critical Care Period data being carried.

COMMISSIONING DATA SET XML SCHEMA DOCUMENTATION

Change to Supporting Information: Changed Description

The use of XML was mandated by the e-Government Interoperability Framework (e-GIF) programme as the standard to be used for messaging by government organisations and accordingly this has been adopted by the NHS.

Note:
e-GIF and the Government Data Standards Catalogue **have been archived** and are available for reference only.

For the most part, the XML Schema applies the data specifications as authorised by the NHS and documented in the NHS Data Model and Dictionary.

The Issued Documentation
~~The Data Dictionary and Messaging Team maintain and issue the following XML Schema documentation:~~The NHS Digital Data Architecture Team maintain and issue the following XML Schema documentation:

- ~~**The XML Schema Files** (generated using ALTOVA XMLSPY ©)~~
  ~~The XML Schema files consist of a series of interpretable XML/HTML statements which define the data structures and content rules for the use of the message. User systems use the XML Schema to either populate or interpret a 'XML Schema instance' that is the resultant XML formatted message file which carries the data.~~
- **The XML Schema Files** (generated using ALTOVA XMLSPY ©)
  The XML Schema files consist of a series of interpretable XML/HTML statements which define the data structures and content rules for the use of the message. User systems use the XML Schema to either populate or interpret an 'XML Schema instance' that is the resultant XML formatted message file which carries the data.

The XML Schema therefore represents the 'design' of the message and it may be necessary therefore to interpret and understand the information inherent in the XML Schema file code.

- ~~**The XML Schema Documentation** (generated using ALTOVA XMLSPY ©)~~
  ~~These files are generated using XMLSPY software and may be read in any browser, e.g. MS Explorer©. The files consist of a 'root' entry HTML formatted file and a (usually) large number of supporting .png graphic files used by the root HTML.~~
- **The XML Schema Documentation** (generated using ALTOVA XMLSPY ©)
  These files are generated using XMLSPY software and may be read in any browser, e.g. Microsoft Edge©. The files consist of a 'root' entry HTML formatted file and a (usually) large number of supporting .png graphic files used by the root HTML.

This documentation enables useful "drill down" functions for investigating structures and data items, but these features are not as powerful as when using a full XML Schema editor (see below).

Most browsers will support printing and thus the XML Schema details can be printed as required but users are warned that browser based prints often generate a large number of pages.

The CDS XML Schema generates approximately 450+ pages of details, printing is therefore not advised.

- ~~**The XML Schema Release Notes**~~
  ~~This is a pdf document identifying the changes applied to the XML Schema release.~~
  ~~References to Information Standards Notices and other technical change requirements are detailed.~~
- **The XML Schema Release Notes**
  This is a pdf document identifying the changes applied to the XML Schema release, from the previous release.
  References to Information Standards Notices and other technical change requirements are detailed.

Reading XML Schema
Whilst XML Schemas can be read as HTML in most browsers, it may be difficult to fully interpret the XML Schema unless the reader has a detailed understanding of HTML.

It is recommended that XML Schemas are read using an XML interpreter (such as ALTOVA XMLSPY ©), many of these are freely available on the internet.

XML Schema technicians may prefer to use such software to examine XML Schemas more deeply as the interactive facilities provided are generally more powerful than browsing the XML/HTML supplied Schema code.

COMMISSIONING DATA SET XML SCHEMA OVERVIEW

Change to Supporting Information: Changed Description

~~The use of XML was mandated by the e-Government Interoperability Framework (e-GIF) programme as the standard to be used for messaging by government organisations and has accordingly been adopted by the NHS.~~The use of XML was mandated by the e-Government Interoperability Framework (e-GIF) programme as the standard to be used for messaging by government organisations and was adopted by the NHS for the submission of Commissioning Data Set data to the Secondary Uses Service.

~~For the submission of Commissioning Data Set data to the Secondary Uses Service, XML based messaging has been developed replacing all previously published Commissioning Data Set Message formats.~~

~~The CDS XML Schema is supported and applied in the Secondary Uses Service front-end software service (the XML Transfer Service - XTS) to enforce a nationally agreed data specification and thus help protect the data quality and integrity of the data submitted to and stored within the Secondary Uses Service.~~The CDS XML Schema is supported and applied in the Secondary Uses Service to enforce a nationally agreed data specification and thus help protect the data quality and integrity of the data submitted to and stored within the Secondary Uses Service.

~~It should be noted that after accepting the XML Schema instance data, the Secondary Uses Service then applies further logical data validations and may identify and report further data conditions.~~It should be noted that after accepting the XML Schema interchange data, the Secondary Uses Service then applies further logical data validations and may identify and report further data conditions.

For the most part, the XML Schema applies the data specifications as authorised by the NHS and documented in the NHS Data Model and Dictionary. However, as the NHS Data Model and Dictionary is updated on a continuous time basis and XML Schemas may be less dynamic and updated on a longer time cycle, there may be subtle differences in the data specifications applied in the XML Schema. For example, additional National Codes may be supported in one version of the Commissioning Data Set XML Schema but not in earlier versions. ~~Where this is the case, information relating to the supported National Codes can be found on the CDS Version 6-2 XML Schema Constraints page and associated Attributes and/or Data Elements.~~ Where this is the case, information relating to the supported National Codes can be found on the CDS Version 6-2 XML Schema Constraints / CDS Version 6-3 XML Schema Constraints page and associated Attributes and/or Data Elements.

Additionally an XML Schema may deliberately retain historic National Codes as well as supporting the new National Codes in order to enable NHS users to be able to process historic data.

XML Schema Standards
The overall standards applied and supported by the XML Schema are:

- W3C schema standards
- e-Government Interoperability Framework (e-GIF)
- e-GOV Best Practice guidelines for XML Schema
- The NHS Data Model and Dictionary

Note:
e-GIF and the Government Data Standards Catalogue **have been archived** and are available for reference only.

XML Schema Naming Conventions
These are in ***CamelCase*** as accepted best practice. Wherever possible, XML Schema data item names are compliant (or intuitively identifiable) with the NHS Data Model and Dictionary naming conventions.

XML Schema Documentation
XML Schema documentation usually consists of several related publications:

- Information Standards Notices (ISN) issued for NHS business, process and definition changes; these will usually include the Data Sets, Data Element definitions etc.
- ~~Information Standards Notices issued to authorise the CDS XML Schema itself~~
- Information Standards Notices or Data Dictionary Change Notices issued to authorise the CDS XML Schema itself
- The CDS XML Schema Release Notes which provides a technical overview of the release (in pdf)
- The XMLSPY© generated XML Schema Documentation which is a large collection of HTML files.

XML Schema Components: Schema Root
The XML Schema root is the control section of the XML Schema and is the only entry point and uses the "XML Include" technique to call all XML Schema sub components:

- The Standard Data Elements
- The Standard Data Structures
- All sub-component XML Schemas for CDS Types including the Commissioning Data Set Headers and Trailers

---

COMMISSIONING DATA SET XML SCHEMA VERSION NUMBERING

Change to Supporting Information: Changed Description

The CDS XML Schema Version Number Format
~~The use of XML was mandated by the e-Government Interoperability Framework (e-GIF) programme as the standard to be used for messaging by government organisations and has accordingly been adopted by the NHS.~~The use of XML was mandated by the e-Government Interoperability Framework (e-GIF) programme as the standard to be used for messaging by government organisations and was adopted by the NHS.

Note:
e-GIF and the Government Data Standards Catalogue **have been archived** and are available for reference only.

The CDS XML Schema adopts version numbering techniques in line with published e-GOV best practice guidelines. All schema components are version numbered and date qualified; the following is an example of the adopted format:

CDS XML Message Root
Example: V6-0-2007-03-01 (Note that dash separators are used).
[Schema Filename] + [Major Version Number] + [Minor Version Number] + [Version Date]

VERSION NUMBER ELEMENT	FORMAT	EXAMPLE AND NOTES
~~XML Schema File Name~~	~~As allocated by Information Standards Delivery, NHS Digital~~	~~CDS-XML_Message_Root-~~
XML Schema File Name	As allocated by Data Architecture at NHS Digital	CDS-XML_Message_Root-
Major Version Number	A maximum of 3 characters incremented numerically without leading zeros	V6-
Minor Version Number	A maximum of 3 characters incremented numerically without leading zeros	0-
Version Date	ccyy-mm-dd	2007-03-01

The Major Version Number:
This is incremented when fundamental change has taken place such as:

- Major addition / deletion / change of XML Schema business functionality
- Major change to the technical design of the schema
- Re-alignment of the XML Schema Version Number after cumulative changes

The Minor Version Number:
This is incremented for all XML Schema changes ***not*** warranting a Major Version Number increment (as above). Examples are:

- Minor changes to XML Schema business functionality
- Minor changes to the XML Schema data structures that are not upwardly compatible*

- Addition and/or deletion of data items that are not upwardly compatible*
- Changes to data item facet definitions that are not upwardly compatible*

The Version Date:
This may be adjusted as a defined reference point for a no risk XML Schema release to reflect minor changes and corrective releases.
Examples are:

- Minor changes to the XML Schema data structures that are upwardly compatible* for instance the addition of an optional data item.
- Changes to data item facet definitions that are upwardly compatible* for instance the addition (but not the deletion) of code values to a data item enumeration list.
- Interim development versions, released for information only

*** Upwardly Compatible:**
Minor changes and adjustments to the XML Schema which introduce little or no risk of increased data rejection are deemed upwardly compatible.

For example, corrective adjustments, which align the XML Schema to the authorised NHS Data Standards as published in the NHS Data Model and Dictionary often fall within this category.

The XML Schema Date:
All XML Schema releases have a designated SchemaDate XML Attribute.

XML Schema Version Control - The Schema Root:
The schema root is the single entry point to the XML Schema and XML Attributes for the following are validated:

- SchemaVersion
- SchemaDate

EMED3 FIT NOTE

Change to Supporting Information: New Supporting Information

The eMED3 Fit Note, formally known as a Statement of Fitness to Work, was introduced in April 2010 across England, Wales and Scotland. It enables CARE PROFESSIONALS such as CONSULTANTS and GENERAL MEDICAL PRACTITIONERS to give advice to their PATIENTS about the impact of their health condition on their fitness for work and is used to provide medical evidence for employers or to support a claim to health-related benefits through the Department for Work and Pensions.

An eMED3 Fit Note is issued after the first 7 days of sickness absence (when PATIENTS can self-certify) if the CARE PROFESSIONAL assesses that the PATIENTs health affects their fitness to work. The CARE PROFESSIONAL may decide that the PATIENT is unfit for work, or may be fit for work subject to certain conditions, with accompanying notes on suggested adjustments or adaptations to the job role or the workplace.

For further information on eMED3 Fit Notes, see the gov.uk website at: Fit Note.

EMED3 FIT NOTE APPLICABLE PERIOD

Change to Supporting Information: New Supporting Information

An eMED3 Fit Note Applicable Period is a PERSON PROPERTY ASSIGNMENT PERIOD.

An eMED3 Fit Note Applicable Period describes the period of time covered when the PATIENT is issued with an eMED3 Fit Note until the EMED3 FIT NOTE END DATE.

If the duration of the eMED3 Fit Note is indefinite, there will be no eMED3 Fit Note Applicable Period end date, and the EMED3 FIT NOTE DURATION will be Default Code '*eMED3 Fit Note is for an indefinite period*'.

This supporting information is also known by these names:

Context	Alias
plural	eMED3 Fit Note Applicable Periods

EMED3 FIT NOTE ASSESSMENT DATE

Change to Supporting Information: New Supporting Information

An eMED3 Fit Note Assessment Date is an ACTIVITY DATE TIME.

An eMED3 Fit Note Assessment Date is the date on which a PATIENT was assessed as requiring an eMED3 Fit Note during a CARE CONTACT or ACTIVITY GROUP.

This supporting information is also known by these names:

Context	Alias
plural	eMED3 Fit Note Assessment Dates

EMED3 FIT NOTE RECORDED DATE

Change to Supporting Information: New Supporting Information

An eMED3 Fit Note Recorded Date is an ACTIVITY DATE TIME.

An eMED3 Fit Note Recorded Date is the date on which a record of an eMED3 Fit Note issued to a PATIENT was recorded on the Health Care Provider's ELECTRONIC HEALTH RECORD.

This supporting information is also known by these names:

Context	Alias
plural	eMED3 Fit Note Assessment Dates

FAST HEALTHCARE INTEROPERABILITY RESOURCES

Change to Supporting Information: New Supporting Information

Fast Healthcare Interoperability Resources (FHIR®) is a standard for exchanging healthcare information electronically, to enable ELECTRONIC HEALTH RECORD data to be structured, standardised and understandable when machine-processed.

For further information on FHIR®, see the HL7 FHIR Release 4 website.

FIRST CONTACT PRACTITIONER

Change to Supporting Information: New Supporting Information

A First Contact Practitioner is a CARE PROFESSIONAL.

First Contact Practitioners are regulated, advanced and autonomous health CARE PROFESSIONALS who are trained to provide expert PATIENT assessment, diagnosis and first-line treatment, self-care advice and, if required, appropriate onward referral to other SERVICES.

For further information on First Contact Practitioners in Musculoskeletal SERVICES, see the NHS Long Term Plan website at: Shorter Waits For Planned Care.

This supporting information is also known by these names:

Context	Alias
plural	First Contact Practitioners

LAST PATIENT CANCELLED DATE

Change to Supporting Information: New Supporting Information

A Last Patient Cancelled Date is an ACTIVITY DATE TIME.

A Last Patient Cancelled Date is the date of the last APPOINTMENT which the PATIENT cancelled on or before their APPOINTMENT DATE.

This supporting information is also known by these names:

Context	Alias
plural	Last Patient Cancelled Dates

LAST PATIENT DID NOT ATTEND DATE

Change to Supporting Information: New Supporting Information

A Last Patient Did Not Attend Date is an ACTIVITY DATE TIME.

A Last Patient Did Not Attend Date is the date of the last APPOINTMENT which the PATIENT did not attend without advance warning.

This supporting information is also known by these names:

Context	Alias
plural	Last Patient Did Not Attend Dates

MAIN SPECIALTY AND TREATMENT FUNCTION CODES TABLE

Change to Supporting Information: Changed Description

For further information regarding the definition and use of MAIN SPECIALTY see the attribute MAIN SPECIALTY CODE.

For further information regarding the definition and use of TREATMENT FUNCTION see the attribute TREATMENT FUNCTION CODE.

For additional queries contact the NHS Digital by email at: enquiries@nhsdigital.nhs.uk with the subject "Main Specialty and Treatment Function Codes".

Note:

- New National Codes for MAIN SPECIALTY CODE and TREATMENT FUNCTION CODE were introduced from 2 April 2020 as part of the update to the DCB0028: Treatment Function and Main Specialty Standard. Submission of these codes for the Commissioning Data Sets is only possible where the healthcare provider has updated their CDS-XML schema version to CDS-XML version 6-2-0. Users of the original CDS-XML schema version 6-2 will be unable to submit the new codes introduced in the release of DCB0028: Treatment Function and Main Specialty Standard in April 2020 or the addendum to DCB0028 released in January 2021 to add a new TREATMENT FUNCTION CODE to represent Post-COVID-19 Syndrome Services.

Table 1 Main Specialty codes

	Code	Main Specialty Title	Comments
Surgical Specialties			
	100	General Surgery	For further information, see: Royal College of Surgeons - General Surgery
	101	Urology	For further information, see: Royal College of Surgeons - Urology
	107	Vascular Surgery	For further information, see: Royal College of Surgeons - Vascular Surgery
	110	Trauma and Orthopaedics	For further information, see: Royal College of Surgeons - Orthopaedic Surgery
	120	Ear Nose and Throat	Formerly known as ENT. For further information, see: Royal College of Surgeons - Ear, Nose and Throat (ENT)
	130	Ophthalmology	For further information, see: The Royal College of Ophthalmologists
	140	Oral Surgery	For further information, see: Royal College of Surgeons - Oral and Maxillofacial Surgery
	141	Restorative Dentistry	For further information, see: The British Society for Restorative Dentistry (BSRD)
	142	Paediatric Dentistry	For further information, see: The British Society of Paediatric Dentistry
	143	Orthodontics	For further information, see: British Orthodontic Society
	145	Oral and Maxillofacial Surgery	For further information, see: Royal College of Surgeons - Oral and Maxillofacial Surgery
	146	Endodontics	For further information, see: British Endodontic Society
	147	Periodontics	For further information, see: British Society of Periodontology
	148	Prosthodontics	For further information, see: The British Society of Prosthodontics (BSSPD)

	149	Surgical Dentistry	For further information, see: Royal College of Surgeons - Faculty of Dental Surgery (FDS)
	150	Neurosurgery	For further information, see: Royal College of Surgeons - Neurosurgery
	160	Plastic Surgery	For further information, see: Royal College of Surgeons - Plastic and Reconstructive
	170	Cardiothoracic Surgery	For further information, see: Royal College of Surgeons - Cardiothoracic Surgery
	171	Paediatric Surgery	For further information, see: Royal College of Surgeons - Paediatric Surgery
	191	Pain Management (Retired 1 April 2004)	
Medical Specialties			
	180	Emergency Medicine	Formerly known as Accident and Emergency. For further information, see: The Royal College of Emergency Medicine
	190	Anaesthetics	For further information, see: Royal College of Anaesthetists
	192	Intensive Care Medicine	Formerly known as Critical Care Medicine. For further information, see: The Faculty of Intensive Care Medicine
	200	Aviation and Space Medicine	For further information, see: Joint Royal Colleges of Physicians Training Board - Aviation and Space Medicine
	300	General Internal Medicine	Formerly known as General Medicine. For further information, see: Joint Royal Colleges of Physicians Training Board - General Internal Medicine (GIM)
	301	Gastroenterology	For further information, see: Joint Royal Colleges of Physicians Training Board - Gastroenterology
	302	Endocrinology and Diabetes	Formerly known as Endocrinology. For further information, see: Joint Royal Colleges of Physicians Training Board - Endocrinology and Diabetes Mellitus
	303	Clinical Haematology	For further information, see: Joint Royal Colleges of Physicians Training Board - Haematology
	304	Clinical Physiology	For further information, see: The Registration Council for Clinical Physiologists
	305	Clinical Pharmacology	For further information, see: Joint Royal Colleges of Physicians Training Board - Clinical Pharmacology and Therapeutics (CPT)
	310	Audio Vestibular Medicine	Formerly known as Audiological Medicine. For further information, see: Joint Royal Colleges of Physicians Training Board - Audio vestibular Medicine
	311	Clinical Genetics	For further information, see: Joint Royal Colleges of Physicians Training Board - Clinical Genetics
*	312	Clinical Cytogenetics and Molecular Genetics (Retired 1 April 2010)	
	313	Clinical Immunology	Formerly known as Clinical Immunology and Allergy. For further information, see: Joint Royal Colleges of Physicians Training Board - Immunology
	314	Rehabilitation Medicine	Formerly known as Rehabilitation. For further information, see: Joint Royal Colleges of Physicians Training Board - Rehabilitation Medicine
	315	Palliative Medicine	For further information, see: Joint Royal Colleges of Physicians Training Board - Palliative Medicine

	317	Allergy	For further information, see: Joint Royal Colleges of Physicians Training Board - Allergy
	320	Cardiology	For further information, see: Joint Royal Colleges of Physicians Training Board - Cardiology
	321	Paediatric Cardiology	For further information, see: Joint Royal Colleges of Physicians Training Board - Paediatric Cardiology
	325	Sport and Exercise Medicine	For further information, see: Faculty of Sport and Exercise Medicine
	326	Acute Internal Medicine	For further information, see: Joint Royal Colleges of Physicians Training Board - Acute Internal Medicine
	330	Dermatology	For further information, see: Joint Royal Colleges of Physicians Training Board - Dermatology
	340	Respiratory Medicine	Also known as Thoracic Medicine. For further information, see: Joint Royal Colleges of Physicians Training Board - Respiratory Medicine
	350	Infectious Diseases	For further information, see: Joint Royal Colleges of Physicians Training Board - Infectious Diseases and Tropical Medicine
	352	Tropical Medicine	For further information, see: Joint Royal Colleges of Physicians Training Board - Infectious Diseases and tropical Medicine
	360	Genitourinary Medicine	For further information, see: Joint Royal Colleges of Physicians Training Board - Genitourinary Medicine
	361	Renal Medicine	Formerly known as Nephrology. For further information, see: Joint Royal Colleges of Physicians Training Board - Renal Medicine
	370	Medical Oncology	For further information, see: Joint Royal Colleges of Physicians Training Board - Medical Oncology
	371	Nuclear Medicine	For further information, see: Joint Royal Colleges of Physicians Training Board - Nuclear Medicine
	400	Neurology	For further information, see: Joint Royal Colleges of Physicians Training Board - Neurology
	401	Clinical Neurophysiology	For further information, see: Joint Royal Colleges of Physicians Training Board - Clinical Neurophysiology
	410	Rheumatology	For further information, see: British Society for Rheumatology
	420	Paediatrics	For further information, see: Royal College of Paediatrics and Child Health - General Paediatrics
	421	Paediatric Neurology	For further information, see: Royal College of Paediatrics and Child Health - Neurology
	430	Geriatric Medicine	For further information, see: Joint Royal Colleges of Physicians Training Board - Geriatric Medicine
	450	Dental Medicine	Formerly known as Dental Medicine Specialties. For further information, see: Royal College of Surgeons - Faculty of Dental Surgery (FDS)
	451	Special Care Dentistry	For further information, see: Special Care Dentistry Association (SCDA)
	460	Medical Ophthalmology	For further information, see: Joint Royal Colleges of Physicians Training Board - Medical Ophthalmology
†	500	Obstetrics and Gynaecology	For further information, see: Royal College of Obstetricians and Gynaecologists
	501	Obstetrics	For further information, see: Royal College of Obstetricians and Gynaecologists
	502	Gynaecology	

			For further information, see: Royal College of Obstetricians and Gynaecologists
	504	Community Sexual and Reproductive Health	For further information, see: Faculty of Sexual & Reproductive Healthcare of the Royal College of Obstetricians & Gynaecologists
	510	Antenatal Clinic (Retired 1 April 2004)	
	520	Postnatal Clinic (Retired 1 April 2004)	
	600	General Medical Practice	For further information, see: Royal College of General Practitioners
	601	General Dental Practice	For further information, see: Royal College of Surgeons - Faculty of Dental Surgery (FDS)
	610	Maternity Function (Retired 1 April 2004)	
	620	Other Than Maternity (Retired 1 April 2004)	
	831	Medical Microbiology and Virology	For further information, see: The Royal College of Pathologists - Medical Microbiology and The Royal College of Pathologists - Virology
	833	Medical Microbiology	Also known as Microbiology and Bacteriology. For further information, see: The Royal College of Pathologists - Medical Microbiology
	834	Medical Virology	For further information, See: The Royal College of Pathologists - Medical Virology
Psychiatry			
	700	Learning Disability	Also known as Intellectual Disability. For further information, see: Royal College of Psychiatrists - Faculty of the Psychiatry of Intellectual Disability and British Institute of Learning Disabilities
	710	Adult Mental Illness	For further information, see: NHS England - Adult and older adult mental health
	711	Child and Adolescent Psychiatry	For further information, see: Royal College of Psychiatrists - Faculty of Child and Adolescent Psychiatry
	712	Forensic Psychiatry	For further information, see: Royal College of Psychiatrists - Faculty of Forensic Psychiatry
	713	Medical Psychotherapy	For further information, see: Royal College of Psychiatrists - Faculty of Medical Psychotherapy
	715	Old Age Psychiatry	For further information, see: Royal College of Psychiatrists - Faculty of Old Age Psychiatry
Other			
	560	Midwifery	Formerly known as Midwife Episode. For further information, see: Royal College of Midwives
	800	Clinical Oncology	Formerly known as Radiotherapy. For further information, see: The Royal College of Radiologists - Clinical Oncology
	810	Radiology	For further information, see: The Royal College of Radiologists (RCR)
	820	General Pathology	For further information, see: The Royal College of Pathologists
	821	Blood Transfusion	For further information, see: The Royal College of Pathologists - Blood Transfusion
	822	Chemical Pathology	For further information, see: The Royal College of Pathologists
	823	Haematology	

			For further information, see: The Royal College of Pathologists - Haematology
	824	Histopathology	For further information, see: The Royal College of Pathologists - Histopathology
	830	Immunopathology	For further information, see: The Royal College of Pathologists - Immunology
	832	Neuropathology (Retired 1 April 2004)	
	900	Community Medicine	For further information, see: Faculty of Public Health
	901	Occupational Medicine	For further information, see: Royal College of Physicians - Faculty of Occupational Medicine
	902	Community Health Services Dental	For further information, see: Faculty of Public Health
	903	Public Health Medicine	For further information, see: Faculty of Public Health
	904	Public Health Dental	For further information, see: GOV.uk - Oral Health
	950	Nursing	Formerly known as Nursing Episode. For further information, see: Nursing & Midwifery Council
	960	Allied Health Professional	Formerly known as Allied Health Professional Episode. For further information, see: Health and Care Professions Council
	990	Joint Consultant Clinics (Retired 1 April 2004)	

Notes:

†	Code 500 is not acceptable for data sets/collections including Hospital Episode Statistics
*	Code 312 is retained for CONSULTANTS qualified in this Main Specialty prior to 1 April 2010.

Table 2 Treatment Function codes

Code	Treatment Function Title	Comments
Surgical Specialties		
100	General Surgery Service	SERVICES delivering surgical ACTIVITY not covered by other subspecialty areas. The majority of elective procedures, about 80 per cent, fall outside subspecialty areas. For further information, see: Royal College of Surgeons - Surgical Specialties
101	Urology Service	Surgical SERVICES for the treatment of disorders of the urinary system and male reproductive system. This includes surgery for gender dysphoria. For further information, see: Royal College of Surgeons - Urology
102	Transplant Surgery Service	SERVICES for pre- and post-operative care for major organ transplants except heart and lung. Excludes Cardiothoracic Transplantation Service - see TREATMENT FUNCTION CODE 174, corneal grafts carried out by Ophthalmology Service - see TREATMENT FUNCTION CODE 130 and Blood and Bone Marrow Transplantation Service - see TREATMENT FUNCTION CODE 308. For further information, see: Royal College of Surgeons - General Surgery
103	Breast Surgery Service	SERVICES which include surgical treatment for cancer, suspected neoplasms, indeterminate breast lesions, benign breast lumps, disorders of the nipple-areolar complex, cysts and post-cancer reconstructive, revision and symmetrising surgery. Includes breast

		surgery for gender dysphoria. Excludes cosmetic surgery. For further information, see: Association of Breast Surgery
104	Colorectal Surgery Service	SERVICES for the surgical treatment of disorders of the lower intestine (colon, anus and rectum)
105	Hepatobiliary and Pancreatic Surgery Service	Specialist surgical SERVICES for hepatobiliary and pancreatic (HPB) disorders. To be used by recognised specialist units and associated outreach SERVICES only. Excludes Transplant Surgery Service - see TREATMENT FUNCTION CODE 102. For further information, see: NHS England - A02. Hepatobiliary and Pancreas
106	Upper Gastrointestinal Surgery Service	SERVICES for surgical treatment of disorders of the upper parts of the gastrointestinal tract. For further information, see: Royal College of Surgeons - General Surgery
107	Vascular Surgery Service	SERVICES for the surgical treatment of diseases of the vascular system. For further information, see: Royal College of Surgeons - Vascular Surgery
108	Spinal Surgery Service	Surgery concentrating on specialised and complex treatment of issues of the back and spine. To be used by recognised specialist units and associated outreach SERVICES only. Excludes Trauma and Orthopaedic Service - see TREATMENT FUNCTION CODE 110, Orthopaedic Service - see TREATMENT FUNCTION CODE 111, Trauma Surgery Service - see TREATMENT FUNCTION CODE 115 and Spinal Injuries Service - see TREATMENT FUNCTION CODE 323. For further information, see: British Association of Spine Surgeons
109	Bariatric Surgery Service	SERVICES assessing, managing and treating obesity, and specifically consideration of bariatric (weight loss) surgery. It includes PATIENTS who are obese and have, or are at risk of, other medical conditions. It does not cover preventing a PERSON from becoming overweight or obese, or lifestyle weight management programmes for a PERSON who is overweight or obese. For further information, see: National Institute for Health and Care Excellence - Obesity
110	Trauma and Orthopaedic Service	SERVICES to treat injuries, congenital and acquired disorders of the bones, joints, and their associated soft tissues, including ligaments, nerves and muscles. Excludes Orthopaedic Surgery Service - TREATMENT FUNCTION CODE 111 and Spinal Surgery Service - see TREATMENT FUNCTION CODE 108. For major trauma centres use Trauma Surgery Service - see TREATMENT FUNCTION CODE 115. For further information, see: Royal College of Surgeons - Major Trauma Surgery and Royal College of Surgeons - Orthopaedic Surgery
111	Orthopaedic Service	SERVICES for the elective or planned surgical assessment or treatment of the musculoskeletal system. Excludes Trauma Surgery Service - see TREATMENT FUNCTION CODE 115. Where there is no dedicated Orthopaedic Service use Trauma and Orthopaedic Service - see TREATMENT FUNCTION CODE 110. For further information, see: Royal College of Surgeons - Orthopaedic Surgery
113	Endocrine Surgery Service	SERVICES for the surgical treatment of diseases of the thyroid and/or other endocrine glands. For further information, see: Royal College of Surgeons - General Surgery

115	Trauma Surgery Service	Major trauma specialist SERVICES at a designated unit, with the specific exclusion of Spinal Surgery Service - see TREATMENT FUNCTION CODE 108. Excludes elective or planned Orthopaedic Surgery Service - see TREATMENT FUNCTION CODE 111. Where there is no major trauma centre use Trauma and Orthopaedics Service - see TREATMENT FUNCTION CODE 110. For further information, see: Royal College of Surgeons - Major Trauma Surgery
120	Ear Nose and Throat Service	Formerly known as ENT. Surgical SERVICES for the assessment, diagnosis, management and treatment of ear, nose and/or throat issues. Excludes Audiology Service - see TREATMENT FUNCTION CODE 840. For further information, see: Royal College of Surgeons - Ear, Nose & Throat (ENT)
130	Ophthalmology Service	The surgical treatment of disorders and diseases of the eye. Excludes Medical Ophthalmology Service - see TREATMENT FUNCTION CODE 460 and Ophthalmic and Vision Science Service - see TREATMENT FUNCTION CODE 461. For further information, see: Royal College of Ophthalmologists
140	Oral Surgery Service	SERVICES for the diagnosis and surgical treatment of diseases, injuries and defects of hard and soft tissues of the mouth. Excludes departments delivering a SERVICE where oral surgery and maxillofacial services are mixed (i.e. an out-patient clinic accepting oral surgery and maxillofacial surgery patients) – see TREATMENT FUNCTION CODE 145. For further information, see: British Association of Oral Surgeons Specialty Training Curriculum – Oral Surgery
141	Restorative Dentistry Service	SERVICES providing examination and treatment of diseases of the oral cavity, the teeth and their supporting structures. Restorative Dentistry includes the dental specialties of Endodontics, Periodontics and Prosthodontics (including implantology), and its foundation is based upon how these interact in the management of cases requiring multifaceted care. For further information, see: British Society for Restorative Dentistry
143	Orthodontic Service	SERVICES for the treatment of malocclusions (improper bites). Orthodontic treatment can focus on dental displacement only, or can deal with the control and modification of facial growth. For further information, see: British Orthodontic Society
144	Maxillofacial Surgery Service	Professional recommendation is to use Oral and Maxillofacial Surgery Service where this SERVICE is combined with oral surgery - see TREATMENT FUNCTION CODE 145. Alternatively, for oral surgery services only see TREATMENT FUNCTION CODE 140. This code has been retained for existing SERVICES which only provide maxillofacial surgery.
145	Oral and Maxillofacial Surgery Service	Combined SERVICES providing diagnosis and surgical treatment of diseases, injuries and defects involving hard and soft tissues of the mouth, jaws, and neck. These SERVICES may have formerly been categorised as TREATMENT FUNCTION CODE 140 (Oral Surgery Service) or TREATMENT FUNCTION CODE 144 (Maxillofacial Surgery Service). For further information, see: British Association of Oral & Maxillofacial Surgeons
149	not a Treatment Function	

150	Neurosurgical Service	Surgical SERVICES for the treatment of disorders of the nervous system including the brain, spinal cord, peripheral nerves, and extra-cranial cerebrovascular system. Excludes Spinal Surgery Service - see TREATMENT FUNCTION CODE 108. For major trauma centres use Trauma Surgery Service – see TREATMENT FUNCTION CODE 115. For further information, see: Royal College of Surgeons - Neurosurgery
160	Plastic Surgery Service	SERVICES to correct or restore form and function. In addition to cosmetic or aesthetic surgery, plastic surgery includes many types of reconstructive surgery, and the treatment of burns. For care given within specialist burn services, use Burns Care Service - see TREATMENT FUNCTION CODE 161. Excludes breast surgery for gender dysphoria, use Breast Surgery Service - see TREATMENT FUNCTION CODE 103. For further information, see: Royal College of Surgeons - Plastic and Reconstructive
161	Burns Care Service	SERVICES for the surgical and non-surgical treatment of burns within recognised specialist burns units and associated outreach SERVICES only. Whilst this does not signify the CRITICAL CARE LEVEL, many PATIENTS will also come within the scope of the Critical Care Minimum Data Set. For further information, see: British Burn Association
170	Cardiothoracic Surgery Service	SERVICES delivering surgical treatment of diseases affecting the heart and organs inside the thorax (the chest). Should only be used where there are no separate SERVICES for Cardiac Surgery and Thoracic Surgery. For further information, see: Royal College of Surgeons - Cardiothoracic Surgery
172	Cardiac Surgery Service	SERVICES delivering surgical treatment of diseases affecting the heart. Procedures are often lengthy and complex, requiring support from advanced forms of technology during surgery and CRITICAL CARE LEVEL 2 and 3 for the PATIENT after surgery. For further information, see: Royal College of Surgeons - Cardiothoracic Surgery
173	Thoracic Surgery Service	SERVICES providing surgical treatment of diseases affecting organs inside the thorax (the chest). Generally, treatment of conditions of the lungs, chest wall, and diaphragm. Predominantly this is surgical treatment of malignant disease or its effects. For further information, see: Royal College of Surgeons - Cardiothoracic Surgery
174	Cardiothoracic Transplantation Service	SERVICES for pre- and post-operative care for heart and lung transplants. To be used by recognised specialist units and associated outreach services only. For further information, see: Royal College of Surgeons - Cardiothoracic Surgery
Other Children's Specialist Services - The Paediatric TREATMENT FUNCTION CODES represent CLINICS OR FACILITIES intended to provide dedicated SERVICES to children with appropriate facilities and support staff, i.e. they are designed for children only. If a CLINIC OR FACILITY provides this but also treats adult PATIENTS as part of the SERVICE then a Paediatric TREATMENT FUNCTION CODE may not be appropriate. The age of the PATIENT attending does not initiate a change to the TREATMENT FUNCTION CODE for the ACTIVITY.		
142	Paediatric Dentistry Service	Dedicated children's SERVICES for dentistry with appropriate facilities and support staff. For further information, see: The British Society of Paediatric Dentistry
171	Paediatric Surgery Service	

		Dedicated children's SERVICES for general surgery. For further information, see: Royal College of Surgeons - Paediatric Surgery
211	Paediatric Urology Service	Dedicated children's SERVICES for surgical treatment of disorders of the urinary system and male reproductive system. For further information, see: British Association of Paediatric Surgeons - Urology
212	Paediatric Transplantation Surgery Service	Dedicated children's SERVICES for pre- and post-operative care for major organ transplants except heart and lung. Excludes Paediatric Cardiac Surgery Service - see TREATMENT FUNCTION CODE 221, Paediatric Thoracic Surgery Service - see TREATMENT FUNCTION CODE 222, corneal grafts carried out by Paediatric Ophthalmology Service - see TREATMENT FUNCTION CODE 216 and Blood and Bone Marrow Transplantation Service - see TREATMENT FUNCTION CODE 308. For further information, see: Royal College of Surgeons - General Surgery
213	Paediatric Gastrointestinal Surgery Service	Dedicated children's SERVICES for surgical treatment of disorders of the gastrointestinal tract. For further information, see: British Association of Paediatric Surgeons - Gastrointestinal
214	Paediatric Trauma and Orthopaedic Service	Dedicated children's SERVICES to treat injuries, congenital and acquired disorders of the bones, joints, and their associated soft tissues, including ligaments, nerves and muscles. Excludes Trauma Surgery Service - see TREATMENT FUNCTION CODE 115 and Spinal Surgery Service - see TREATMENT FUNCTION CODE 108 For further information, see: British Society for Children's Orthopaedic Surgery (BSCOS)
215	Paediatric Ear Nose and Throat Service	Dedicated children's surgical SERVICES for the assessment, diagnosis, management and treatment of ear, nose and/or throat issues. Excludes Audiology Service - see TREATMENT FUNCTION CODE 840. For further information, see: British Association for Paediatric Otolaryngology
216	Paediatric Ophthalmology Service	Dedicated children's SERVICES for the surgical treatment of disorders and diseases of the eye. For further information, see: British & Irish Paediatric Ophthalmology and Strabismus Association
217	Paediatric Oral and Maxillofacial Surgery Service	Dedicated children’s SERVICES providing diagnosis and surgical treatment of diseases, injuries and defects involving hard and soft tissues of the mouth, jaws, and neck. Excludes Paediatric Dentistry Services - see TREATMENT FUNCTION CODE 142. For further information, see: British Association of Oral & Maxillofacial Surgeons
218	Paediatric Neurosurgery Service	Dedicated children's SERVICES for the surgical treatment of disorders which affect any portion of the nervous system including the brain, spinal cord, peripheral nerves, and extra-cranial cerebrovascular system. For further information, see: Royal College of Surgeons - Neurosurgery
219	Paediatric Plastic Surgery Service	Dedicated children's SERVICES for correction or to restore form and function. In addition to cosmetic or aesthetic surgery, plastic surgery includes many types of reconstructive surgery, and the treatment of burns. For care given within specialist paediatric burn services, use Paediatric Burns Care Service - see TREATMENT FUNCTION CODE

		220. For further information, see: NHS England: E02. Specialised Surgery in Children
220	Paediatric Burns Care Service	Dedicated children's SERVICES for the surgical and non-surgical treatment of burns within recognised specialist burns units and associated outreach SERVICES only. Whilst this does not signify the CRITICAL CARE LEVEL, many PATIENTS will also come within the scope of the Critical Care Minimum Data Set. For further information, see: British Burn Association
221	Paediatric Cardiac Surgery Service	Dedicated children's SERVICES for the surgical treatment of the heart or great vessels. For further information, see: NHS England: E05. Congenital Heart Services
222	Paediatric Thoracic Surgery Service	Dedicated children's SERVICES for the surgical treatment of diseases affecting organs inside the thorax (the chest). Generally, treatment of conditions of the lungs, chest wall, and diaphragm. For further information, see: British Association of Paediatric Surgeons - Thoracic
223	Paediatric Epilepsy Service	Dedicated children's SERVICES by CONSULTANT paediatrician with expertise in epilepsy supported by specialist staff. For further information, see: Royal College of Paediatrics and Child Health - Epilepsy
230	Paediatric Clinical Pharmacology Service	Dedicated children's SERVICES providing advice and support locally and nationally regarding the introduction of new medicines, adverse drug reactions, poisoning and toxicity, and prescribing policies. For further information, see: Royal College of Paediatrics and Child Health - Drugs and medicines
240	Paediatric Palliative Medicine Service	Dedicated children's SERVICES improving the quality of life of PATIENTS and their families facing the problems associated with life-limiting illness. Prevention and relief of suffering by means of early identification, assessment and treatment of pain and other problems, physical, psychosocial and spiritual. For further information, see: Royal College of Paediatrics and Child Health - Palliative care
241	Paediatric Pain Management Service	Dedicated children's SERVICES for complex pain disorders requiring diagnosis and treatment by a specialist Multidisciplinary Team. For further information, see: Royal College of Paediatrics and Child Health - Pain management
242	Paediatric Intensive Care Service	Dedicated children's SERVICES only to be used by designated Paediatric Intensive Care Units. For further information, see: Royal College of Paediatrics and Child Health - Intensive care medicine
250	Paediatric Hepatology Service	Dedicated children's SERVICES for the treatment of disease of the liver. For further information, see: Royal College of Paediatrics and Child Health - Hepatology
251	Paediatric Gastroenterology Service	Dedicated children's SERVICES for the treatment of disorders of the digestive system. For further information, see: Royal College of Paediatrics and Child Health - Gastroenterology
252	Paediatric Endocrinology Service	Dedicated children's SERVICES for the treatment of disorders of the endocrine system. Excludes Paediatric Diabetes Service - see TREATMENT FUNCTION CODES 263.

		For further information, see: British Society for Paediatric Endocrinology and Diabetes
253	Paediatric Clinical Haematology Service	Dedicated children's SERVICES contributing to the diagnosis and management of diseases of the blood and bone marrow. May be consultative in other specialties including intensive care. Excludes Anticoagulant Service - see TREATMENT FUNCTION CODE 324. For further information, see: NHS England: E03. Paediatric Medicine
254	Paediatric Audio Vestibular Medicine Service	Dedicated children's SERVICES for the investigation, diagnosis and management of patients with disorders of balance, hearing, tinnitus and auditory communication. Excludes Audiology Service - see TREATMENT FUNCTION CODE 840. For further information, see: British Association of Paediatricians in Audiology
255	Paediatric Clinical Immunology and Allergy Service	Dedicated children's SERVICES for the treatment of disorders of the immune system and allergic disease. For further information, see: Royal College of Paediatrics and Child Health - Paediatric allergy, immunology and infectious diseases - sub-specialty
256	Paediatric Infectious Diseases Service	Dedicated children's SERVICES for the diagnosis and treatment of contagious or communicable diseases. For further information, see: Royal College of Paediatrics and Child Health - Paediatric allergy, immunology and infectious diseases - sub-specialty
257	Paediatric Dermatology Service	Dedicated children's SERVICES for the treatment of diseases of the skin. For further information, see: The British Society for Paediatric Dermatology (BSPD)
258	Paediatric Respiratory Medicine Service	Dedicated children's SERVICES for the diagnosis and treatment of respiratory conditions. Also known as Thoracic Medicine and Pulmonary Medicine. For further information, see: Royal College of Paediatrics and Child Health - Paediatric respiratory medicine - sub-specialty
259	Paediatric Nephrology Service	Dedicated children's SERVICES for the diagnosis and treatment of kidney conditions and abnormalities. Also known as Renal Medicine. For further information, see: Royal College of Paediatrics and Child Health - Nephrology
260	Paediatric Medical Oncology Service	Dedicated children's SERVICES for the diagnosis and treatment, typically with Chemotherapy, of PATIENTS with cancer. For further information, see: Royal College of Paediatrics and Child Health - Oncology
261	Paediatric Inherited Metabolic Medicine Service	Formerly known as Paediatric Metabolic Disease. Dedicated children's SERVICES for the diagnosis and management of inherited metabolic conditions utilising biochemistry and metabolic characteristics requiring the expertise of both the physician and chemical pathologist. For further information, see: Royal College of Paediatrics and Child Health - Inherited metabolic medicine
262	Paediatric Rheumatology Service	Dedicated children's SERVICES incorporating the investigation, multidisciplinary holistic management and rehabilitation of PATIENTS with a wide spectrum of disorders of the musculoskeletal system encompassing the locomotor apparatus, bone and connective tissues and blood vessels.

		For further information, see: Royal College of Paediatrics and Child Health - Rheumatology
263	Paediatric Diabetes Service	Formerly known as Paediatric Diabetes Medicine. Dedicated children's SERVICES for the diagnosis, treatment and support of PATIENTS with diabetes. For further information, see: Royal College of Paediatrics and Child Health - Diabetes
264	Paediatric Cystic Fibrosis Service	Dedicated multidisciplinary children's SERVICES concerned with the diagnosis, assessment and management of PATIENTS with cystic fibrosis. This TREATMENT FUNCTION CODE should be used by recognised specialist centres only. For further information, see: NHS England: A01. Specialised Respiratory
270	Paediatric Emergency Medicine Service	Dedicated children's SERVICES to care for PATIENTS with urgent problems delivered as part of an Emergency Care Attendance. Excludes Trauma Surgery Service - see TREATMENT FUNCTION CODE 115. For further information, see: Royal College of Paediatrics and Child Health - Emergency Medicine
280	Paediatric Interventional Radiology Service	Dedicated children's SERVICES for the diagnosis and treatment of diseases utilising minimally invasive image-guided procedures. Not to be used for Diagnostic Imaging Service - see TREATMENT FUNCTION CODE 812. For further information, see: British Society of Interventional Radiology - What is Interventional Radiology
290	Community Paediatric Service	SERVICES providing assessment and care to vulnerable children, including those with developmental disorders and disabilities, complex behavioural presentations, and those at risk of abuse or are being abused. Excludes Paediatric Neurodisability Service - see TREATMENT FUNCTION CODE 291. For further information, see: Royal College of Paediatrics and Child Health - Community child health - sub-specialty
291	Paediatric Neurodisability Service	Dedicated children's SERVICES for the diagnosis and treatment of Cerebral Palsy and non-progressive handicapping neurological conditions, with or without Learning Disability/Intellectual Disability. For further information, see: Royal College of Paediatrics and Child Health - Neurodisability
321	Paediatric Cardiology Service	Dedicated children's SERVICES for diseases and abnormalities of the heart. Excludes Congenital Heart Disease Service - see TREATMENT FUNCTION CODE 331. For further information, see: Joint Royal Colleges of Physicians Training Board – Paediatric Cardiology
421	Paediatric Neurology Service	Dedicated children's SERVICES for diagnosis, management and medical treatment of conditions and diseases of the central nervous system, with appropriate facilities and support staff. Excludes Paediatric Epilepsy Service - see TREATMENT FUNCTION CODE 223. For further information, see: Royal College of Paediatrics and Child Health - Neurology
Medical Specialties		
180	Emergency Medicine Service	Formerly known as Accident & Emergency. SERVICES to care for PATIENTS with urgent problems delivered as part of an Emergency Care Attendance. Excludes Trauma Surgery

		Service - see TREATMENT FUNCTION CODE 115. For further information, see: The Royal College of Emergency Medicine
190	Anaesthetic Service	SERVICES for PATIENTS being assessed for anaesthesia, as well as the provision of sedation and anaesthesia for patients undergoing interventional radiology and radiotherapy. This can be used in out-patients only. Pain Management Service should be recorded in TREATMENT FUNCTION CODE 191. Intensive Care Medicine Service should be recorded in TREATMENT FUNCTION CODE 192. For further information, see: Royal college of Anaesthetists - Anaesthetists
191	Pain Management Service	SERVICES for complex pain disorders requiring diagnosis and treatment by a specialist Multidisciplinary Team
192	Intensive Care Medicine Service	Formerly known as Critical Care Medicine. SERVICES using a body of specialist knowledge and practice concerned with the treatment of PATIENTS, with, at risk of, or recovering from potentially life-threatening failure of one or more of the body's organ systems. It includes the provision of organ system support, the investigation, diagnosis, and treatment of acute illness, systems management and PATIENT safety, ethics, end-of-life care, and the support of families. Typically, this will refer to CRITICAL CARE LEVEL 2 and 3 beds within the scope of the Critical Care Minimum Data Set. For further information, see: Faculty of Intensive Care Medicine
200	Aviation and Space Medicine Service	Also known as Aerospace Medicine Services. Aviation and Space Medicine SERVICES study all factors affecting the PERSON in flight. This may include pre-flight preparation and checks as well as inflight care to minimise the potentially harmful effects of their abnormal environment. For further information, see: Royal College of Physicians - Aviation and Space Medicine
300	General Internal Medicine Service	Formerly known as General Medicine. SERVICES include adults admitted as emergencies with acute medical problems, including multiple disorders. PATIENTS with problems that are not clearly within the remit of a particular medical specialty are referred for the opinion of a general physician. For further information, see: Joint Royal Colleges of Physicians Training Board - General Internal Medicine (GIM)
301	Gastroenterology Service	Screening, diagnostic and therapeutic endoscopy SERVICES including upper and lower gastrointestinal (GI) endoscopy and hepatobiliary endoscopy. Excludes Hepatology Service - see TREATMENT FUNCTION CODE 306.
302	Endocrinology Service	The treatment of disorders of the endocrine system, excluding specific Diabetes Services - see TREATMENT FUNCTION CODE 307. For further information, see: Joint Royal Colleges of Physicians Training Board - Endocrinology and Diabetes Mellitus
303	Clinical Haematology Service	SERVICES contributing to the diagnosis and management of diseases of the blood and bone marrow. May be consultative in other specialties including intensive care. Excludes Anticoagulant Service - see TREATMENT FUNCTION CODE 324. For further information, see: Joint Royal Colleges of Physicians Training Board - Haematology
304	Clinical Physiology Service	Physiological measurement. Excludes Clinical Neurophysiology Service - see TREATMENT FUNCTION CODE 401, Audiology Service - see TREATMENT FUNCTION CODE 840, Respiratory Physiology

		Service - see TREATMENT FUNCTION CODE 341, Cardiac Physiology Service - see TREATMENT FUNCTION CODE 675, Gastrointestinal Physiology Service - see TREATMENT FUNCTION CODE 677, Urological Physiology Service - see TREATMENT FUNCTION CODE 670, Vascular Physiology Service - see TREATMENT FUNCTION CODE 673 and Ophthalmic and Vision Science - see TREATMENT FUNCTION CODE 461. For further information, see: The Registration Council for Clinical Physiologists
305	Clinical Pharmacology Service	SERVICES undertaking and interpreting clinical investigations including clinical trials; optimising the therapeutic use of drugs; detection and analysis of adverse drug effects; contribution to medicines evaluation and management of poisoning. For further information, see: Joint Royal Colleges of Physicians Training Board - Clinical Pharmacology and Therapeutics (CPT)
306	Hepatology Service	Medical SERVICES for the diagnosis and treatment of liver disease. Also known as liver medicine. For hepatobiliary endoscopy, use Gastroenterology Service - see TREATMENT FUNCTION CODE 301
307	Diabetes Service	Formerly known as Diabetes Medicine. SERVICES to diagnose, treat and support PATIENTS with diabetes. For further information, see: Joint Royal Colleges of Physicians Training Board - Endocrinology and Diabetes Mellitus
308	Blood and Marrow Transplantation Service	SERVICES recognised as specialist units and associated outreach services only. Includes pre- and post-operative specialised services for autologous, allogeneic or syngeneic Blood and Marrow Transplantation. For further information, see: British Society of Blood and Marrow Transplantation
309	Haemophilia Service	Specialist SERVICES for the diagnosis, treatment and management of haemophilia. For further information, see: NHS England - F02. Specialised Blood Disorders
310	Audio Vestibular Medicine Service	Formerly known as Audiological Medicine. SERVICES concerned with the diagnosis and management of hearing and balance disorders, for example tinnitus, dysacusis and communication disorders. Rehabilitative/habilitative care is delivered by Multidisciplinary Teams and is aimed at improving the well-being and quality of life of the PATIENT concerned. Excludes Audiology Service - see TREATMENT FUNCTION CODE 840. For further information, see: Joint Royal College of Physicians Training Board - Audio vestibular Medicine
311	Clinical Genetics Service	SERVICES for the diagnosis and management of genetic disorders affecting individuals and their families. For further information, see: Clinical Genetics
312	not a Treatment Function	
313	Clinical Immunology and Allergy Service	SERVICES for the diagnosis and management of PATIENTS with diseases resulting from disordered immunological mechanisms, and allergic disease (abnormal immune responses to external substances). Should only be used where there are no separate SERVICES for Clinical Immunology and Allergy. For separate services - See Clinical Immunology Service - TREATMENT FUNCTION CODE 316 and Allergy Service - TREATMENT FUNCTION CODE 317.

		For further information, see: Welcome to the British Society for Allergy & Clinical Immunology (BSACI)
314	Rehabilitation Medicine Service	Formerly known as Rehabilitation Service. SERVICES for the prevention, diagnosis, treatment and rehabilitation management of disabling conditions. Rehabilitation medicine is broadly divided into neurological rehabilitation, spinal cord injury, limb loss and prosthetics and/or musculoskeletal rehabilitation. Excludes Mental Health Recovery and Rehabilitation Service - see TREATMENT FUNCTION CODE 725, Cardiac Rehabilitation Service - see TREATMENT FUNCTION CODE 327, Pulmonary Rehabilitation Service - see TREATMENT FUNCTION CODE 342, Orthotics Service - See TREATMENT FUNCTION CODE 658 or Prosthetics Service - see TREATMENT FUNCTION CODE 657. For further information, see: Joint Royal Colleges of Physicians Training Board - Rehabilitation medicine
315	Palliative Medicine Service	SERVICES improving the quality of life of PATIENTS and their families facing the problems associated with life-limiting illness and end of life care. Prevention and relief of suffering by means of early identification, assessment and treatment of pain and other physical, psychosocial and spiritual problems. For further information, see: Joint Royal College of Physicians - Specialty spotlight – palliative medicine
316	Clinical Immunology Service	SERVICES for the diagnosis and management of PATIENTS with diseases resulting from disordered immunological mechanisms, and conditions in which immunological manipulations form an important part of therapy. Allergy SERVICES should be recorded against Allergy Service - see TREATMENT FUNCTION CODE 317. For further information, see: Joint Royal College of Physicians Training Board - Immunology
317	Allergy Service	SERVICES for the diagnosis and management of allergic disease (abnormal immune responses to external substances) and the exclusion of allergic causes in other conditions. For further information, see: Joint Royal College of Physicians Training Board - Allergy
318	Intermediate Care Service	SERVICES encompassing a range of multidisciplinary approaches, designed to safeguard independence by maximising rehabilitation and recovery after illness or injury. For further information, see: National Institute for Health and Care Excellence - Understanding intermediate care, including reablement
319	Respite Care Service	SERVICES providing temporary care of a dependant PERSON, providing relief for their usual caregivers
320	Cardiology Service	SERVICES for PATIENTS with heart disease covering a wide range of clinical activities. Management can involve interventional treatment, cardiac imaging, preventative and therapeutic options. This includes both diagnostic and interventional procedures in the cardiac catheterisation laboratory. For further information, see: Royal College of Physicians - Cardiology
322	Clinical Microbiology Service	SERVICES for the diagnosis, management and treatment of PATIENTS with diseases caused by bacteria, viruses, fungi and parasites.
323	Spinal Injuries Service	SERVICES for non-surgical management of issues of the back and spine. To be used by recognised specialist units and associated outreach SERVICES only.

		Excludes Spinal Surgery Service - see TREATMENT FUNCTION CODE 108
324	Anticoagulant Service	SERVICES providing the monitoring and control of anticoagulant therapy, including the initiation and/or supervision of oral anticoagulant therapy and the determination of anticoagulant dosage. This can be used in out-patients only
325	Sport and Exercise Medicine Service	Specific SERVICES providing diagnosis and management of medical problems caused by physical activity, the prevention of related injury and disease and the role of exercise in disease treatment. Excludes Trauma and Orthopaedic Service - see TREATMENT FUNCTION CODE 110, Orthopaedic Surgery Service - see TREATMENT FUNCTION CODE 111, and Trauma Surgery Service - see TREATMENT FUNCTION CODE 115. For further information, see: Joint Royal Colleges of Physicians Training Board - Sport and Exercise Medicine
326	Acute Internal Medicine Service	SERVICES concerned with the assessment, diagnosis and management of adults presenting to secondary care with acute medical illness. For further information, see: Acute Internal Medicine
327	Cardiac Rehabilitation Service	SERVICES for PATIENTS recovering from heart-related conditions such as heart attacks or procedures such as coronary artery bypass surgery to ensure that they achieve their full potential in terms of physical and psychological health
328	Stroke Medicine Service	SERVICES for diagnosis, investigation, treatment and care of stroke PATIENTS. Excludes out-patients for Transient Ischaemic Attack Service - see TREATMENT FUNCTION CODE 329. For further information, see: Joint Royal Colleges of Physicians Training Board - Stroke Medicine (sub-specialty)
329	Transient Ischaemic Attack Service	A multidisciplinary out-patient SERVICE for rapid diagnosis and treatment of PATIENTS presenting with suspected Transient Ischaemic Attack and mini-strokes to minimise the chance of a full stroke occurring and maximise the chances of independent living after a stroke. For further information, see: National Institute for Health and Care Excellence - Stroke and transient ischaemic attack
330	Dermatology Service	SERVICES for the treatment of diseases of the skin. For further information, see: Joint Royal Colleges of Physicians Training Board - Dermatology
331	Congenital Heart Disease Service	The management and treatment of congenital heart disease, including the ongoing care of children into adulthood. For further information, see: Joint Royal Colleges of Physicians Training Board - Paediatric cardiology
333	Rare Disease Service	SERVICES for rare diseases, many of which are present at birth and are either caused by a genetic problem or deficiencies or exposures to substances around the time of conception or during pregnancy. This TREATMENT FUNCTION CODE should be used by designated specialist centres only. For further information, see: National Congenital Anomaly and Rare Disease Registration Service
335	Inherited Metabolic Medicine Service	SERVICES for the diagnosis and management of inherited metabolic conditions utilising biochemistry and metabolic characteristics requiring the expertise of both the physician and chemical pathologist. For further information, see: Joint Royal Colleges of Physicians Training Board - Metabolic Medicine

340	Respiratory Medicine Service	Respiratory Medicine is also known as Thoracic Medicine and Pulmonary Medicine. SERVICES for the investigation, diagnosis, management and treatment of PATIENTS with respiratory complaints. Excludes acute respiratory failure and adult respiratory distress syndrome (ARDS) - see Intensive Care Medicine Service TREATMENT FUNCTION CODE 192 and Respiratory Physiology Service - see TREATMENT FUNCTION CODE 341. For further information, see: Joint Royal Colleges of Physicians Training Board - Respiratory Medicine
341	Respiratory Physiology Service	SERVICES for the physiological measurement of the function of the respiratory system. Excludes Sleep Medicine Service - see TREATMENT FUNCTION CODE 347. For further information, see: Association for Respiratory Technology & Physiology
342	Pulmonary Rehabilitation Service	Formerly known as Programmed Pulmonary Rehabilitation. A multidisciplinary SERVICE for PATIENTS with chronic respiratory impairment. For further information, see: NHS England: Pulmonary rehabilitation
343	Adult Cystic Fibrosis Service	Multidisciplinary SERVICE concerned with the diagnosis, assessment and management of PATIENTS with cystic fibrosis. This TREATMENT FUNCTION CODE should be used by designated specialist centres only. For further information, see: NHS England: A01. Specialised Respiratory
344	Complex Specialised Rehabilitation Service	This TREATMENT FUNCTION CODE will be removed from use from April 2022. No new services should use this code in submissions. However, the previous definition has been retained below for reference: Complex specialised rehabilitation SERVICE which meets the NHS Specialised Services Rehabilitation Services' criteria and is registered as a Level 1 service
345	Specialist Rehabilitation Service	This TREATMENT FUNCTION CODE will be removed from use from April 2022. No new services should use this code in submissions. However, the previous definition has been retained below for reference: Specialist rehabilitation SERVICE which meets the NHS Specialised Services Rehabilitation Services' criteria and is registered as a Level 2a service.
346	Local Specialist Rehabilitation Service	This TREATMENT FUNCTION CODE will be removed from use from April 2022. No new services should use this code in submissions. However, the previous definition has been retained below for reference: Local specialist rehabilitation SERVICE which meets the NHS Specialised Services Rehabilitation Services' criteria and is registered as a Level 2b service.
347	Sleep Medicine Service	SERVICES providing diagnosis and management of sleep disorders including parasomnias, excessive daytime sleepiness and sleep apnoea. For further information, see: Royal Society of Medicine - Sleep Medicine Section
348	Post-COVID-19 Syndrome Service	Multidisciplinary SERVICES for PATIENTS experiencing long-term health effects following COVID-19 infection, whether or not this was diagnosed at the time of acute illness or the patient was initially

		asymptomatic. Post-COVID-19 syndrome has also been known as 'long COVID'. For further information, see: National Institute for Health and Care Excellence - COVID-19 guideline: management of the long-term effects of COVID-19 and NHS England and NHS Improvement coronavirus - National guidance for post-COVID syndrome assessment clinics
350	Infectious Diseases Service	SERVICES for the diagnosis, management and treatment of infectious diseases. Excludes Tropical Medicine Service - see TREATMENT FUNCTION CODE 352. For further information, see: Joint Royal Colleges of Physicians Training Board - Infectious Diseases
352	Tropical Medicine Service	SERVICES for the diagnosis, management and treatment of diseases that are found most often in tropical or sub-tropical regions. This TREATMENT FUNCTION CODE should be used by designated specialist centres only. Excludes Infectious Diseases Service - see TREATMENT FUNCTION CODE 350. For further information, see: Joint Royal Colleges of Physicians Training Board - Infectious Diseases and Tropical Medicine
360	Genitourinary Medicine Service	SERVICES for the investigation and management of sexually transmitted infections and HIV. For further information, see: Joint Royal Colleges of Physicians Training Board - Genitourinary Medicine (GUM)
361	Renal Medicine Service	Formerly known as Nephrology. SERVICES for PATIENTS with acute renal failure and chronic kidney disease requiring long term care with the help of a Multidisciplinary Team. Most general medical problems in PATIENTS with kidney disease are managed by the Renal Medicine Service. Excludes acute renal replacement therapy in the critical care setting, see Intensive Care Medicine Service - TREATMENT FUNCTION CODE 192. For further information, see: Joint Royal Colleges of Physicians Training Board - Renal Medicine
370	Medical Oncology Service	SERVICES for the specialised assessment and management of PATIENTS with cancer using chemotherapy. Includes treatment option discussions with PATIENTS, supervision of therapy and management of any complications of disease and/or treatment that may arise. For further information, see: Joint Royal Colleges of Physicians Training Board - Medical Oncology
371	Nuclear Medicine Service	SERVICES responsible for administration of unsealed radioactive substances to PATIENTS for the purposes of diagnosis, therapy or research. For further information, see: Joint Royal Colleges of Physicians Training Board - Nuclear Medicine
400	Neurology Service	SERVICES for the diagnosis, management and medical treatment of neurological conditions. Excludes Stroke Medicine Service - TREATMENT FUNCTION CODE 328, out-patients for Transient Ischaemic Attack Service – see TREATMENT FUNCTION CODE 329. For further information, see: Joint Royal Colleges of Physicians Training Board - Neurology
401	Clinical Neurophysiology Service	Primarily diagnostic SERVICE concerned with recording electrical activity from the nervous system to aid diagnosis, classification and management of neurological disease. Includes Electroencephalogram (EEG) and Electromyography (EMG).

		For further information, see: Joint Royal College of Physicians - Clinical Neurophysiology
410	Rheumatology Service	SERVICES incorporating the investigation, holistic management and rehabilitation of PATIENTS with a wide spectrum of disorders of the musculoskeletal system encompassing the locomotor apparatus, bone and connective tissues and blood vessels. For further information, see: Joint Royal College of Physicians - Rheumatology
420	Paediatric Service	Dedicated children's SERVICES for the treatment of patients typically aged 0 to 18 for medical conditions, however the environments and other members of the multidisciplinary service are likely to care for surgical PATIENTS too. For further information, see: Royal College of Paediatrics and Child Health - General paediatrics - level 3 training
422	Neonatal Critical Care Service	Formerly known as Neonatology. SERVICES providing care for all babies that require on-going, enhanced medical care following birth. Neonatal critical care SERVICES are provided in a variety of settings dependent upon the interventions required for the baby and with dedicated transport services to support babies being transferred to and from neonatal care units. Use when NEONATAL LEVEL OF CARE = 1, 2 or 3. Includes Special Care Baby Units (SCBU), Local Neonatal Units (LNU) and Neonatal Intensive Care Units (NICU). Any readmission would be to Paediatric Service - see TREATMENT FUNCTION CODE 420, or Paediatric Intensive Care Service - see TREATMENT FUNCTION CODE 242. For further information, see: Royal College of Paediatrics and Child Health - Neonatal medicine - sub-specialty and NHS England - E08. Neonatal Critical Care
424	Well Baby Service	SERVICES for healthy infants born and referenced by the Maternity record who do not require any intervention other than health screening and prophylactic healthcare. General care given by the mother/substitute with healthcare education if needed. **Use when NEONATAL LEVEL OF CARE = 0 - Normal Care**. Excludes Neonatal Critical Care Service - see TREATMENT FUNCTION CODE 422
430	Elderly Medicine Service	Formerly known as Geriatric Medicine. SERVICES to treat diseases and disabilities in older adults, particularly those with multiple morbidities. There is no set age at which PATIENTS may be under the care of the Elderly Medicine Service, this decision should be determined by the individual PATIENT's needs. For further information, see: Joint Royal Colleges of Physicians Training Board - Geriatric Medicine
431	Orthogeriatric Medicine Service	Multidisciplinary SERVICES addressing clinical and social needs in the management of PATIENTS with fragility fractures, including hip fractures. The care provided aims to be holistic and to include secondary prevention of fractures as well as acute care. For further information, see: GM - Orthogeriatrics
450	Dental Medicine Service	SERVICES for dental treatment carried out in a hospital setting. Includes Oral Medicine. For further information, see: British Dental Association
451	Special Care Dentistry Service	SERVICES concerned with the improvement of the oral health of PATIENTS and groups in society who have a physical, sensory, intellectual, mental, medical, emotional or social impairment or

		DISABILITY or, more often, a combination of these factors. The specialty focuses on adolescents and adults only and includes the important period of transition as the adolescent moves into adulthood. For further information, see: Special Care Dentistry Association (SCDA)
460	Medical Ophthalmology Service	Medically-led SERVICES including assessment, investigation, diagnosis and management of inflammatory, vascular and neurological disorders affecting vision. May include public health screening, for example diabetic retinopathy screening. For further information, see: Joint Royal Colleges of Physicians Training Board - Medical Ophthalmology
461	Ophthalmic and Vision Science Service	SERVICES providing physiological measurement of the function of the eye and vision. Includes diagnostic electrophysiology of vision, imaging and biometry. For further information, see: NHS Health Education England: Ophthalmic and vision science
500	not a Treatment Function	
501	Obstetrics Service	SERVICES managing high risk pregnancy and childbirth including miscarriages and stillbirths but specifically excluding planned terminations. Excludes Midwifery Service - see TREATMENT FUNCTION CODE 560. For further information, see: Royal College of Obstetricians & Gynaecologists - Obstetrics and Gynaecology
502	Gynaecology Service	SERVICES for the diagnosis, management and treatment of disorders of the female reproductive system. Includes planned terminations of pregnancy. For further information, see: Royal College of Obstetricians & Gynaecologists - Obstetrics and Gynaecology
503	Gynaecological Oncology Service	SERVICES to treat cancers of the female reproductive system, principally involving surgical members of the Multidisciplinary Team. For further information, see: British Gynaecological Cancer Society
504	Community Sexual and Reproductive Health Service	SERVICES supporting people to have a positive and respectful approach to sexuality and sexual relationships and to have pleasurable and safe sexual experiences, free of infection, coercion, discrimination and violence. The SERVICE also provides access to contraception and signposts Maternity Services to support pregnancy and childbirth. Excludes Genitourinary Medicine Service - see TREATMENT FUNCTION CODE 360 and Midwifery Service - see TREATMENT FUNCTION CODE 560. For further information, see: Faculty of Sexual and Reproductive Healthcare (FSRH)
505	Fetal Medicine Service	SERVICES providing specialist care at a designated centre for the fetus or fetuses and mother. This includes assessment of fetal growth and wellbeing; the diagnosis and management of identified fetal disorders (including fetal abnormalities); prenatal fetal intervention and surgery; and counselling and support for parents. Excludes routine maternity screening activities - see Midwifery Service TREATMENT FUNCTION CODE 560.
510	Retired	Record as Obstetrics, antenatal clinic can be used as a local sub-specialty if required
520	Retired	Record as Obstetrics, postnatal clinic can be used as a local sub-specialty if required
600	not a Treatment Function	
610	Retired	Record as Obstetrics

620	Retired	Use the appropriate function under which the patient is treated
834	Medical Virology Service	Clinical SERVICES for the diagnosis, management and prevention of blood-borne and/or airborne viral infections. For further information, see: Royal College of Pathologists - MEDICAL VIROLOGY
Mental Health Services		
656	Clinical Psychology Service	Mental Health Services for the assessment, management and treatment of problems including addiction, anxiety, depression, behavioural difficulties and relationship issues. Methods of assessment include psychometric tests, interviews and direct observation of behaviour. Assessment may lead to advice, counselling or therapy. For further information, see: The British Psychological Society
700	Learning Disability Service	Also known as Intellectual Disability Service. Mental Health Services provided to PATIENTS with a Learning Disability. For further information, see: Royal College of Psychiatrists - Faculty of the Psychiatry of Intellectual Disability and British Institute of Learning Disabilities
710	Adult Mental Health Service	Mental Health Services provided to adult PATIENTS for the assessment, diagnosis and treatment of mental illness and maintenance of mental health. For further information, see: Royal College of Psychiatrists - Faculty of General Adult Psychiatry
711	Child and Adolescent Psychiatry Service	Mental Health Services for children and young people with somatisation and complex presentations, behavioural challenges, eating disorders, mood disorders, anxiety, and other mental health presentations. Excludes Paediatric Neurodisability Service - see TREATMENT FUNCTION CODE 291 and specialist Eating Disorders Service - see TREATMENT FUNCTION CODE 720. For further information, see: Royal College of Psychiatrists - Faculty of Child and Adolescent Psychiatry
712	Forensic Psychiatry Service	Mental Health Services for the assessment, management and treatment of PATIENTS who are being held in high, medium and low secure units or prisons. This includes prevention of further harm in the community or to the individual themselves. For further information, see: Royal College of Psychiatrists - Faculty of Forensic Psychiatry
713	Medical Psychotherapy Service	Formerly known as Psychotherapy. Multidisciplinary Mental Health Services to assess, manage and treat children and adults with mental health problems using talking therapies and other psychotherapeutic techniques. For further information, see: Faculty of Medical Psychotherapy
715	Old Age Psychiatry Service	Mental Health Services providing the specialised assessment, treatment and continuing care for older adults suffering a range of mental illnesses, including dementia, depression or schizophrenia. Excludes specific Dementia Assessment Service - see TREATMENT FUNCTION CODE 727. For further information, see: Royal College of Psychiatrists - Faculty of Old Age Psychiatry
720	Eating Disorders Service	A specialist SERVICE for the diagnosis and treatment of eating disorders including anorexia, bulimia and compulsive overeating. This is usually a multidisciplinary service which needs to consider both physical and mental health aspects of the PATIENT's care.

		For further information, see: Royal College of Psychiatrists - Faculty of Eating Disorders Psychiatry
721	Addiction Service	Mental Health Services for the treatment of addictive behaviour, including substance misuse, drugs, alcohol, tobacco and gambling. Excludes PATIENTS with both severe mental illness and problematic substance misuse, see Mental Health Dual Diagnosis Service - TREATMENT FUNCTION CODE 726. For further information, see: Royal College of Psychiatrists - Faculty of Addictions Psychiatry
722	Liaison Psychiatry Service	Mental Health Services for the provision of psychiatric treatment to PATIENTS attending acute hospitals including Out-Patient Clinics, Emergency Care Departments and admission to WARDS. Deals with the interface between physical and psychological health. For further information, see: Royal College of Psychiatrists - Faculty of Liaison Psychiatry
723	Psychiatric Intensive Care Service	Mental Health Services provided to vulnerable individuals with severe disturbances who are admitted to Psychiatric Intensive Care Units from mental health acute wards and forensic settings. For further information, see: Royal College of Psychiatrists - Quality Network for Psychiatric Intensive Care Units
724	Perinatal Mental Health Service	Formerly known as Perinatal Psychiatry. Specialist Mental Health Services for the assessment, management and treatment of pre-existing or new mental health issues during pregnancy or after delivery. For further information, see: Royal College of Psychiatrists - Faculty of Perinatal Psychiatry
725	Mental Health Recovery and Rehabilitation Service	Mental Health Services provided to support recovery from mental illness that maximises the PATIENTS' quality of life and social inclusion by encouraging their skills, promoting independence and autonomy. For further information, see: Faculty of Rehabilitation and Social Psychiatry
726	Mental Health Dual Diagnosis Service	Mental Health Services to provide support to PATIENTS with both severe mental illness and substance misuse problems. For further information, see: Mind: Recreational drugs and alcohol
727	Dementia Assessment Service	Designated Mental Health Services for the assessment of PATIENTS who have or are suspected to have dementia. Dementia complicates care giving and can occur at any stage of the illness and at any age. In addition to memory impairment, dementia may include behavioural and psychological problems. For non-specific Old Age Psychiatry Service - see TREATMENT FUNCTION CODE 715. For further information, see: Royal College of Psychiatrists - Dementia pathway
730	Neuropsychiatry Service	Mental Health Services for brain disorders and integration of psychiatry within clinical neurosciences. For further information, see: Royal College of Psychiatrists - Faculty of Neuropsychiatry
Other Services		
560	Midwifery Service	SERVICES for managing antenatal and perinatal care during pregnancy, and postnatal care following delivery, provided under the direct care of a MIDWIFE. Excludes Obstetrics Service - see TREATMENT FUNCTION CODE 501. For further information, see: Royal College of Midwives
650	Physiotherapy Service	

		SERVICES helping PATIENTS affected by injury, illness or DISABILITY through movement and exercise, manual therapy, education and advice to manage pain and prevent disease. To encourage development and facilitate recovery, enabling maintenance of work and independence for as long as possible. For further information, see: Chartered Society of Physiotherapy (CSP) - Physiotherapy
651	Occupational Therapy Service	SERVICES using specific activities to limit the effects of DISABILITY and promote independence in all aspects of daily life
652	Speech and Language Therapy Service	SERVICES providing assessment, management and treatment of speech, language, communication and swallowing issues in PATIENTS of all ages. For further information, see: Royal College of Speech & Language Therapists - Speech and language therapy
653	Podiatry Service	Also known as Chiropody. SERVICES for the diagnosis and treatment of disorders, diseases and deformities of the feet. Excludes Podiatric Surgery Service - see TREATMENT FUNCTION CODE 663. For further information, see: The College of Podiatry
654	Dietetics Service	SERVICES applying the science of nutrition to improve health and treat diseases/conditions by educating and giving practical, personalised advice to PATIENTS, Patient Proxies and other members of the Multidisciplinary Team. They advise on and help to maintain nutritional status during dietary interventions such as exclusion diets and to recommend nutritional supplements. For further information, see: British Dietetic Association
655	Orthoptics Service	SERVICES providing the diagnosis and treatment of visual problems involving eye movement and alignment. For further information, see: British and Irish Orthoptic Society
657	Prosthetics Service	SERVICES providing gait analysis and engineering solutions to patients with limb loss. They design and provide prostheses that replicate the structural or functional characteristics of the PATIENTS absent limb. They often work autonomously or part of Multidisciplinary Teams working closely with Physiotherapists and Occupational Therapists as part of multidisciplinary amputee rehabilitation teams. For further information, see: British Association of Prosthetists and Orthotists (BAPO) - Prosthetists
658	Orthotics Service	SERVICES providing gait analysis and engineering solutions to PATIENTS with needs of the neuro, muscular and skeletal systems. They design and provide orthoses that modify the structural or functional characteristics of the PATIENTS neuro-muscular and skeletal systems enabling patients to mobilise, eliminate gait deviations, reduce falls, reduce pain, prevent and facilitate healing of ulcers. They often work autonomously or part of Multidisciplinary Teams such as within the diabetic foot team or neuro-rehabilitation team. For further information, see: The British Association of Prosthetists and Orthotists (BAPO) - Orthotists
659	Dramatherapy Service	SERVICES providing dramatherapy which is a form of psychological therapy focussing on the use of performance arts within the therapeutic relationship. For further information, see: British Association of Dramatherapists
660	Art Therapy Service	SERVICES delivering a form of psychotherapy that uses art media as its primary mode of expression and communication. Within this context, art is not used as diagnostic tool but as a medium to address emotional

		issues which may be confusing and distressing. For further information, see: British Association of Art Therapists
661	Music Therapy Service	SERVICES delivering a form of psychotherapy that uses music to support psychological, emotional, cognitive, physical, communicative and/or social needs. For further information, see: British Association for Music Therapy
662	Optometry Service	SERVICES providing the diagnosis and non-surgical treatment of disorders of the eye and vision care
663	Podiatric Surgery Service	SERVICES involved in the complex management of the foot and ankle involving surgery under both local and general anaesthetic. Excludes Podiatry Service - see TREATMENT FUNCTION CODE - 653. For further information, see: The College of Podiatry
670	Urological Physiology Service	Diagnostic SERVICES for the study of erectile, upper and lower urinary tract function, including urodynamics. For further information, see: The British Association of Urological Surgeons
673	Vascular Physiology Service	Diagnostic SERVICES for the study of arterial and venous circulation primarily using Doppler ultrasound but including tests such as pressure measurement and plethysmography. Excludes Cardiac Physiology Service - see TREATMENT FUNCTION CODE 675. For further information, see: The Society for Vascular Technology
675	Cardiac Physiology Service	SERVICES providing physiological measurements of the heart structure/function and response to therapeutic/surgical intervention through the means of a wide spectrum of non-invasive and invasive cardiac diagnostic testing. Examples include echocardiography, cardiac device management. For further information, see: Society for Cardiological Science and Technology (SCST)
677	Gastrointestinal Physiology Service	SERVICES providing physiological measurement of the gastrointestinal tract. This includes standard catheter based oesophageal pH studies, oesophageal pH impedance, oesophageal manometry, ano-rectal manometry, wireless capsule studies. Excludes Gastroenterology Service - see TREATMENT FUNCTION CODE 301. For further information, see: AGIP – Association of GI Physiologists
800	Clinical Oncology Service	Formerly known as Radiotherapy. The diagnosis and treatment, typically with Radiotherapy, of PATIENTS with cancer. For further information, see: Royal College of Radiologists - Clinical oncology
810	not a Treatment Function	
811	Interventional Radiology Service	SERVICES delivering a range of techniques using radiological image guidance including X-ray fluoroscopy, ultrasound, Computerised Tomography Scan, or Magnetic Resonance Imaging Scan (MRI) to precisely target therapy. Excludes Interventional Cardiology - see Cardiology Service TREATMENT FUNCTION CODE 320, and Diagnostic Imaging Service - see TREATMENT FUNCTION CODE 812. For further information, see: British Society of Interventional Radiology - What is Interventional Radiology
812	Diagnostic Imaging Service	SERVICES providing medical imaging, especially X-ray based examinations, Ultrasound scan, MRI Scan, PET Scan or CT Scan. Diagnostic imaging is used to confirm, assess and document diseases, as well as to assess responses to treatment. For further information, see: WHO: Diagnostic imaging

820	not a Treatment Function	
821	not a Treatment Function	
822	Chemical Pathology Service	SERVICES interpreting biochemical investigation results to assess, diagnose and treat diseases. To be used for the clinical management of PATIENTS by chemical pathology only. For further information, see: Royal College of Pathologists - CHEMICAL PATHOLOGY
823	not a Treatment Function	See Clinical Haematology
824	not a Treatment Function	
830	not a Treatment Function	See Clinical Immunology
831	not a Treatment Function	See Clinical Microbiology
832	Retired	
840	Audiology Service	SERVICES providing physiological measurement and diagnosis of hearing disorders, and the rehabilitation of PATIENTS with hearing loss. Include hearing services activity, such as hearing tests and the fitting of hearing aids. For further information, see: British Society of Audiology
900	not a Treatment Function	
901	not a Treatment Function	
902	not a Treatment Function	
903	not a Treatment Function	
904	not a Treatment Function	
920	Diabetic Education Service	SERVICES providing dedicated small group education courses regarding self-management for diabetic PATIENTS
950	not a Treatment Function	Use the appropriate function under which the patient is treated
960	not a Treatment Function	Use the appropriate function under which the patient is treated
990	Retired	

Notes:

†	Code 500 is not acceptable for data sets/collections including Hospital Episode Statistics
	TREATMENT FUNCTION CODES should be used for all data sets/collections unless otherwise stated e.g. National Workforce Data Set uses MAIN SPECIALTY CODES
	~~GENERAL MEDICAL PRACTITIONER, NURSE and Allied Health Professional/ Biomedical Scientist/ Clinical Scientist ACTIVITY should be recorded against the TREATMENT FUNCTION under which the PATIENT is treated~~
	GENERAL MEDICAL PRACTITIONER, NURSE and ALLIED HEALTH PROFESSIONAL/ Biomedical Scientist/ Clinical Scientist ACTIVITY should be recorded against the TREATMENT FUNCTION under which the PATIENT is treated
	Joint Consultant Clinic ACTIVITY should be recorded against the TREATMENT FUNCTION which best describes the specialised service

---

NHS ALLIED HEALTH PROFESSIONAL SERVICE (REFERRAL TO TREATMENT MEASUREMENT)

Change to Supporting Information: Changed Description

An NHS Allied Health Professional Service (Referral To Treatment Measurement) is a SERVICE.

~~An NHS Allied Health Professional Service (Referral To Treatment Measurement) is a SERVICE involving the treatment of a PATIENT by one of the following types of Allied Health Professional:~~An NHS Allied Health Professional Service (Referral To Treatment Measurement) is a SERVICE involving the treatment of a PATIENT by one of the following types of ALLIED HEALTH PROFESSIONAL:

- Art Therapists, Music Therapists and Dramatherapists (Arts Therapists)
- Chiropodists/Podiatrists
- Dietitians
- Occupational Therapists
- Orthoptists
- Physiotherapists
- Prosthetists and Orthotists
- Radiographers (Diagnostic and Therapeutic)
- Speech and Language Therapists

~~Where the Allied Health Professional works in a Community Health Service, the Department of Health and Social Care requires their Allied Health Professional Referral To Treatment Measurement activity to be reported in the Community Services Data Set.~~Where the ALLIED HEALTH PROFESSIONAL works in a Community Health Service, the Department of Health and Social Care requires their Allied Health Professional Referral To Treatment Measurement activity to be reported in the Community Services Data Set.

~~Where the Allied Health Professional activity took place at an Out-Patient Clinic, the Allied Health Professional Referral To Treatment Measurement activity must be reported in the CDS V6-2 Type 020 - Outpatient Commissioning Data Set. In addition to this, where an Allied Health Professional sees a PATIENT on a WARD but the ACTIVITY is not related to the Hospital Provider Spell the PATIENT is being treated under, this should be regarded as replacing an Out-Patient Appointment Non-Consultant, and a CDS V6-2 Type 020 - Outpatient Commissioning Data Set record should flow. ACTIVITY LOCATION TYPE CODE may be submitted to allow identification of this Allied Health Professional ACTIVITY. For example, if a Podiatrist were asked to see a patient who was currently admitted for a condition where the agreed care pathway did not include Podiatry services, then an Out-Patient Appointment Non-Consultant should be recorded, with the ACTIVITY LOCATION TYPE CODE of E02 'WARD', and the relevant Referral To Treatment data items also completed.~~Where the ALLIED HEALTH PROFESSIONAL ACTIVITY took place at an Out-Patient Clinic, the Allied Health Professional Referral To Treatment Measurement activity must be reported in the CDS V6-2 Type 020 - Outpatient Commissioning Data Set / CDS V6-3 Type 020 - Outpatient Commissioning Data Set.

In addition, where an ALLIED HEALTH PROFESSIONAL sees a PATIENT on a WARD but the ACTIVITY is not related to the Hospital Provider Spell the PATIENT is being treated under, this should be regarded as replacing a Care Professional Out-Patient Attendance under the management of the ALLIED HEALTH PROFESSIONAL , and a CDS V6-2 Type 020 - Outpatient Commissioning Data Set / CDS V6-3 Type 020 - Outpatient Commissioning Data Set record should be recorded and submitted to the Secondary Uses Service. The ACTIVITY LOCATION TYPE CODE in the CDS V6-2 Type 020 - Outpatient Commissioning Data Set / CDS V6-3 Type 020 - Outpatient Commissioning Data Set may be submitted to allow identification of this ALLIED HEALTH PROFESSIONAL ACTIVITY.

For example, if a Podiatrist were asked to see a PATIENT who was currently admitted for a condition where the agreed care pathway did not include Podiatry services, then a Care Professional Out-Patient Attendance should be recorded, with the ACTIVITY LOCATION TYPE CODE National Code '*WARD*', and the relevant Referral To Treatment data items also completed.

Further guidance relating to Allied Health Professional Referral To Treatment initiative can be found on the Department of Health and Social Care part of the gov.uk website at: the Revised guide for referral to treatment for allied health professionals.

NHS AT HOME SERVICE

Change to Supporting Information: New Supporting Information

An NHS At Home Service is a SERVICE.

An NHS At Home Service is a nationally-led programme of work providing better connected, more personalised care in PEOPLE's homes, including in Care Homes. It aims to ensure that PEOPLE have faster access to more appropriate and targeted care, maximising the use of technology to support better management of care at home.

NHS At Home Service care encompasses both the active treatment at home by health CARE PROFESSIONALS of PATIENTS who may otherwise be admitted to hospital, and early supported discharge schemes following a Hospital Provider Spell.

For further information on NHS At Home Services, see the NHS England and NHS Improvement website at: NHS @Home.

This supporting information is also known by these names:

Context	Alias
plural	NHS At Home Services

PATIENT INITIATED OUT-PATIENT FOLLOW UP APPOINTMENT

Change to Supporting Information: New Supporting Information

A Patient Initiated Out-Patient Follow Up Appointment is an APPOINTMENT.

A Patient Initiated Out-Patient Follow Up Appointment is a follow-up Out-Patient Appointment initiated by a PATIENT.

A Patient Initiated Out-Patient Follow Up Appointment is usually triggered by a PATIENT who is on a formal Patient Initiated Out-Patient Follow-Up Pathway, but APPOINTMENTS requested by a PATIENT who does not have this arrangement in place would also be recorded as Patient Initiated Out-Patient Follow Up Appointments.

For further information on Patient Initiated Out-Patient Follow Up Appointments, see the NHS England and NHS Improvement Outpatient Transformation Programme website at: Patient Initiated Follow Up.

This supporting information is also known by these names:

Context	Alias
plural	Patient Initiated Out-Patient Follow Up Appointments

PATIENT INITIATED OUT-PATIENT FOLLOW-UP PATHWAY

Change to Supporting Information: New Supporting Information

A Patient Initiated Out-Patient Follow-Up Pathway is a PATIENT PATHWAY.

A Patient Initiated Out-Patient Follow-Up Pathway allows the PATIENT to initiate their own follow-up Out-Patient Appointments and is intended to support the PATIENT to manage their own condition and book APPOINTMENTS when they are needed, rather than at routine intervals.

For further information on Patient Initiated Out-Patient Follow-Up Pathways, see the NHS England and NHS Improvement Outpatient Transformation Programme website at: Patient Initiated Follow Up.

This supporting information is also known by these names:

Context	Alias
plural	Patient Initiated Out-Patient Follow-Up Pathways

PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY

Change to Supporting Information: New Supporting Information

A Personalised Out-Patient Follow Up Pathway is a PATIENT PATHWAY.

A Personalised Out-Patient Follow Up Pathway tailors a PATIENT's follow up out-patient care to their individual clinical need, circumstances and preferences.

Personalised Out-Patient Follow Up Pathways may include the following models of care:

- Patient Initiated Out-Patient Follow-Up Pathway
- Remote Monitoring

For further information on Personalised Out-Patient Follow Up Pathways, see the NHS England and NHS Improvement Outpatient Transformation Programme website at: Patient Initiated Follow Up.

This supporting information is also known by these names:

Context	Alias
alsoknownas	Personalised Out-Patient Follow Up
plural	Personalised Out-Patient Follow Up Pathways

PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE

Change to Supporting Information: New Supporting Information

A Personalised Out-Patient Follow Up Pathway Expiry Date is a PLANNED ACTIVITY DATE TIME.

A Personalised Out-Patient Follow Up Pathway Expiry Date is the date that a Personalised Out-Patient Follow Up Pathway will expire.

This supporting information is also known by these names:

Context	Alias

plural	Personalised Out-Patient Follow Up Pathway Expiry Dates

PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY REVIEW DATE

Change to Supporting Information: New Supporting Information

A Personalised Out-Patient Follow Up Pathway Review Date is a PLANNED ACTIVITY DATE TIME.

A Personalised Out-Patient Follow Up Pathway Review Date is the date that review of a Personalised Out-Patient Follow Up Pathway will take place.

This supporting information is also known by these names:

Context	Alias
plural	Personalised Out-Patient Follow Up Pathway Review Dates

REFERRAL TO TREATMENT CLOCK STOP ADMINISTRATIVE EVENT

Change to Supporting Information: Changed Description

DSCN 18/2006 published in December 2006, defined essential new data items required to support the measurement of 18 week REFERRAL TO TREATMENT PERIODS (monitoring of DH PSA target 13 - "By 2008, no one will have to wait longer than 18 weeks from GP referral to hospital treatment").

In particular, DSCN 18/2006 introduced the following new data items.

- PATIENT PATHWAY IDENTIFIER
- REFERRAL TO TREATMENT PERIOD START DATE
- REFERRAL TO TREATMENT PERIOD END DATE

Strategic reporting of 18 weeks will be undertaken by the Secondary Uses Service using data obtained via the Commissioning Data Sets. The data items defined in DSCN 18/2006 are enabled to flow in Commissioning Data Set.

However, an event which results in an update to the REFERRAL TO TREATMENT PERIOD STATUS may occur outside the events that are defined in the Commissioning Data Sets (typically Outpatient or Inpatient encounters) and will therefore not flow to the Secondary Uses Service. These types of events have been termed as "administrative events". They can be defined as any communication event between the Health Care Provider and the PATIENT that occurs outside of an outpatient attendance or inpatient admission and that results in the PATIENT's REFERRAL TO TREATMENT PERIOD STATUS being changed to stop the 18 week clock. These events are not face to face consultations and do not necessarily involve clinical staff.

These Referral To Treatment Clock Stop Administrative Events may be carried using the Commissioning Data Set Type 020 Outpatient record type. They are differentiated from PATIENT contact ACTIVITY by the FIRST ATTENDANCE value carried within them. FIRST ATTENDANCE national code 5 "Referral to treatment clock stop administrative event" signifies that an ACTIVITY has taken place which has ended the REFERRAL TO TREATMENT PERIOD and changed the REFERRAL TO TREATMENT PERIOD STATUS to one of the following:

- 30 Start of First Definitive Treatment
- 31 Start of Active Monitoring initiated by the PATIENT
- 32 Start of Active Monitoring initiated by the CARE PROFESSIONAL
- 34 Decision not to treat - decision not to treat made or no further contact required
- 35 PATIENT declined offered treatment

- 36 PATIENT died before treatment

When to Use Referral To Treatment Clock Stop Administrative Events

These events may happen because:

- The ACTIVITY ending the event does not qualify as a "patient contact" between a clinician and PATIENT, or
- The ACTIVITY occurred in a setting where IT systems cannot produce REFERRAL TO TREATMENT PERIOD data items, or
- The ACTIVITY would be carried in a Commissioning Data Set record type not currently processed by the Secondary Uses Service

Secondary Uses Service Processing

The Secondary Uses Service currently processes the following Commissioning Data Set record types in order to build Referral To Treatment pathways.

- ~~CDS V6-2 Type 020 - Outpatient Commissioning Data Set~~
- ~~CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set~~
- ~~CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set~~
- CDS V6-2 Type 020 - Outpatient Commissioning Data Set / CDS V6-3 Type 020 - Outpatient Commissioning Data Set
- CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set / CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set
- CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set / CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set

All other types are not currently processed and so if they carry the REFERRAL TO TREATMENT PERIOD END DATE for a REFERRAL TO TREATMENT PERIOD, a Referral To Treatment Clock Stop Administrative Event must also be sent in order to inform the Secondary Uses Service of the clock stop.

~~Note that future versions of the Secondary Uses Service will also process:~~CDS V6-2 Type 120 - Admitted Patient Care - Finished Birth Episode Commissioning Data Set

- ~~CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set~~
- ~~CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) Commissioning Data Set~~
- ~~CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) Commissioning Data Set~~
- ~~CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) Commissioning Data Set~~

~~The dates when ORGANISATIONS submitting REFERRAL TO TREATMENT PERIOD data to the Secondary Uses Service can cease having to also send a Referral To Treatment Clock Stop Administrative Event when a clock stop is carried in one of the Elective Admission List Commissioning Data Set Types, will be notified as part of the Secondary Uses Service release documentation. A cancelled future APPOINTMENT record could carry a REFERRAL TO TREATMENT PERIOD Clock Stop. Again the timescales will be notified as part of the Secondary Uses Service release documentation.~~

~~There are no current plans for the Secondary Uses Service to process the remaining Commissioning Data Set Types:~~

- ~~CDS V6-2 Type 040 - Elective Admission List - End of Period Census (Old) Commissioning Data Set~~
- ~~CDS V6-2 Type 050 - Elective Admission List - End of Period Census (New) Commissioning Data Set~~
- ~~CDS V6-2 Type 090 - Elective Admission List - Event During Period (Available or Unavailable) Commissioning Data Set~~
- ~~CDS V6-2 Type 100 - Elective Admission List - Event During Period (Old Service Agreement) Commissioning Data Set~~
- ~~CDS V6-2 Type 110 - Elective Admission List - Event During Period (New Service Agreement) Commissioning Data Set~~

- CDS V6-2 Type 120 - Admitted Patient Care - Finished Birth Episode Commissioning Data Set
- CDS V6-2 Type 140 - Admitted Patient Care - Finished Delivery Episode Commissioning Data Set
- CDS V6-2 Type 150 - Admitted Patient Care - Other Birth Event Commissioning Data Set
- CDS V6-2 Type 160 - Admitted Patient Care - Other Delivery Event Commissioning Data Set
- CDS V6-2 Type 170 - Admitted Patient Care - Detained and or Long Term Psychiatric Census Commissioning Data Set
- CDS V6-2 Type 180 - Admitted Patient Care - Unfinished Birth Episode Commissioning Data Set
- CDS V6-2 Type 180 - Admitted Patient Care - Unfinished Birth Episode Commissioning Data Set
- CDS V6-2 Type 200 - Admitted Patient Care - Unfinished Delivery Episode Commissioning Data Set

This is because a Referral To Treatment Clock Stop Administrative Event occurring in the scenarios where these record types are generated, would be rare. However this will be reviewed as part of the ongoing maintenance of the Referral To Treatment Clock Stop Administrative Event, and the requirements for the Secondary Uses Service.

When NOT to Use a Referral To Treatment Clock Stop Administrative Event

The Referral To Treatment Clock Stop Administrative Event should NOT be used to correct previously submitted records where a REFERRAL TO TREATMENT PERIOD END DATE was submitted incorrectly to the Secondary Uses Service.

For example, if an Out-Patient Appointment took place where First Definitive Treatment was started, but the REFERRAL TO TREATMENT PERIOD END DATE was not sent in the corresponding CDS V6-2 Type 020 - Outpatient Commissioning Data Set record as it was not entered on the Patient Administration System until later; then the CDS V6-2 Type 020 - Outpatient Commissioning Data Set record should be resubmitted with the correct data.For example, if an Out-Patient Appointment took place where First Definitive Treatment was started, but the REFERRAL TO TREATMENT PERIOD END DATE was not sent in the corresponding CDS V6-2 Type 020 - Outpatient Commissioning Data Set/CDS V6-3 Type 020 - Outpatient Commissioning Data Set record as it was not entered on the Patient Administration System until later; then the CDS V6-2 Type 020 - Outpatient Commissioning Data Set/CDS V6-3 Type 020 - Outpatient Commissioning Data Set record should be resubmitted with the correct data. A Referral To Treatment Clock Stop Administrative Event should NOT be used.

Where an ORGANISATION's Patient Administration System supports the submission of cancelled and Did Not Attend appointments in the CDS V6-2 Type 020 - Outpatient Commissioning Data Set, the Referral To Treatment Clock Stop Administrative Event should NOT be used when a PATIENT has a booked Out-Patient Appointment, which is then cancelled because, for example, the PATIENT dies. In these cases the CDS V6-2 Type 020 - Outpatient Commissioning Data Set can carry the details of a cancelled CARE ACTIVITY, including the REFERRAL TO TREATMENT PERIOD END DATE and update to the REFERRAL TO TREATMENT PERIOD STATUS.Where an ORGANISATION's Patient Administration System supports the submission of cancelled and Did Not Attend appointments in the CDS V6-2 Type 020 - Outpatient Commissioning Data Set/CDS V6-3 Type 020 - Outpatient Commissioning Data Set, the Referral To Treatment Clock Stop Administrative Event should NOT be used when a PATIENT has a booked Out-Patient Appointment, which is then cancelled because, for example, the PATIENT dies. In these cases the CDS V6-2 Type 020 - Outpatient Commissioning Data Set/CDS V6-3 Type 020 - Outpatient Commissioning Data Set can carry the details of a cancelled CARE ACTIVITY, including the REFERRAL TO TREATMENT PERIOD END DATE and update to the REFERRAL TO TREATMENT PERIOD STATUS. (Note - not all Patient Administration Systems provide functionality to create and submit Commissioning Data Set records for cancellations/Did Not Attend's as this is not yet mandated - you should contact your Patient Administration System support team to ascertain whether your Patient Administration System supports this. If not, then it is permissible to send a Referral To Treatment Clock Stop Administrative Event in order to stop the clock in the Secondary Uses Service instead).

Referral To Treatment Clock Stop Administrative Events only require a sub-set of the data elements contained in the CDS V6-2 Type 020 - Outpatient Commissioning Data Set record, to be submitted to the Secondary Uses Service. All other data elements not listed should be omitted from the XML submission of the CDS V6-2 Type 020 - Outpatient Commissioning Data Set record to the Secondary Uses Service.Referral To Treatment Clock Stop Administrative Events only require a sub-set of the data elements contained in the CDS V6-2 Type 020 - Outpatient Commissioning

Data Set/CDS V6-3 Type 020 - Outpatient Commissioning Data Set record, to be submitted to the Secondary Uses Service. All other data elements not listed should be omitted from the XML submission of the CDS V6-2 Type 020 - Outpatient Commissioning Data Set/CDS V6-3 Type 020 - Outpatient Commissioning Data Set record to the Secondary Uses Service. The submission of a Referral To Treatment Clock Stop Administrative Event is not reliant on the use of the Net Change Commissioning Data Set Submission Protocol to the Secondary Uses Service

The required data elements making up a Referral To Treatment Clock Stop Administrative Event are:

Data Element Required	Notes
~~UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) or PATIENT PATHWAY IDENTIFIER~~	~~The Commissioning Data Set Schema version 6-2 requires EITHER the PATIENT PATHWAY IDENTIFIER, or the UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) to be populated.~~
~~ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)~~	~~If the UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) is used, the ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) should contain X09 (which relates to the Choose and Book system)~~
UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) or PATIENT PATHWAY IDENTIFIER	The Commissioning Data Set XML Schema versions 6-2 and 6-3 for Type 020 Outpatients require EITHER the PATIENT PATHWAY IDENTIFIER, or the UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) to be populated
ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)/ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	If the UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) is used, the ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)/ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER) should contain X09 (which relates to the Choose and Book system)
REFERRAL TO TREATMENT PERIOD STATUS	This should contain only one of the following codes to signify that the REFERRAL TO TREATMENT PERIOD has ended: • 30 Start of First Definitive Treatment • 31 Start of Active Monitoring initiated by the PATIENT • 32 Start of Active Monitoring initiated CARE PROFESSIONAL • 34 Decision not to treat - decision not to treat made or no further contact required • 35 PATIENT declined offered treatment • 36 PATIENT died before treatment
~~WAITING TIME MEASUREMENT TYPE~~	~~This item is XML mandatory in the CDS V6-2 schema.~~
WAITING TIME MEASUREMENT TYPE/WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)	This item is mandatory in the Commissioning Data Set XML schema versions 6-2 and 6-3 XML schema
REFERRAL TO TREATMENT PERIOD START DATE	
REFERRAL TO TREATMENT PERIOD END DATE	
NHS NUMBER	
NHS NUMBER STATUS INDICATOR CODE	
POSTCODE OF USUAL ADDRESS	
~~ORGANISATION CODE (RESIDENCE RESPONSIBILITY)~~	

ORGANISATION CODE (RESIDENCE RESPONSIBILITY)/ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	
FIRST ATTENDANCE CODE	This should always hold the National code 5 - "Referral to Treatment Period Clock Stop Administrative Event"
~~APPOINTMENT DATE~~	~~This field is XML mandatory in Commissioning Data Set Schema version 6-2 for Type 020 Outpatients, and for the purposes of the Referral To Treatment Clock Stop Administrative Event, should hold the same date as the REFERRAL TO TREATMENT PERIOD END DATE~~
~~AGE AT CDS ACTIVITY DATE~~	~~This field is XML mandatory in the Commissioning Data Set Schema version 6-2 for Type 020 Outpatients, and should hold the PATIENTS age at REFERRAL TO TREATMENT PERIOD END DATE~~
~~ORGANISATION CODE (CODE OF PROVIDER)~~	~~This field is mandatory in the CDS V6-2 schema~~
~~ORGANISATION CODE (CODE OF COMMISSIONER)~~	~~This field is mandatory in the CDS V6-2 schema~~
APPOINTMENT DATE	This field is mandatory in the Commissioning Data Set XML Schema versions 6-2 and 6-3 for Type 020 Outpatients, and for the purposes of the Referral To Treatment Clock Stop Administrative Event, should hold the same date as the REFERRAL TO TREATMENT PERIOD END DATE
AGE AT CDS ACTIVITY DATE	This field is mandatory in the Commissioning Data Set XML Schema versions 6-2 and 6-3 for Type 020 Outpatients, and should hold the PATIENTS age at REFERRAL TO TREATMENT PERIOD END DATE
ORGANISATION CODE (CODE OF PROVIDER)/ORGANISATION IDENTIFIER (CODE OF PROVIDER)	This field is mandatory in the Commissioning Data Set XML schema versions 6-2 and 6-3 for Type 020 Outpatients
ORGANISATION CODE (CODE OF COMMISSIONER)/ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	This field is mandatory in the Commissioning Data Set XML schema versions 6-2 and 6-3 for Type 020 Outpatients

REMOTE MONITORING

Change to Supporting Information: New Supporting Information

Remote Monitoring is a CLINICAL INTERVENTION.

Remote Monitoring is the monitoring of a PATIENT (using MEDICAL DEVICES, applications, Clinical Investigation results, or ASSESSMENT TOOLS), to allow a CARE PROFESSIONAL or SERVICE to initiate an Out-Patient Appointment when required to manage the PATIENT's condition.

For further information on Remote Monitoring, see the NHS England and NHS Improvement Outpatient Transformation Programme website at: Patient Initiated Follow Up.

REMOTE MONITORING TRIGGERED OUT-PATIENT FOLLOW UP APPOINTMENT

Change to Supporting Information: New Supporting Information

A Remote Monitoring Triggered Out-Patient Follow Up Appointment is an APPOINTMENT.

A Remote Monitoring Triggered Out-Patient Follow Up Appointment is a follow-up Out-Patient Appointment which is triggered by a CARE PROFESSIONAL as a result of review of the outcome of Remote Monitoring of a PATIENT.

For further information on Remote Monitoring, see the NHS England and NHS Improvement Outpatient Transformation Programme website at: Patient Initiated Follow Up.

This supporting information is also known by these names:

Context	Alias
plural	Remote Monitoring Triggered Out-Patient Follow Up Appointments

SECURITY ISSUES AND PATIENT CONFIDENTIALITY

Change to Supporting Information: Changed Description

A. Removal of name and address where the NHS Number is present

- From 1 April 1999, PATIENT NAME and PATIENT USUAL ADDRESS (not POSTCODE OF USUAL ADDRESS) must be removed from all Commissioning Data Sets where a valid NHS NUMBER is present. This applies to all nationally defined Commissioning Data Set data and any additional locally agreed flows from service providers to commissioning bodies.

- A valid NHS NUMBER is one that has passed the check digit calculation on entry into the source system. If an NHS NUMBER is not valid (i.e. does not conform with the check digit algorithm) then PATIENT NAMES and PATIENT USUAL ADDRESSES should not be removed, as the reliability of the NHS NUMBER will not be known.

- The NHS NUMBER STATUS INDICATOR CODE is a mandatory part of the Commissioning Data Set. PATIENT NAME and PATIENT USUAL ADDRESS should be removed when a valid NHS NUMBER is present, even if the NHS NUMBER STATUS INDICATOR CODE does not have a status of 01, *Number present and verified*.

B. Sensitive data

- The Human Fertilisation and Embryology Act 1990 as amended by the Human Fertilisation and Embryology (Disclosure of Information) Act 1992 imposes statutory restrictions on the disclosure of information about identifiable individuals in connection with certain infertility treatments.

- ~~The latest approved list of codes which can be used to identify the relevant PATIENT record in which the patient-identifiable data are to be omitted from the CDS Types can be accessed via Technology Reference Data Update Distribution (TRUD). In these cases the NHS NUMBER, LOCAL PATIENT IDENTIFIER, PATIENT NAMES, POSTCODE OF USUAL ADDRESS and PERSON BIRTH DATE should be omitted from the CDS Types.~~

- ~~From Commissioning Data Set Version 6-2, records where the patient-identifiable data has been withheld should be submitted using the PATIENT IDENTITY - WITHHELD IDENTITY STRUCTURE data group in CDS types where identification is carried. This data group allows only the NHS NUMBER STATUS INDICATOR CODE (the actual value held on source systems should be used), ORGANISATION CODE (RESIDENCE RESPONSIBILITY) and WITHHELD IDENTITY REASON to flow. The WITHHELD IDENTITY REASON allows Health Care Providers to inform their Commissioners why a record has been anonymised. Note that the same rules apply to the additional PATIENT IDENTITY structures relating to Mother and Baby in the Delivery and Birth CDS types.~~

- The latest approved list of codes which can be used to identify the relevant PATIENT record in which the patient-identifiable data are to be omitted from the CDS Types can be accessed via the Secondary Uses Service website. In these cases the NHS NUMBER, LOCAL PATIENT IDENTIFIER/LOCAL PATIENT IDENTIFIER (EXTENDED), PATIENT NAMES, POSTCODE OF USUAL ADDRESS and PERSON BIRTH DATE should be omitted from the Commissioning Data Set submission.

- From Commissioning Data Set Version 6-2 onwards, records where the patient-identifiable data has been withheld should be submitted using the PATIENT IDENTITY - WITHHELD IDENTITY STRUCTURE data group in the Commissioning Data Set XML schema. This data group allows only the NHS NUMBER STATUS INDICATOR CODE (the actual value held on source systems should be used), ORGANISATION CODE (RESIDENCE RESPONSIBILITY)/ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) and WITHHELD IDENTITY REASON to flow. The WITHHELD IDENTITY REASON allows Health Care Providers to inform their Commissioners why a record has been anonymised. Note that the same rules apply to the additional PATIENT IDENTITY structures relating to Mother and Baby in the Delivery and Birth CDS types.

- Other statutory restrictions on the disclosure of PATIENT information do not prohibit the disclosure to individuals involved with the treatment and prevention of certain specific diseases (HIV/AIDS and venereal diseases) in the population.

- ~~**All records containing patient identifiable information, other than those covered by the Sensitive Data section, should be treated as sensitive.** ORGANISATIONS may continue to exchange records containing NHS NUMBER, POSTCODE OF USUAL ADDRESS and PERSON BIRTH DATE in these cases, but receiving ORGANISATIONS must ensure that only those staff with legitimate need have access to this information, e.g. public health departments, and strictly on a need to know basis. No-one should have unrestricted access unless fully justified in accordance with the principles of the Caldicott Committee Report.~~

- ~~Where PATIENT level data is required for other purposes within an ORGANISATION, it should be anonymised/aggregated prior to disclosure by someone with legitimate access. If this is not practicable, local protocols defining which CDS Types are particularly sensitive (including, but not necessarily restricted to HIV/AIDS and venereal disease) agreed by the ORGANISATION Caldicott Guardian, should be put in place and identifiers stripped from these records.~~

- **All records containing patient identifiable information, other than those covered by the Sensitive Data section, should be treated as sensitive.** ORGANISATIONS may continue to exchange records containing NHS NUMBER, POSTCODE OF USUAL ADDRESS and PERSON BIRTH DATE in these cases, but receiving ORGANISATIONS must ensure that only those staff with legitimate need have access to this information, e.g. public health departments, and strictly on a need to know basis. No-one should have unrestricted access unless fully justified in accordance with the Caldicott Principles.

- Where PATIENT level data is required for other purposes within an ORGANISATION, it should be anonymised/aggregated prior to disclosure by someone with legitimate access. If this is not practicable, local protocols defining which CDS Types are particularly sensitive (including, but not necessarily restricted to HIV/AIDS and venereal disease) agreed by the ORGANISATION Caldicott Guardian, should be put in place and identifiers stripped from these records.

- Your Caldicott Guardian will be able to advise you further on all issues relating to patient confidentiality.

- Where appropriate, further information about confidentiality is contained within the notes for individual data items.

SUPPORTING DEFINITIONS MENU

Change to Supporting Information: Changed Description

Supporting Definitions:

- 18 Weeks
- Accessible Information
- Assistive Technology
- Automatic Identification and Data Capture
- Care Programme Approach
- Children's Nursing
- Children Act 2004
- Choose and Book
- Community Treatment Order
- Community Treatment Order Recall
- Contract Monitoring
- Data Dictionary Change Notice
- Data Dictionary for Care
- Data Landing Portal
- Data Processing Services
- Data Services for Commissioners
- Delen
- Department
- Department for Work and Pensions Overseas Healthcare Team
- Discharge After Patient Did Not Attend
- e-Government Interoperability Framework
- Elective Admission
- Electronic Staff Record
- Electronic Staff Record Data Warehouse
- eMED3 Fit Note
- European Economic Area
- Fast Healthcare Interoperability Resources
- Fever Nursing
- Government Data Standards Catalogue
- GS1 Application Identifier (Global)
- GS1 Application Identifier (Internal)
- GS1 Global Service Relation Number
- Healthcare Resource Group
- HES Data Dictionary
- Hospital Episode Statistics
- Information Standards and Collections (Including Extraction)
- Information Standards Board for Health and Social Care
- Information Standards Notice
- Integrated Care System
- International Esophageal Database
- Internet Enabled Therapy Activity Log
- Laboratory
- Learning Disabilities Nursing
- Market Forces Factor
- Mental Health Care Cluster Super Class
- Mental Health Nursing
- National Casemix Office
- National Health Service (Overseas Visitors Hospital Charging Regulations)
- National Health Service Act 2006
- National Tariff Payment System
- Neonatal Critical Care Unit

- Neonatal Unit
- NHS Continuing Healthcare Local Appeal
- NHS Continuing Healthcare Local Resolution
- NHS Data Model and Dictionary Service
- NHS England (Region)
- NHS Standard Contract
- Non-Contract Activity
- Organisation Data Service
- Overseas Visitor Treatment Portal
- Patient Level Information Costing
- Personal Demographics Service
- Point of Delivery
- Primary Care Network
- Reciprocal Healthcare Agreement
- Rupture of Membranes
- S2
- Secondary Uses Service
- Special Education Needs
- Standardisation Committee for Care Information
- Strategic Data Collection Service
- Strategic Data Collection Service in the Cloud
- Sustainability and Transformation Partnership
- Technology Reference Data Update Distribution (TRUD)
- Terminology and Classifications Delivery Service

TIMED OUT-PATIENT FOLLOW UP APPOINTMENT

Change to Supporting Information: New Supporting Information

A Timed Out-Patient Follow Up Appointment is an APPOINTMENT.

A Timed Out-Patient Follow Up Appointment is a follow-up Out-Patient Appointment which is planned with the PATIENT during an Out-Patient Appointment, with the length of time between APPOINTMENTS based on the individual PATIENT's needs.

For further information on Timed Out-Patient Follow Up Appointments, see the NHS England and NHS Improvement Outpatient Transformation Programme website at: Patient Initiated Follow Up.

This supporting information is also known by these names:

Context	Alias
plural	Timed Out-Patient Follow Up Appointments

ACTIVITY GROUP

Change to Class: Changed Attributes

Attributes of this Class are:

ACTIVITY GROUP TYPE
ADJUSTED LENGTH OF STAY FOR PATIENT LEVEL INFORMATION COSTING
ADMISSION METHOD
ADMISSION SOURCE

CANCER OR SYMPTOMATIC BREAST REFERRAL PATIENT STATUS
CANCER TRANSFER REASON FOR INTER PROVIDER TRANSFER
CANCER TREATMENT INTENT
CARE PACKAGE IDENTIFIER FOR NHS CONTINUING HEALTHCARE
CARE PACKAGE REVIEW ELIGIBILITY OUTCOME FOR NHS CONTINUING HEALTHCARE
CARE PACKAGE REVIEW OUTCOME CODE FOR NHS CONTINUING HEALTHCARE
CARE PACKAGE REVIEW TYPE FOR NHS CONTINUING HEALTHCARE
CARER RESIDENT INDICATION CODE FOR NATIONAL NEONATAL DATA SET
CHILDREN TEENAGERS AND YOUNG ADULTS AGE CATEGORY
CLINICAL COMMISSIONING GROUP ELIGIBILITY DECISION OUTCOME FOR NHS CONTINUING HEALTHCARE STANDARD
CLINICAL COMMISSIONING GROUP REVIEW ELIGIBILITY DECISION OUTCOME FOR NHS CONTINUING HEALTHCARE
COMMUNITY TREATMENT ORDER END REASON
CONSULTANT EPISODE COMPLETION STATUS FOR PATIENT LEVEL INFORMATION COSTING
CONTINUITY OF CARER PATHWAY INDICATOR
DAUGHTER BORN AT THIS ENCOUNTER INDICATOR
DELIVERY PLACE CHANGE REASON
DESTINATION OF DISCHARGE
DISCHARGE DESTINATION
DISCHARGED TO HOSPITAL AT HOME SERVICE INDICATOR
DISCHARGED TO NHS AT HOME SERVICE INDICATOR
DISCHARGE FROM IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES SERVICE REASON
DISCHARGE METHOD
DISCHARGE REASON FOR MOTHER MATERNITY SERVICES
ESTIMATED DATE OF DELIVERY
FIRST REGULAR DAY OR NIGHT ADMISSION
FITNESS ASSESSMENT FOR OLDER PATIENTS WITH BREAST CANCER INDICATOR
HOLISTIC NEEDS ASSESSMENT POINT OF PATHWAY FOR CANCER
HOSPITAL PROVIDER SPELL COMPLETION STATUS FOR PATIENT LEVEL INFORMATION COSTING
LAST EPISODE IN SPELL INDICATOR CODE
LENGTH OF STAY ADJUSTMENT
LENGTH OF STAY ADJUSTMENT REASON
MATERNAL CRITICAL INCIDENT INDICATOR
MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY
MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION
MENTAL HEALTH CONDITIONAL DISCHARGE END REASON
MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE
MENTAL HEALTH DELAYED DISCHARGE REASON
METHOD OF ADMISSION
METHOD OF DISCHARGE
MULTIDISCIPLINARY TEAM RECOMMENDATION FOR NHS CONTINUING HEALTHCARE STANDARD
NEONATAL CRITICAL INCIDENT INDICATOR
NEONATAL LEVEL OF CARE
NHS CONTINUING HEALTHCARE ACTIVITY TYPE
NHS CONTINUING HEALTHCARE COMMISSIONED SERVICES INDICATOR

NHS CONTINUING HEALTHCARE PREVIOUSLY UNASSESSED PERIOD OF CARE DECISION OUTCOME
NHS CONTINUING HEALTHCARE REFERRAL EXCEEDING 28 DAYS TIME BAND CATEGORY
NHS CONTINUING HEALTHCARE TYPE
NON SMOKING CONFIRMATION STATUS AT 4 WEEKS
OPERATION FUNDING FOR NATIONAL JOINT REGISTRY
OUTCOME AT 4 WEEK FOLLOW UP FOR STOP SMOKING
OUTPATIENT ATTENDANCE OUTCOME
PALLIATIVE CARE SPECIALIST SEEN INDICATOR
PALLIATIVE TREATMENT REASON FOR UPPER GASTROINTESTINAL
PATIENT ATTENDANCE SYMPTOMATIC INDICATOR FOR SEXUAL HEALTH SERVICE
PATIENT CLASSIFICATION
PATIENT ON PATIENT INITIATED OUTPATIENT FOLLOW UP PATHWAY INDICATOR
PATIENT RECEIVING ONE TO ONE NURSING CARE INDICATOR
PERSONALISED CARE AND SUPPORT PLANNING POINT OF CANCER PATHWAY
PHARMACOTHERAPY STOP SMOKING AID RECEIVED
PLANNED DELIVERY SETTING CHANGE REASON
PREGNANCY OUTCOME
PSYCHIATRIC PATIENT STATUS
SOURCE OF ADMISSION

ALLIED HEALTH PROFESSIONAL

Change to Class: New Class

A subtype of CARE PROFESSIONAL.

A PERSON who is registered with and regulated by the Health and Care Professions Council.

This class is also known by these names:

Context	Alias
plural	ALLIED HEALTH PROFESSIONALS

ALLIED HEALTH PROFESSIONAL

Change to Class: New Class

This class has no attributes.

ALLIED HEALTH PROFESSIONAL

Change to Class: New Class

APPOINTMENT

Change to Class: Changed Attributes

Attributes of this Class are:

K	APPOINTMENT DATE
K	APPOINTMENT IDENTIFIER
K	APPOINTMENT TIME
	APPOINTMENT BOOKED REASON
	APPOINTMENT CANCELLED DATE
	APPOINTMENT FIRST ATTENDANCE
	APPOINTMENT TYPE FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES
	ATTENDED OR DID NOT ATTEND
	UNIQUE BOOKING REFERENCE NUMBER CONVERTED

CARE PROFESSIONAL TEAM

Change to Class: Changed Attributes

Attributes of this Class are:

K	CARE PROFESSIONAL TEAM IDENTIFIER
	CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE
	MEMBER OF SPECIALIST MULTIDISCIPLINARY TEAM INDICATOR
	REHABILITATION ASSESSMENT TEAM TYPE
	RESPONSIBLE CARE PROFESSIONAL INDICATOR

CLINICAL INTERVENTION

Change to Class: Changed Attributes

Attributes of this Class are:

ABDOMINAL XRAY PERFORMED REASON
ABDOMINAL XRAY PERFORMED TO INVESTIGATE ABDOMINAL SIGNS INDICATOR
ABLATIVE THERAPY TYPE
ACUTE ONCOLOGY ASSESSMENT PATIENT PRESENTATION TYPE
ACUTE ONCOLOGY EPISODE OUTCOME
ADDITIONAL UNPLANNED PROCEDURE REQUIRED INDICATOR
ADJUNCTIVE THERAPY TYPE
ANAESTHETIC TYPE FOR JOINT REPLACEMENT
ANTIRETROVIRAL THERAPY DRUG REGIMEN GROUP CODE
ANTIRETROVIRAL THERAPY HOME DELIVERY INDICATOR
ARTHROPLASTY REVISION TYPE FOR HIP KNEE AND ANKLE REPLACEMENT
ARTHROPLASTY REVISION TYPE FOR SHOULDER AND ELBOW REPLACEMENT
ASA PHYSICAL STATUS CLASSIFICATION SYSTEM CODE
ASA PHYSICAL STATUS CLASSIFICATION SYSTEM CODE FOR NATIONAL JOINT REGISTRY
ASSOCIATED PROCEDURE TYPE FOR ANKLE REPLACEMENT
BIOLOGICAL GLENOID RESURFACING TYPE FOR SHOULDER REPLACEMENT
BIOPSY ANAESTHETIC TYPE
BIOPSY TYPE FOR CENTRAL NERVOUS SYSTEM TUMOURS
BLOOD PRODUCTS REQUIRED FOLLOWING OESOPHAGECTOMY INDICATION CODE
BLOOD TRANSFUSION PRODUCT TYPE
BLOOD TRANSFUSION TYPE

BONE GRAFT INDICATOR FOR JOINT REPLACEMENT
BONE GRAFT SOURCE FOR JOINT REPLACEMENT
BONE GRAFT STRUCTURE FOR JOINT REPLACEMENT
BREAST ASSESSMENT OUTCOME
BREAST TRIPLE DIAGNOSTIC ASSESSMENT INDICATOR
BRONCHOSCOPY PERFORMED TYPE
CANCER CARE SETTING FOR TREATMENT
CANCER IMAGING MODALITY
CANCER IMAGING OUTCOME
CANCER SURGICAL ADMISSION TYPE
CANCER TREATMENT MODALITY
CANCER TREATMENT MODALITY FOR REGISTRATION
CARDIOPULMONARY EXERCISE TEST TYPE
CD4 CELL COUNT PERFORMED INDICATOR
CEMENT REMOVAL INDICATOR FOR JOINT REPLACEMENT
CHEMICAL THROMBOPROPHYLAXIS REGIME TYPE FOR JOINT REPLACEMENT
CHEST DRAIN IN SITU INDICATOR
CHRONIC VIRAL LIVER DISEASE TREATMENT INDICATOR FOR HIV
CLINICAL INTERVENTION TEXT STRING
CLINICAL INTERVENTION TYPE
CO MORBIDITY ADJUSTMENT INDICATOR
COMPONENT REMOVAL INDICATOR FOR JOINT REPLACEMENT
COMPUTER GUIDED SURGERY INDICATOR FOR JOINT REPLACEMENT
CONTINUOUS INFUSION OF PULMONARY VASODILATOR RECEIVED INDICATOR
CONTRACEPTION METHOD STATUS
DEINFIBULATION UNDERTAKEN REASON
DELIVERED IN WATER INDICATOR
DELIVERY INSTRUMENT TYPE
DIEPOXYBUTANE TEST RESULT
DRUG REGIMEN ACRONYM
EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR
ENDOSCOPIC OR RADIOLOGICAL COMPLICATION TYPE
ENDOSCOPIC PROCEDURE TYPE
ENTERAL FEEDING METHOD
ENTERAL FEED TYPE GIVEN
ESCALATION IN LEVEL OF PATIENT CARE FOLLOWING OESOPHAGECTOMY INDICATOR
EXCISION TYPE FOR CENTRAL NERVOUS SYSTEM TUMOURS
FETAL ORDER
FIRST ANTIRETROVIRAL THERAPY IN THE UNITED KINGDOM INDICATOR
FIXATION TYPE FOR ELBOW REPLACEMENT
FIXATION TYPE FOR SHOULDER REPLACEMENT
FORMULA MILK OR MILK FORTIFIER TYPE
FRACTION NUMBER
GERMLINE GENETIC TEST TYPE OFFERED
HIP JOINT SURGERY PATIENT POSITION
HUMAN PAPILLOMAVIRUS VACCINATION DOSE GIVEN
IMAGE GUIDED SURGERY INDICATOR

IMAGING ANATOMICAL SITE
INFECTION CULTURE TEST INDICATOR
INTERNATIONAL ESOPHAGEAL DATABASE SURGICAL COMPLICATIONS
INTERVENTION SESSION TYPE FOR STOP SMOKING
INTERVENTION SETTING TYPE FOR STOP SMOKING
INTRAPARTUM ANTIBIOTICS GIVEN INDICATOR
INTRAVESICAL CHEMOTHERAPY RECEIVED INDICATOR
INTRAVESICAL IMMUNOTHERAPY RECEIVED INDICATOR
JOINT REPLACEMENT PATIENT PROCEDURE PERFORMED INDICATOR
JOINT REPLACEMENT REVISION REASON CODE FOR ANKLE
JOINT REPLACEMENT REVISION REASON CODE FOR ELBOW
JOINT REPLACEMENT REVISION REASON CODE FOR HIP
JOINT REPLACEMENT REVISION REASON CODE FOR KNEE
JOINT REPLACEMENT REVISION REASON CODE FOR SHOULDER
KI 67 STAINING PERFORMED INDICATION CODE
LABOUR OR DELIVERY ONSET METHOD
LABOUR OR DELIVERY ONSET METHOD CODE FOR NATIONAL NEONATAL DATA SET
LAPAROTOMY FOR NECROTISING ENTEROCOLITIS INDICATION CODE
LATENT TUBERCULOSIS TEST PERFORMED INDICATOR
LINER REMOVAL INDICATOR FOR JOINT REPLACEMENT
LIVER CANCER SURVEILLANCE SCAN INDICATOR
LIVER SURGERY PERFORMED TYPE
LIVER TRANSARTERIAL EMBOLISATION MATERIAL INJECTION TYPE
MALIGNANCY TREATMENT INDICATOR FOR HIV
MARGIN INVOLVED INDICATION CODE
MARGIN INVOLVED INDICATION CODE FOR COLORECTAL
MATERNITY CARE SETTING
MECHANICAL THROMBOPROPHYLAXIS REGIME TYPE FOR JOINT REPLACEMENT
MECONIUM PRESENT IN LIQUOR INDICATOR
MEDIASTINAL SAMPLING INDICATOR
MINIMALLY INVASIVE OESOPHAGECTOMY SURGICAL APPROACH TYPE
MINIMALLY INVASIVE SURGERY INDICATOR FOR JOINT REPLACEMENT
MORE THAN THREE RECTAL WASHOUTS RECEIVED INDICATOR
MRI ULTRASOUND FUSION GUIDED BIOPSY INDICATOR
MULTIPARAMETRIC MRI SCAN INDICATOR
NEOADJUVANT THERAPY INDICATOR
NEONATAL RESUSCITATION METHOD FOR NATIONAL NEONATAL DATA SET
NEURODEVELOPMENTAL ASSESSMENT ALREADY TAKEN INDICATOR
NEWBORN HEARING SCREENING TEST TYPE
NITRIC OXIDE GIVEN INDICATOR
NUMBER OF TELETHERAPY FIELDS
OBSERVATION SCHEME IN USE
OESOPHAGECTOMY ANASTOMOSIS TYPE
OESOPHAGECTOMY NECK DISSECTION INDICATOR
OESOPHAGECTOMY OESOPHAGEAL CONDUIT TYPE
OESOPHAGECTOMY SURGICAL APPROACH TYPE
OPEN OESOPHAGECTOMY SURGICAL APPROACH TYPE

OPERATION STATUS CODE
PARENTAL CONSENT TO ADMINISTER VITAMIN K INDICATOR
PARENTAL CONSENT TO POST MORTEM INDICATOR
PARENTERAL NUTRITION RECEIVED INDICATOR
PATHOLOGY INVESTIGATION TYPE
PATHOLOGY INVESTIGATION TYPE FOR BREAST SCREENING
PATIENT CONSENT FOR TISSUE BANKED AT DIAGNOSIS INDICATION CODE
PATIENT DIAGNOSIS TREATMENT PROVIDED INDICATION CODE FOR SEXUAL HEALTH SERVICE
PATIENT PROCEDURE PERFORMED INDICATOR
PATIENT PROCEDURE TYPE FOR PRIMARY ANKLE REPLACEMENT
PATIENT PROCEDURE TYPE FOR PRIMARY ELBOW REPLACEMENT
PATIENT PROCEDURE TYPE FOR PRIMARY HIP REPLACEMENT
PATIENT PROCEDURE TYPE FOR PRIMARY KNEE REPLACEMENT
PATIENT PROCEDURE TYPE FOR PRIMARY SHOULDER REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION ANKLE REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION ELBOW REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION HIP REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION KNEE REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION SHOULDER REPLACEMENT
PATIENT SPECIFIC INSTRUMENTS INDICATOR FOR SHOULDER OR KNEE REPLACEMENT
PATIENT SUBJECT TO REMOTE MONITORING INDICATOR
PATIENT TREATED TO CHILDRENS CANCER AND LEUKAEMIA GROUP GUIDELINES INDICATOR
PLANE OF SURGICAL EXCISION INDICATOR
POST MORTEM CARRIED OUT INDICATOR
POST MORTEM CONFIRMED NECROTISING ENTEROCOLITIS DIAGNOSIS INDICATOR
PRETREATMENT PROSTATE BIOPSY TECHNIQUE TYPE
PREVIOUS BONY INFECTION INDICATOR OF TIBIA OR HINDFOOT FOR ANKLE REPLACEMENT
PREVIOUS FRACTURE OF INDEX JOINT INDICATOR FOR ANKLE REPLACEMENT
PREVIOUS INDEX JOINT SURGERY TYPE FOR ANKLE REPLACEMENT
PREVIOUS SURGERY TYPE FOR SHOULDER REPLACEMENT
PRIMARY INDUCTION CHEMOTHERAPY FAILURE INDICATOR
PRINCIPAL DIAGNOSTIC IMAGING TYPE
PROCEDURE SCHEME IN USE
PROSTATE NERVE SPARING SURGERY TYPE
RADICAL PROSTATECTOMY MARGIN STATUS
RADIOISOTOPE
RADIOTHERAPY ACTUAL DOSE
RADIOTHERAPY BEAM TYPE
RADIOTHERAPY INTENT
RADIOTHERAPY PRESCRIBED DOSE
RADIOTHERAPY TREATMENT MODALITY
REGIONAL ANAESTHETIC TECHNIQUE FOR CANCER
RELAPSE METHOD DETECTION TYPE
RENAL VEIN TUMOUR INDICATOR FOR PAEDIATRIC KIDNEY
RENAL VEIN TUMOUR THROMBUS INDICATION CODE FOR UROLOGICAL
REPLOGLE TUBE IN SITU INDICATOR
RESPIRATORY SUPPORT DEVICE TYPE FOR NATIONAL NEONATAL DATA SET

RESPIRATORY SUPPORT MODE FOR NATIONAL NEONATAL DATA SET
RESUSCITATION METHOD CODE
RETINOPATHY OF PREMATURITY SCREENING OUTCOME STATUS CODE
REVISION PROCEDURE TYPE FOR ANKLE REPLACEMENT
REVISION PROCEDURE TYPE FOR ELBOW REPLACEMENT
REVISION PROCEDURE TYPE FOR HIP REPLACEMENT
REVISION PROCEDURE TYPE FOR KNEE REPLACEMENT
REVISION PROCEDURE TYPE FOR SHOULDER REPLACEMENT
ROTATOR CUFF CONDITION FOR SHOULDER REPLACEMENT
ROTATOR CUFF REPAIRED INDICATOR FOR SHOULDER REPLACEMENT
ROTATOR CUFF REPAIR TYPE FOR SHOULDER REPLACEMENT
SENTINEL LYMPH NODE BIOPSY TYPE
SIGNIFICANT MATERNAL PYREXIA IN LABOUR INDICATOR
STAFF ROLE CARRYING OUT HOLISTIC NEEDS ASSESSMENT OR PERSONALISED CARE AND SUPPORT PLANNING
STEM CELL INFUSION DONOR TYPE
STEM CELL INFUSION SOURCE CODE
STEM CELL TRANSPLANT CONDITIONING REGIMEN
STEROIDS GIVEN DURING PREGNANCY TO MATURE FETAL LUNGS INDICATOR
STOMA PRESENT INDICATOR
SURFACTANT GIVEN INDICATOR
SURGICAL ACCESS TYPE
SURGICAL ACCESS TYPE FOR HEAD AND NECK CANCER
SURGICAL APPROACH FOR PRIMARY HIP REPLACEMENT
SURGICAL APPROACH FOR PRIMARY KNEE REPLACEMENT
SURGICAL APPROACH FOR PRIMARY OR REVISION ANKLE REPLACEMENT
SURGICAL APPROACH FOR PRIMARY OR REVISION ELBOW REPLACEMENT
SURGICAL APPROACH FOR PRIMARY OR REVISION SHOULDER REPLACEMENT
SURGICAL APPROACH FOR REVISION HIP REPLACEMENT
SURGICAL APPROACH FOR REVISION KNEE REPLACEMENT
SURGICAL PALLIATION TYPE
SYSTEMIC ANTI CANCER THERAPY CURATIVE TREATMENT COMPLETED AS PLANNED INDICATOR
SYSTEMIC ANTI CANCER THERAPY CURATIVE TREATMENT NOT COMPLETED OUTCOME REASON
SYSTEMIC ANTI CANCER THERAPY DRUG REGIMEN MODIFICATION INDICATOR FOR DOSE REDUCTION
SYSTEMIC ANTI CANCER THERAPY DRUG REGIMEN TREATMENT INTENT
SYSTEMIC ANTI CANCER THERAPY DRUG ROUTE OF ADMINISTRATION
SYSTEMIC ANTI CANCER THERAPY NON CURATIVE TREATMENT PATIENT BENEFIT INDICATOR
TRACHEOSTOMY TUBE IN SITU INDICATOR
TREATMENT TYPE FOR NECROTISING ENTEROCOLITIS
TREATMENT TYPE FOR PATENT DUCTUS ARTERIOSUS
TUBERCULOSIS TREATMENT INDICATOR FOR HIV
UNITS OF BLOOD TRANSFUSED FOLLOWING OESOPHAGECTOMY
UNTOWARD INTRAOPERATIVE EVENT CODE FOR ANKLE REPLACEMENT
UNTOWARD INTRAOPERATIVE EVENT CODE FOR ELBOW REPLACEMENT
UNTOWARD INTRAOPERATIVE EVENT CODE FOR HIP REPLACEMENT

UNTOWARD INTRAOPERATIVE EVENT CODE FOR KNEE REPLACEMENT
UNTOWARD INTRAOPERATIVE EVENT CODE FOR SHOULDER REPLACEMENT
VASCULAR LINE TYPE IN SITU
VIRAL LOAD COUNT PERFORMED INDICATOR
VISUAL INSPECTION CONFIRMED NECROTISING ENTEROCOLITIS DURING LAPAROTOMY INDICATOR
VITAMIN K ADMINISTERED INDICATOR
VITAMIN K ROUTE OF ADMINISTRATION

CODED CLINICAL ENTRY

Change to Class: Changed Relationships, Description, Attributes

~~A CLINICAL TERMINOLOGY CODE or CLINICAL CLASSIFICATION CODE.~~An entry in an ELECTRONIC HEALTH RECORD, recorded by a CARE PROFESSIONAL, PATIENT or Patient Proxy, or other authorised PERSON, relating to ACTIVITIES for the care and treatment of a PATIENT.

~~This may describe:~~CODED CLINICAL ENTRIES may describe:

- CLINICAL INTERVENTIONS
- CLINICAL INVESTIGATION RESULT ITEMS
- PATIENT DIAGNOSES
- PERSON PROPERTIES
- PLANNED ACTIVITIES
- ~~ACTIVITY DRUGS.~~
- ACTIVITY DRUGS
- CARE PLANS
- ACTIVITY GROUPS
- CARE ACTIVITIES
- any other aspect of PATIENT care and management.

A CODED CLINICAL ENTRY in an ELECTRONIC HEALTH RECORD should include the recording of relevant CLINICAL TERMINOLOGY CODES and/or CLINICAL CLASSIFICATION CODES. Where information to complete the CODED CLINICAL ENTRY is missing, a DATA ABSENT REASON should be recorded.

CODED CLINICAL ENTRY

Change to Class: Changed Relationships, Description, Attributes

Attributes of this Class are:

CLINICAL CLASSIFICATION CODE
CLINICAL TERMINOLOGY CODE
CODED CLINICAL ENTRY SEQUENCE NUMBER
DATA ABSENT REASON
DM AND D TAXONOMY CODE
SNOMED VERSION

CODED CLINICAL ENTRY

Change to Class: Changed Relationships, Description, Attributes

Each CODED CLINICAL ENTRY

must be an entry in one and only one ELECTRONIC HEALTH RECORD
may be a classification for one or more ACTIVITY DRUG
may be a classification for one or more CLINICAL INTERVENTION
may be a classification for one or more CLINICAL INVESTIGATION RESULT ITEM
may be a classification for one or more PATIENT DIAGNOSIS
may be a classification for one or more PERSON PROPERTY
may be a classification for one or more PLANNED ACTIVITY

NHS SERVICE AGREEMENT

Change to Class: Changed Attributes

Attributes of this Class are:

~~K~~	~~NHS SERVICE AGREEMENT NUMBER~~
K	NHS SERVICE AGREEMENT IDENTIFIER
	NHS SERVICE AGREEMENT NUMBER

NHS SERVICE AGREEMENT LINE

Change to Class: Changed Attributes

Attributes of this Class are:

~~K~~	~~NHS SERVICE AGREEMENT LINE NUMBER~~
K	NHS SERVICE AGREEMENT LINE IDENTIFIER
	NHS SERVICE AGREEMENT LINE NUMBER

PATIENT PATHWAY

Change to Class: Changed Attributes

Attributes of this Class are:

K	PATIENT PATHWAY IDENTIFIER
	CANCER FASTER DIAGNOSIS PATHWAY END REASON
	CANCER FASTER DIAGNOSIS PATHWAY EXCLUSION REASON
	CANCER TREATMENT EVENT TYPE
	PERSONALISED OUTPATIENT FOLLOW UP PATHWAY EXPIRY DATE
	RAPID DIAGNOSTIC CENTRE PATHWAY COMPLIANCE INDICATOR
	WAITING TIME MEASUREMENT TYPE

PERSON PROPERTY ASSIGNMENT PERIOD

Change to Class: Changed Attributes

Attributes of this Class are:

	PERSON PROPERTY ASSIGNMENT PERIOD DURATION
	PERSON PROPERTY ASSIGNMENT PERIOD TYPE

SERVICE PROVIDED UNDER AGREEMENT

Change to Class: Changed Attributes

Attributes of this Class are:

BEST PRACTICE TARIFF CODE
CARE PRODUCT TYPE FOR NHS CONTINUING HEALTHCARE
COMMISSIONED SERVICE CATEGORY CODE
CONTRACT UNIT FREQUENCY CODE FOR NHS CONTINUING HEALTHCARE
COST CENTRE CODE FOR NHS CONTINUING HEALTHCARE
HEALTHCARE RESOURCE GROUP CODE
LOCAL POINT OF DELIVERY DESCRIPTION
NUMBER OF COMMISSIONED WEEKLY HOURS OF CARE FOR NHS CONTINUING HEALTHCARE
PERSONAL HEALTH BUDGET TYPE
POINT OF DELIVERY CODE
POINT OF DELIVERY CODE FOR PATIENT LEVEL INFORMATION COSTING
POINT OF DELIVERY FURTHER DETAIL CODE
POINT OF DELIVERY FURTHER DETAIL DESCRIPTION
PROVIDER REFERENCE IDENTIFIER
PROVIDER REFERENCE NUMBER
SERVICE PROVIDED UNDER AGREEMENT TEXT STRING
SPECIALISED MENTAL HEALTH SERVICE CATEGORY CODE
SPECIALISED SERVICE CODE
SPECIALIST SERVICES FLAG
SUBJECTIVE CODE FOR NHS CONTINUING HEALTHCARE
UNBUNDLED ACTIVITY CURRENCY SCHEME IN USE
UNBUNDLED CARE ACTIVITY TYPE FOR PATIENT LEVEL INFORMATION COSTING
UNBUNDLED CURRENCY CODE
UNBUNDLED EPISODE INDICATOR

SERVICE REQUEST

Change to Class: Changed Attributes

Attributes of this Class are:

K SERVICE REQUEST IDENTIFIER
ACTIVITY SERVICE REQUEST DATE
ACTIVITY SERVICE REQUEST TIME
CLINICAL RESPONSE PRIORITY TYPE
COMMISSIONER REFERENCE IDENTIFIER
DIRECT ACCESS REFERRAL INDICATOR
ONWARD REFERRAL REASON
ORIGINAL REFERRAL REQUEST RECEIVED DATE
REASON FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH
REFERRAL OR NOTIFICATION OUTCOME FOR NHS CONTINUING HEALTHCARE STANDARD
REFERRAL OR NOTIFICATION TYPE FOR NHS CONTINUING HEALTHCARE STANDARD
REFERRAL REQUEST OR NOTIFICATION RECEIVED DATE FOR NHS CONTINUING HEALTHCARE STANDARD

REFERRAL REQUEST RECEIVED DATE
REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR
REFERRED OUT OF AREA REASON FOR ADULT ACUTE MENTAL HEALTH
SERVICE REQUEST DATE
SERVICE REQUEST RAISED REASON
SOURCE OF REFERRAL FOR NHS CONTINUING HEALTHCARE STANDARD

WARD OPERATIONAL PLAN

Change to Class: Changed Description, Attributes

~~A statement of the operational planning intent for a particular WARD, including intended time and Hospital Bed availability, TREATMENT FUNCTION and CLINICAL CARE INTENSITY.~~A statement of the operational planning intent for a WARD, including intended Hospital Bed numbers and times available, the TREATMENT FUNCTION the Hospital Beds are planned to be assigned to, and the WARD INTENDED CLINICAL CARE INTENSITY.

~~Hospital Bed availability, in the above, is expressed as the WARD Total Beds Intended (CONSULTANT Care, NURSE Care and MIDWIFE Care) available for the use of PATIENTS.~~Hospital Bed availability, in the above, is expressed as the total number of Hospital Beds intended to be available for the use of PATIENTS receiving CONSULTANT Care, NURSE Care or MIDWIFE Care. This should reflect the number of places available for PATIENT care rather than just a count of physical devices that may be used as a Hospital Bed.

WARD OPERATIONAL PLAN

Change to Class: Changed Description, Attributes

Attributes of this Class are:

K WARD OPERATIONAL PLAN START DATE
AGE GROUP INTENDED
AGE GROUP INTENDED FOR MENTAL HEALTH
CLINICAL CARE INTENSITY
SEX OF PATIENTS
WARD DAY PERIOD AVAILABILITY
WARD INTENDED AGE GROUP
WARD INTENDED CLINICAL CARE INTENSITY
WARD INTENDED DAY PERIOD AVAILABILITY
WARD INTENDED NIGHT PERIOD AVAILABILITY
WARD INTENDED SEX OF PATIENTS
WARD NIGHT PERIOD AVAILABILITY
WARD OPERATIONAL PLAN END DATE

ACTIVITY DATE TYPE

Change to Attribute: Changed Description

The type of date that defines the usage with regard to the ACTIVITY.

An ACTIVITY may have many dates associated with it but may only have one date of a particular type.

National Codes:

001 Angiogram Date (Retired July 2012)
002 Arrival Date At Accident and Emergency Department (Retired 01 November 2020)
003 Breast Assessment Date (Retired 1 January 2013)
004 Cancer Dental Assessment Date (Retired September 2018)
005 Colorectal or Stoma Nurse Seen Date (Retired 1 January 2013)
006 Coronary Angiography Date (Retired July 2012)
007 Care Programme Approach Review Date (Retired September 2018)
008 Date Biopsy Taken (Retired 01 April 2014)
009 Discharge Date
010 Discharge Ready Date
011 End Date
012 Event Date (Retired July 2012)
013 Expected Delivery Date (Retired September 2012)
014 First Antenatal Assessment Date
015 Full Postnatal Examination Date (Retired September 2012)
016 Initial Patient Contact Date (Retired July 2012)
017 Investigation Transfer Date (Retired July 2012)
018 Intrauterine Device Application Date (Retired September 2012)
019 Intrauterine Device Fitted Date (Retired September 2012)
020 Last Dosage Date (Retired April 2019)
021 Mental Health Care Assessment Date (Retired September 2012)
022 Miscarriage Date (Retired September 2012)
023 Pathology Result Due Date (Retired April 2019)
024 Patient Informed Biopsy Result Date (Retired April 2019)
025 Patient Informed Of Outcome Date (Retired September 2012)
026 Smoking Quit Date (Retired October 2017)
027 Review Planned Date (Retired 01 April 2014)
028 Screening Result Date (Retired 01 April 2014)
029 Screening Result Sent Date (Retired April 2019)
030 Specialist Palliative Care Date (Retired 01 April 2014)
031 Start Date
032 Cancer Symptoms First Noted Date (Retired September 2018)
033 Attendance Date (Retired September 2018)
034 Clinical Intervention Date
035 Immunisation Completion Date (Retired 01 September 2015)
036 Clinical Status Assessment Date (Retired September 2018)
037 Dose Given Date (Retired September 2012)
038 Test Date (Retired September 2012)
039 Contact Date (Retired September 2018)
040 Appointment Date (Retired September 2018)
041 Primary Procedure Date (Retired September 2018)
042 Second Operation Date (Retired 01 April 2014)
043 Speech and Language Assessment Date (Retired September 2018)
044 Third Operation Date (Retired 01 April 2014)
045 Date First Seen (Retired September 2018)
046 Statutory Assessment Date (Retired 01 January 2016)
047 Screening Test Date (Retired September 2018)
048 Genitourinary Care Contact Date (Retired January 2014)

049 Consultant Upgrade Date
101 Referral Closure Date (Community Care) (Retired 01 September 2015)
102 Discharge Letter Issued Date (Community Care) (Retired 01 September 2015)
103 Systemic Anti-Cancer Therapy Administration Date (Retired September 2018)
104 Procedure Date
105 Immunisation Date (Retired September 2018)
106 Antenatal Appointment Date (Retired 1 April 2019)
107 Antenatal Booking Appointment Date (Retired September 2018)
108 Pregnancy First Contact Date
109 Screening Test Information Given Date (Retired 1 April 2019)
110 Assessment Date For Transplant Suitability
111 Accident and Emergency Initial Assessment Date (Retired 01 November 2020)
112 Accident and Emergency Date Seen For Treatment (Retired 01 November 2020)
113 Accident and Emergency Attendance Conclusion Date (Retired 01 November 2020)
114 Accident and Emergency Departure Date (Retired 01 November 2020)
115 Clinical Assessment Date (Retired September 2018)
116 Imaging or Radiodiagnostic Event Date (Retired September 2018)
117 Neonatal Critical Care Daily Care Date
118 Two Year Neonatal Outcomes Assessment Date (Retired September 2018)
119 Date of Pregnancy Outcome (Current Fetus) (Retired 1 April 2019)
120 Neonatal Critical Incident Date (Retired 1 April 2019)
121 American Joint Committee on Cancer Stage Date (Retired September 2018)
122 Ann Arbor Stage Date (Retired September 2018)
123 Barcelona Clinic Liver Cancer Stage Date (Retired September 2018)
124 Binet Stage Date (Retired September 2018)
125 Chang Staging System Stage Date (Retired September 2018)
126 Clinical Stage Date (Pancreatic Cancer) (Retired September 2018)
127 Final Figo Stage Date (Retired September 2018)
128 Holistic Needs Assessment Completed Date (Retired September 2018)
129 Intergroup Rhabdomyosarcoma Study Post Surgical Group Date (Retired September 2018)
130 International Neuroblastoma Staging System Date (Retired 01 April 2017)
131 Myeloma International Staging System Stage Date (Retired September 2018)
132 Modified Dukes Stage Date (Retired September 2018)
133 Multidisciplinary Team Discussion Date (Cancer)
134 Multidisciplinary Team Meeting Date (Cancer)
135 Murphy St Jude Stage Date (Retired September 2018)
136 Rai Stage Date (Retired 01 April 2017)
137 Retinoblastoma Assessment Date (Retired September 2018)
138 TNM Stage Grouping Date (Final Pretreatment) (Retired September 2018)
139 TNM Stage Grouping Date (Integrated) (Retired September 2018)
140 Wilms Tumour Stage Date (Retired September 2018)
141 Care Contact Cancellation Date
142 Care Contact Date
143 Child Protection Plan End Date (Retired September 2018)
144 Child Protection Plan Start Date (Retired September 2018)
145 Discharge Letter Issued Date (Mental Health and Community Care)
146 Health Visitor First Antenatal Visit Date (Retired September 2018)
147 Infant Physical Examination Date (Retired September 2018)
148 Onward Referral Date (Retired September 2018)

149 Referral Closure Date
150 Referral Rejection Date
151 Replacement Appointment Booked Date
152 Replacement Appointment Date Offered
153 Service Discharge Date (Retired September 2018)
154 Date of Restrictive Intervention (Retired 01 April 2019)
155 Indirect Activity Date
156 Mental Health Crisis Plan Creation Date (Retired 01 April 2017)
157 Mental Health Crisis Plan Last Updated Date (Retired 01 April 2017)
158 Care Plan Agreed Date
159 Care Plan Creation Date
160 Care Plan Implementation Date
161 Care Plan Last Updated Date
162 Five Forensic Pathways Assessment Date (Retired September 2018)
163 International Neuroblastoma Risk Group Staging System Stage Date (Retired September 2018)
164 Stage Grouping Date (Testicular Cancer) (Retired September 2018)
165 Emergency Care Arrival Date
166 Emergency Care Initial Assessment Date
167 Emergency Care Date Seen For Treatment
168 Emergency Care Attendance Conclusion Date
169 Emergency Care Departure Date
170 Injury Date (Retired September 2018)
171 Referred To Service Assessment Date (Retired September 2018)
172 Intended Smoking Quit Date (Moved to PLANNED ACTIVITY DATE TYPE September 2018)
173 Cancer Transformation Agreed Date (Primary Cancer Pathway)
174 Cancer Progression Agreed Date (Primary Cancer Pathway)
175 Clinical Trial Decision Date
176 Treatment Start Date (Cancer) (Retired September 2018)
177 Cancer Faster Diagnosis Pathway End Date (Retired September 2018)
178 Cancer Referral To Treatment Period Start Date (Retired September 2018)
179 Cancer Treatment Period Start Date (Retired September 2018)
180 Observable Entity Date
181 Package of Care or Year of Care Start Date (Contract Monitoring)
182 NHS Continuing Healthcare Standard Checklist Completed Date
183 Clinical Commissioning Group Eligibility Decision Date (NHS Continuing Healthcare Standard)
184 Clinical Commissioning Group Eligibility Decision Outcome Communicated To Patient Date (NHS Continuing Healthcare Standard)
185 NHS Continuing Healthcare Fast Track Pathway Tool Completed Date
186 NHS Continuing Healthcare Request Received Date
187 NHS Continuing Healthcare Local Resolution Formal Meeting Date
188 NHS Continuing Healthcare Local Resolution Informal Meeting Date
189 Local Resolution Eligibility Decision Outcome Communicated To Patient Date (NHS Continuing Healthcare)
190 NHS Continuing Healthcare Care Package Eligibility Status Change Date
191 NHS Continuing Healthcare Eligibility Start Date Following Independent Review
192 NHS Continuing Healthcare Previously Unassessed Period Of Care Decision Made Date
193 NHS Continuing Healthcare Previously Unassessed Period Of Care Eligibility Decision Communicated To Requester Date
194 Unbundled Care Activity Date
195 Activity Date for Age (Contract Monitoring)

196 Activity End Date (Contract Monitoring)
197 Activity Start Date (Contract Monitoring)
198 Care Plan Content Agreed Date
??? eMED3 Fit Note Assessment Date
??? eMED3 Fit Note Recorded Date
??? Last Patient Did Not Attend Date
??? Last Patient Cancelled Date

ACTIVITY GROUP TYPE

Change to Attribute: Changed Description

The type of ACTIVITY GROUP.

National Codes:

01 Accident and Emergency Episode (Retired 01 November 2020)
02 Acute Myocardial Infarction Care Spell (Retired July 2012)
03 Augmented Care Period (Retired 1 April 2006)
04 Breast Cancer Care Spell
05 Cancer Care Spell
06 Care Home Stay (Consultant Care)
07 Care Home Stay (Midwife Care)
08 Care Home Stay (Nursing Care)
09 Care Home Stay (Residential)
10 Care Programme Approach Care Episode
11 Colorectal Cancer Care Spell
12 Community Episode (Retired 01 January 2016)
13 Mental Health Care Professional Episode (Acute Home-Based) (Retired 01 January 2016)
14 Consultant Episode (Hospital Provider)
15 Consultant Out-Patient Episode
16 Dental Episode (Retired 01 April 2014)
17 Drug Misuse Episode (Retired 1 April 2019)
18 Sexual Health and HIV Episode
19 Head and Neck Cancer Care Spell
20 Home Dialysis Episode (Retired October 2019)
21 Hospital Provider Spell
22 Lung Cancer Care Spell
23 Adult Mental Health, Learning Disability or Autism Spectrum Disorder Care Spell (Retired 01 January 2016)
24 Midwife Episode
25 Neonatal Level Of Care Period
26 Nursing Episode
27 Palliative Care Episode
28 Person Stop Smoking Episode
29 Pregnancy Episode (Retired 1 April 2019)
30 Professional Staff Group Episode (Retired 01 January 2016)
31 Regular Attender Episode (Retired 01 January 2016)
32 Road Traffic Accident Treatment (Retired 01 April 2014)

33 Sarcoma Cancer Care Spell
34 Skin Cancer Care Spell
35 Supervised Discharge Episode (Retired 01 April 2014)
36 Supervision Register Episode (Retired 01 April 2014)
37 Upper Gastrointestinal Cancer Care Spell
38 Urological Cancer Care Spell
39 Ward Stay
40 Hospital Stay
41 Care Spell
42 CRITICAL CARE PERIOD
43 PATIENT PATHWAY
44 REFERRAL TO TREATMENT PERIOD
45 Active Monitoring
46 Supervised Community Treatment Recall (Retired 01 January 2016)
47 Supervised Community Treatment (Retired 01 January 2016)
48 Mental Health Care Without Patient Consent (Retired 01 January 2016)
49 Cancer Treatment Period
50 Gynaecological Cancer Care Spell
51 Mental Health Care Spell (Retired 01 January 2016)
52 Improving Access to Psychological Therapies Care Spell (Retired 1 April 2020)
53 Adult Mental Health Care Team Episode (Retired 01 January 2016)
54 Mental Health NHS Day Care Episode (Retired 01 January 2016)
55 Mental Health Delayed Discharge Period
56 Mental Health Care Cluster Assignment Period (Retired 01 January 2016)
57 Mental Health Care Coordinator Assignment Period
58 Child and Adolescent Mental Health Clinical Intervention Episode (Retired 01 January 2016)
59 Child and Adolescent Mental Health Care Spell (Retired 01 January 2016)
60 Maternity Episode
61 HIV Episode
62 Central Nervous System Cancer Care Spell
63 Children Teenagers and Young Adults Cancer Care Spell
64 Haematological Cancer Care Spell
65 Lung Cancer Care Spell (Retired 1 April 2018)
66 Commissioner Assignment Period
67 Breast Screening Episode
68 High Risk Breast Screening Episode
69 Open Breast Screening Episode
70 Neonatal Critical Care Spell
71 Radiotherapy Episode
72 Healthy Person Stay
73 Mental Health Responsible Clinician Assignment Period
74 Mental Health Conditional Discharge Period
75 Mental Health Act Legal Status Classification Period (Moved to PERSON PROPERTY ASSIGNMENT PERIOD TYPE 01 January 2016)
76 Care Professional Admitted Care Episode
77 Liver Cancer Care Spell
78 NHS Continuing Healthcare
79 NHS-funded Nursing Care
80 Package of Care

81 Acute Oncology Episode
82 Personalised Care and Support Planning
83 Community Bed-based Intermediate Care
84 Crisis Response Intermediate Care
85 Home-based Intermediate Care
86 Reablement Intermediate Care
87 Emergency Care Episode
?? Care Professional Out-Patient Episode

ACTIVITY LOCATION TYPE CODE

Change to Attribute: Changed Description

The type of LOCATION for an ACTIVITY:

- where PATIENTS are seen
- where SERVICES are provided or
- from which requests for SERVICES are sent.

Notes:

- ~~The following National Code is **only** valid for the Community Services Data Set, Improving Access to Psychological Therapies Data Set, Maternity Services Data Set and Mental Health Services Data Set. Users of other data sets must map National Code G04 locally to other appropriate ACTIVITY LOCATION TYPE CODES for the purposes of flowing data:~~
  - ~~G04 *'Integrated Care Home Without Nursing and Care Home With Nursing'*~~
- ~~The following National Codes have been introduced for the Improving Access to Psychological Therapies Data Set and Mental Health Services Data Set **only** to add further granularity to National Code M04 '*Young Offender Institution*'. However, National Code M04 is still valid for the Improving Access to Psychological Therapies Data Set and Mental Health Services Data Set where extra detail cannot be collected:~~
  - ~~M06 '*Young Offender Institution (15-17)*'~~
  - ~~M07 '*Young Offender Institution (18-21)*'~~
- National Code G04 *'Integrated Care Home Without Nursing and Care Home With Nursing'* is **not** valid for the Commissioning Data Set Version 6-2.
- The following National Codes have been introduced for the Improving Access to Psychological Therapies Data Set and Mental Health Services Data Set **only** to add further granularity to National Code M04 '*Young Offender Institution*'. However, National Code M04 is still valid for the Improving Access to Psychological Therapies Data Set and Mental Health Services Data Set where extra detail cannot be collected:
  - M06 '*Young Offender Institution (15-17)*'
  - M07 '*Young Offender Institution (18-21)*'
- The following National Code has been updated in DCB0092-2062: Commissioning Data Sets: Emergency Care Data Set. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct:
  - E04 '*Emergency Care Department or Minor Injuries Department*'.

Further information on the groupings and scope of each ACTIVITY LOCATION TYPE CODE is provided at: Activity Location Type Codes.

National Codes:

A01 PATIENT's Home
A02 Carer's Home
A03 PATIENT's Workplace

A04 Other PATIENT Related Location
B01 Primary Care Health Centre
B02 Polyclinic
C01 General Medical Practitioner Practice
C02 Dental Practice
C03 OPHTHALMIC MEDICAL PRACTITIONER Premises
D01 Walk In Centre
D02 Out of Hours Centre
D03 Emergency Community Dental Service
E01 Out-Patient Clinic
E02 WARD
E03 Day Hospital
E04 Emergency Care Department or Minor Injuries Department
E99 Other Departments
F01 Hospice
G01 Care Home Without Nursing
G02 Care Home With Nursing
G03 Children's Home
G04 Integrated Care Home Without Nursing and Care Home With Nursing
H01 Day Centre
J01 Resource Centre
K01 Sure Start Children's Centre
K02 Child Development Centre
L01 School
L02 Further Education College
L03 University
L04 Nursery Premises
L05 Other Childcare Premises
L06 Training Establishments
L99 Other Educational Premises
M01 Prison
M02 Probation Service Premises
M03 Police Station / Police Custody Suite
M04 Young Offender Institution
M05 Immigration Removal Centre
M06 Young Offender Institution (15-17)
M07 Young Offender Institution (18-21)
N01 Street or other public open space
N02 Other publicly accessible area or building
N03 Voluntary or charitable agency premises
N04 Dispensing Optician Premises
N05 Dispensing Pharmacy Premises
X01 Other locations not elsewhere classified

AGE GROUP INTENDED

Change to Attribute: Changed Description

The age group of PATIENTS intended to use a WARD indicated in the operational plan.

National Codes:

1	Neonates
2	Children and/or adolescents
3	Elderly
8	Any age

AGE GROUP INTENDED will be replaced with WARD INTENDED AGE GROUP, which is the most recent approved national information standard to describe the required definition.

APPOINTMENT BOOKED REASON

Change to Attribute: New Attribute

The reason that an APPOINTMENT was booked.

National Codes:

1	Timed Out-Patient Follow Up Appointment
2	Patient Initiated Out-Patient Follow Up Appointment
3	Remote Monitoring Triggered Out-Patient Follow Up Appointment

This attribute is also known by these names:

Context	Alias
plural	APPOINTMENT BOOKED REASONS

APPOINTMENT BOOKED REASON

Change to Attribute: New Attribute

APPOINTMENT BOOKED REASON

Data Elements:

APPOINTMENT BOOKED REASON

CARE CONTACT TYPE

Change to Attribute: Changed Description

The type of CARE CONTACT.

National Codes:

01	Accident and Emergency Attendance (Retired 01 November 2020)
02	Acute Home-Based Contact (Retired 01 January 2016)
03	Audiology Attendance (Retired 01 April 2014)
04	Cancer Clinical Status Assessment

05 Care Programme Approach Review
06 Clinic Attendance Consultant
07 Clinic Attendance Sexual and Reproductive Health Service (Retired November 2014)
08 Clinic Attendance Midwife
09 Clinic Attendance Non-Consultant
10 Clinic Attendance Nurse
11 Contact Tracing Activity (Retired 01 April 2014)
12 Dental Treatment Contact (Retired 01 April 2014)
13 Day Care Attendance (Retired 01 January 2016)
14 Domiciliary Consultation
15 Emergency Dental Attendance (Retired 01 April 2014)
16 Face To Face Contact Community Care (Retired 01 January 2016)
17 Face To Face Contact CPA Care Coordinator (Retired 01 January 2016)
18 Face To Face Contact Dental (Retired 01 April 2014)
19 Face To Face Contact Optical (Retired 01 April 2014)
20 Face To Face Contact Social Worker (Retired 01 April 2011)
21 Face To Face Contact Surveillance (Retired 01 April 2014)
22 Sexual and Reproductive Health Domiciliary Visit
23 Genitourinary Consultant Clinic Attendance
24 GMP Consultation (Retired 01 April 2014)
25 GMP Practice Consultation (Retired 01 April 2014)
26 Home Assessment Visit (Retired 01 January 2016)
27 Maternity Domiciliary Visit
28 Night Consultation Visit (Retired 01 April 2014)
29 Nurse or Midwife Contact
30 Out-Patient Attendance Consultant
31 Registration Health Check (Retired 01 April 2014)
32 Sheltered Work Attendance (Retired 01 April 2011)
33 Sight Test (Retired 01 April 2014)
34 Social Services Statutory Assessment (Retired 01 January 2016)
35 Professional Advice And Support Contact (Retired 01 April 2014)
36 Professional Staff Group Contact (Retired 01 January 2016)
37 Telephone Contact NHS Direct (Mental Health) (Retired 01 April 2011)
38 Theatre Case
39 Ward Attendance
40 Genitourinary Care Contact (Retired January 2014)
41 Improving Access to Psychological Therapies Contact
42 NHS Health Check Assessment (Retired April 2019)
43 Antenatal Booking Appointment (Retired 1 April 2019)
44 Pregnancy First Contact
45 Nutritional Assessment
46 HIV Clinic Attendance
47 Multi-Disciplinary Consultation (National Tariff Payment System)
48 Multi-Professional Consultation (National Tariff Payment System)
49 Two Year Neonatal Outcomes Assessment
50 Radiotherapy Attendance
51 Holistic Needs Assessment
52 Emergency Care Attendance
?? Care Professional Out-Patient Attendance

CARE PROFESSIONAL TYPE

Change to Attribute: Changed Description

The type of CARE PROFESSIONAL.

National Codes:

010	Arts Therapist (Art Therapists, Music Therapists and Dramatherapists)
020	Biomedical Scientist
030	Chiropodist / Podiatrist
040	Chiropractor
050	Clinical Scientist
060	CONSULTANT
070	Clinical Dental Technician
080	Dental Hygienist
090	Dental Nurse
100	Dental Technician
110	Dental Therapist
120	Orthodontic Therapist
130	Dietitian
140	Dispensing Optician
150	GENERAL DENTAL PRACTITIONER
160	GENERAL MEDICAL PRACTITIONER
170	MIDWIFE
180	NURSE
190	Occupational Therapist
200	Operating Department Practitioner
210	OPHTHALMIC MEDICAL PRACTITIONER
220	OPTOMETRIST
230	Orthoptist
240	Orthotist
250	Osteopath
260	Paramedic
270	Pharmacist
280	Physiotherapist
290	Practitioner Psychologist
300	Prosthetist
310	Radiographer
320	Specialist Community Public Health Nurse: Family Health Nurse
330	Specialist Community Public Health Nurse: Health Visitor
340	Specialist Community Public Health Nurse: Occupational Health Nurse
350	Specialist Community Public Health Nurse: School Nurse
360	Speech and Language Therapist
370	Hearing Aid Dispenser
380	Pharmacy Technician
390	Social Worker in England
400	Improving Access to Psychological Therapies Care Professional

410 ALLIED HEALTH PROFESSIONAL
XXX Other (not listed)

CDS BULK REPLACEMENT GROUP CODE

Change to Attribute: Changed Description

The Commissioning Data Set Group into which CDS Types must be grouped when using the Commissioning Data Set Bulk Replacement Update Mechanism.

Note:

- National Code 160 '*Emergency Care Attendance*' is **only** valid for:
  - CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol
  - CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol
  - CDS V6-2-2 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol
  - CDS V6-2-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol
  - CDS V6-2-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol
  - CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol
- ~~National Code 140 '*Accident and Emergency Attendance*' will no longer be accepted from 01 November 2020.~~

~~*National Codes:*~~

- CDS Type 010 *'Accident and Emergency Attendance'* was retired from 1 November 2020 and is no longer accepted for submission to the Secondary Uses Service.

- Commissioning Data Set version 6-3 does not require submission of the following CDS Types:
  - Detained and/or Long Term Psychiatric Census
  - Any Elective Admission List CDS Type
  - Future Outpatient

National Codes:

010 Finished General, Delivery and Birth Episodes
020 Unfinished General, Delivery and Birth Episodes
030 Other Delivery
040 Other Birth
050 Detained and/or Long Term Psychiatric Census
060 Outpatient
070 Standard variation of Elective Admission List End Of Period Census
080 New and Old variations of Elective Admission List End Of Period Census
090 Add variation of Elective Admission List Event During Period
100 Remove variation of Elective Admission List Event During Period
110 Offer variation of Elective Admission List Event During Period
120 Available/Unavailable variation of Elective Admission List Event During Period
130 New and Old variations of Elective Admission List Event During Period
~~140 Accident and Emergency Attendance~~
140 Accident and Emergency Attendance (Retired 1 November 2020)
150 Future Outpatient
160 Emergency Care Attendance

CDS MESSAGE VERSION NUMBER

Change to Attribute: Changed Description

The version number of the Commissioning Data Set XML Schema in use.

The Commissioning Data Set message version numbers are updated as required during the on-going message development processes.

National Codes:

NHS003	The 2000 / 2001 Specification
NHS004	The 2004 / 2005 CDS XML Specification
NHS005	The 2005 / 2006 CDS XML Specification: For implementation of XML messaging in the Secondary Uses Service
CDS006	The 2007 CDS-XML Specification (CDS V6-0/6-1/6-1-1): Note the change to the prefix **CDS**
CDS062	The 2012 CDS XML Specification (V6-2/6-2-1/6-2-2/6-2-3/6-2-0): Note the change to the format which represents the sub-version identifier (version 6-2)
CDS063	The 2022 CDS XML Specification (V6-3)

CDS TYPE CODE

Change to Attribute: Changed Description

A code to identify the specific type of Commissioning Data Set data.

Note:

- ~~National Code 011 '*Emergency Care Attendance*' is **only** valid for:~~
  - ~~CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol~~
  - ~~CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol~~
  - ~~CDS V6-2-2 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol~~
  - ~~CDS V6-2-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol~~
  - ~~CDS V6-2-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol~~
  - ~~CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol.~~
- National Code 011 '*Emergency Care Attendance*' is **only** valid for:
  - CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol
  - CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol
  - CDS V6-2-2 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol
  - CDS V6-2-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol
  - CDS V6-2-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol
  - CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol

- CDS Type 010 *'Accident and Emergency Attendance'* was retired on 1 November 2020 and is no longer accepted for submission to the Secondary Uses Service.

- Commissioning Data Set version 6-3 does not require submission of the following CDS Types:
  - Detained and/or Long Term Psychiatric Census
  - Any Elective Admission List CDS Type
  - Future Outpatient

~~Note:~~

- ~~CDS Type 010 *'Accident and Emergency Attendance'* will no longer be accepted from 01 November 2020.~~

National Codes:

~~010~~	~~Accident and Emergency Attendance~~
010	Accident and Emergency Attendance (Retired 1 November 2020)
011	Emergency Care Attendance
020	Outpatient May also be used to submit a Referral To Treatment Clock Stop Administrative Event
021	Future Outpatient
030	Elective Admission List End of Period Census (Standard)
040	Elective Admission List End of Period Census (Old)
050	Elective Admission List End of Period Census (New)
060	Elective Admission List Event During Period (Add)
070	Elective Admission List Event During Period (Remove)
080	Elective Admission List Event During Period (Offer)
090	Elective Admission List Event During Period (Available/Unavailable)
100	Elective Admission List Event During Period (Old Service Agreement)
110	Elective Admission List Event During Period (New Service Agreement)
120	Finished Birth Episode
130	Finished General Episode
140	Finished Delivery Episode
150	Other Birth
160	Other Delivery
170	Detained and/or Long-Term Psychiatric Census
180	Unfinished Birth Episode
190	Unfinished General Episode
200	Unfinished Delivery Episode

CDS UPDATE TYPE

Change to Attribute: Changed Description

A code to indicate the required database update process for the submitted Commissioning Data Set Message.

National Codes:

1	To indicate a CDS Deletion or Cancellation
~~9~~	~~To indicate a CDS Original or Replacement~~
9	To indicate a CDS Original or Replacement

CLINICAL CARE INTENSITY

Change to Attribute: Changed Description

The level of resources and intensity of care which it is intended to provide or is provided in a particular WARD.

Notes:

- National Code descriptions have been updated to remove National Code headings and add prefixes. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

National Codes:

51	Mental Illness intensive care: specially designated ward for PATIENTS needing containment and more intensive management (e.g. Psychiatric Intensive Care Unit (PICU)). This is not to be confused with intensive nursing where PATIENTS may require one to one nursing while on a standard WARD
52	Mental Illness short stay: PATIENTS intended to stay less than a year
53	Mental Illness long stay: PATIENTS intended to stay a year or more
61	Learning Disability PATIENTS in a designated or interim secure unit
62	Learning Disability PATIENTS intending to stay less than a year
63	Learning Disability PATIENTS intending to stay a year or more
41	Only for maternity PATIENTS looked after by CONSULTANTS
43	Only for maternity PATIENTS looked after by GENERAL MEDICAL PRACTITIONERS
42	Joint use for maternity PATIENTS looked after by CONSULTANTS and GENERAL MEDICAL PRACTITIONERS
33	Neonates: maternity: associated with the maternity WARD in that cots are in the maternity WARD nursery or in the WARD itself
32	Neonates: non-maternity: not associated with the maternity WARD and without designated cots for intensive care
31	Neonates: not associated with the maternity WARD and in which there are some designated cots for intensive care
21	Younger physically disabled PATIENTS: spinal units, only those units which are nationally recognised
22	Younger physically disabled PATIENTS: other units
81	Terminally ill/Palliative Care PATIENTS
11	General PATIENTS: for intensive therapy, including high dependency care
12	General PATIENTS: for normal therapy: where resources permit the admission of PATIENTS who might need all but intensive or high dependency therapy
13	General PATIENTS: for limited therapy: where nursing care rather than continuous medical care is provided. Such WARDS can be used only for PATIENTS carefully selected and restricted to a narrow range in terms of the extent and nature of disease
71	Home Leave, non-psychiatric
72	Home Leave, psychiatric

CLINICAL CARE INTENSITY will be replaced with WARD INTENDED CLINICAL CARE INTENSITY, which is the most recent approved national information standard to describe the required definition.

CLINICAL INTERVENTION TYPE

Change to Attribute: Changed Description

The type of CLINICAL INTERVENTION.

National Codes:

01	Anaesthetic Service (Retired November 2013)
02	Anti-Cancer Drug Cycle (Retired 1 September 2019)

03 Anti-Cancer Drug Fraction (Retired 1 January 2013)
04 Anti-Cancer Drug Programme (Retired 1 September 2019)
05 Anti-Cancer Drug Regimen
06 Brachytherapy Treatment Course (Retired 1 April 2020)
07 Contraceptive Service (Retired November 2013)
08 Dental Haemorrhage Service (Retired November 2013)
09 Dental Treatment (Retired 01 April 2014)
10 Drug Dosage and Administration (Retired 1 January 2013)
11 Drug Treatment (Retired April 2019)
12 Emergency Treatment Service (Retired November 2013)
13 Endocrine Therapy (Retired 1 January 2013)
14 Fraction
15 Primary Hip Replacement Surgery
16 Imaging or Radiodiagnostic Event
17 Immunisation Dose Given (Retired April 2019)
18 Joint Replacement Surgery
19 Primary Knee Replacement Surgery
20 Labour and Delivery
21 Lithotripsy Course Attendance (Retired 1 April 2014)
22 Maternity Medical Service (Retired November 2013)
23 Minor Surgery Procedure (Retired November 2013)
24 Pathology Laboratory Investigation (Retired January 2015)
25 Patient Procedure
26 Post Mortem
27 Radiotherapy Treatment Course
28 Screening Test (Retired November 2013)
29 Teletherapy Treatment Course (Retired 1 April 2014)
30 Test Of Immunity (Retired November 2013)
31 Therapy After Discharge (Retired July 2012)
32 Thromboprophylaxis Regime
33 Unsealed Source Treatment Course (Retired 1 April 2014)
34 Vaccination Service (Retired November 2013)
35 Vasectomy Performed (Retired November 2013)
36 Clinical Investigation
37 Systemic Anti-Cancer Therapy Drug Cycle
38 Systemic Anti-Cancer Therapy Drug Programme (Retired 1 September 2019)
39 Systemic Anti-Cancer Therapy Drug Regimen
40 Chemotherapy
41 Cytotoxic Chemotherapy
42 Hormone Therapy
43 Immunotherapy
44 Diagnostic Imaging (Retired January 2015)
45 6 - 8 Week Physical Examination (Retired January 2015)
46 Ultrasound Scan In Pregnancy (Retired January 2015)
47 Newborn Physical Examination (Retired January 2015)
48 Biological Therapy
49 Brachytherapy
50 Chemoradiotherapy
51 Cryotherapy

52	High Intensity Focused Ultrasound
53	Hyperbaric Oxygen Therapy
54	Laser Treatment
55	Light Therapy
56	Photodynamic Therapy
57	Proton Therapy
58	Psoralen and Ultraviolet A Therapy
59	Radiofrequency Ablation
60	Radioisotope Therapy
61	Radiosurgery
62	Radiotherapy
63	Teletherapy
64	Tissue Typing (Retired January 2015)
65	Blood Transfusion
66	Renal Dialysis
67	Antiretroviral Therapy
68	Drug Regimen
69	Ablative Therapy
70	Laparoscopy
71	Primary Ankle Replacement Surgery
72	Revision Ankle Replacement Surgery
73	Primary Elbow Replacement Surgery
74	Revision Elbow Replacement Surgery
75	Revision Hip Replacement Surgery
76	Revision Knee Replacement Surgery
77	Primary Shoulder Replacement Surgery
78	Revision Shoulder Replacement Surgery
79	Oxygen Therapy
80	Therapeutic Hypothermia
81	Parenteral Nutrition
82	Enteral Feeding
83	Radiotherapy Exposure
84	Mental Health Treatment (Retired 01 January 2016)
85	Restrictive Intervention
86	Adjunctive Therapy
87	Acute Oncology Assessment
88	Breast Triple Diagnostic Assessment
89	Diagnostic Procedure
90	Enhanced Supportive Care
91	Internet Enabled Therapy Programme
??	Remote Monitoring

COMMISSIONER REFERENCE IDENTIFIER

Change to Attribute: New Attribute

The identifier of a SERVICE REQUEST allocated by the commissioner of a SERVICE.

COMMISSIONER REFERENCE NUMBER will be replaced with COMMISSIONER REFERENCE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.

This attribute is also known by these names:

Context	Alias
plural	COMMISSIONER REFERENCE IDENTIFIERS

COMMISSIONER REFERENCE IDENTIFIER

Change to Attribute: New Attribute

COMMISSIONER REFERENCE IDENTIFIER

Data Elements:

COMMISSIONER REFERENCE IDENTIFIER

COMMISSIONER REFERENCE NUMBER

Change to Attribute: Changed Description

A number (alphanumeric) allocated by the commissioner to a REFERRAL REQUEST.

COMMISSIONER REFERENCE NUMBER will be replaced with COMMISSIONER REFERENCE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.

CRITICAL CARE ACTIVITY CODE

Change to Attribute: Changed Description

A type of CRITICAL CARE ACTIVITY provided to a PATIENT during a CRITICAL CARE PERIOD.

Note:

- ~~National Codes 80-97 should not be reported nationally until the functionality to do so becomes available in the next release of the Commissioning Data Sets and the associated XML Schema. Prior to this release, these codes must be recorded locally, however the National Codes 80-97 cannot be transmitted in the current version of the Commissioning Data Sets (Version 6-2). Further guidance can be found on the NHS Digital website at: SCCI0075 and SCCI0076.~~
- National Codes 80-97 cannot be reported nationally in Commissioning Data Sets version 6-2. Users of this Commissioning Data Set release must record these codes locally. Further guidance can be found on the NHS Digital website at: SCCI0075 and SCCI0076.
- User of Commissioning Data Sets version 6-3 are able to submit all National Codes.

National Codes:

01	Respiratory support via a tracheal tube (Respiratory support via a tracheal tube provided)
02	Nasal Continuous Positive Airway Pressure (nCPAP) (PATIENT receiving nCPAP for any part of the day)
03	Surgery (PATIENT received surgery)
04	Exchange Transfusion (PATIENT received exchange transfusion)

05 Peritoneal Dialysis (PATIENT received Peritoneal Dialysis)
06 Continuous infusion of inotrope, pulmonary vasodilator or prostaglandin (PATIENT received a continuous infusion of an inotrope, vasodilator (includes pulmonary vasodilators) or prostaglandin)
07 Parenteral Nutrition (PATIENT receiving Parenteral Nutrition (amino acids +/- lipids))
08 Convulsions (PATIENT having convulsions requiring treatment)
09 Oxygen Therapy (PATIENT receiving additional oxygen)
10 Neonatal abstinence syndrome (PATIENT receiving drug treatment for neonatal abstinence (withdrawal) syndrome)
11 Care of an intra-arterial catheter or chest drain (PATIENT receiving care of an intra-arterial catheter or chest drain)
12 Dilution Exchange Transfusion (PATIENT received Dilution Exchange Transfusion)
13 Tracheostomy cared for by nursing staff (PATIENT receiving care of tracheostomy cared for by nursing staff not by an external Carer (e.g. parent))
14 Tracheostomy cared for by external Carer (PATIENT receiving care of tracheostomy cared for by an external Carer (e.g. parent) not by a NURSE)
15 Recurrent apnoea (PATIENT has recurrent apnoea needing frequent intervention, i.e. over 5 stimulations in 8 hours, or resuscitation with IPPV two or more times in 24 hours)
16 Haemofiltration (PATIENT received Haemofiltration)
21 Carer Resident - Caring for Baby (External Carer (for example, parent) resident with the baby and reducing nursing required by caring for the baby)
22 Continuous monitoring (PATIENT requiring continuous monitoring (by mechanical monitoring equipment) of respiration or heart rate, or by transcutaneous transducers or by Saturation Monitors. Note: apnoea alarms and monitors are *excluded* as forms of continuous monitoring)
23 Intravenous glucose and electrolyte solutions (PATIENT being given intravenous glucose and electrolyte solutions)
24 Tube-fed (PATIENT being tube-fed)
25 Barrier nursed (PATIENT being barrier nursed)
26 Phototherapy (PATIENT receiving phototherapy)
27 Special monitoring (PATIENT receiving special monitoring of blood glucose or serum bilirubin measurement at a minimum frequency of more than one per calendar day)
28 Observations at regular intervals (PATIENT requiring recorded observations for Temperature, Heart Rate, Respiratory Rate, Blood Pressure or scoring for neonatal abstinence syndrome. Recorded observations must be at a minimum frequency of 4 hourly)
29 Intravenous medication (PATIENT receiving intravenous medication)
50 Continuous electrocardiogram monitoring
51 Invasive ventilation via endotracheal tube
52 Invasive ventilation via tracheostomy tube
53 Non-invasive ventilatory support
55 Nasopharyngeal airway
56 Advanced ventilatory support (Jet or Oscillatory ventilation)
57 Upper airway obstruction requiring nebulised Epinephrine/ Adrenaline
58 Apnoea requiring intervention
59 Acute severe asthma requiring intravenous bronchodilator therapy or continuous nebuliser
60 Arterial line monitoring
61 Cardiac pacing via an external box (pacing wires or external pads or oesophageal pacing)
62 Central venous pressure monitoring
63 Bolus intravenous fluids (> 80 ml/kg/day) in addition to maintenance intravenous fluids
64 Cardio-pulmonary resuscitation (CPR)
65 Extracorporeal membrane oxygenation (ECMO) or Ventricular Assist Device (VAD) or aortic balloon pump
66 Haemodialysis (acute PATIENTS only i.e. excluding chronic)
67 Plasma filtration or Plasma exchange

68 ICP-intracranial pressure monitoring
69 Intraventricular catheter or external ventricular drain
70 Diabetic ketoacidosis (DKA) requiring continuous infusion of insulin
71 Intravenous infusion of thrombolytic agent (limited to tissue plasminogen activator [tPA] and streptokinase)
72 Extracorporeal liver support using Molecular Absorbent Liver Recirculating System (MARS)
73 Continuous pulse oximetry
74 PATIENT nursed in single occupancy cubicle
80 Heated Humidified High Flow Therapy (HHHFT) (PATIENT receiving HHHFT)
81 Presence of an umbilical venous line
82 Continuous infusion of insulin (PATIENT receiving a continuous infusion of insulin)
83 Therapeutic hypothermia (PATIENT receiving therapeutic hypothermia)
84 PATIENT has a Replogle tube in situ
85 PATIENT has an epidural catheter in situ
86 PATIENT has an abdominal silo
87 Administration of intravenous (IV) blood products
88 PATIENT has a central venous or long line (Peripherally Inserted Central Catheter line) in situ
89 PATIENT has an indwelling urinary or suprapubic catheter in situ
90 PATIENT has a trans-anastomotic tube in situ following oesophageal atresia repair
91 PATIENT has confirmed clinical seizure(s) today and/or continuous cerebral function monitoring (CFM)
92 PATIENT has a ventricular tap via needle or reservoir today
93 PATIENT has a stoma
94 PATIENT has arrhythmia requiring intravenous anti-arrhythmic therapy
95 PATIENT has reduced conscious level (Glasgow Coma Score 12 or below) and hourly (or more frequent) Glasgow Coma Score monitoring
96 Intravenous infusion of sedative agent (PATIENT receiving continuous intravenous infusion of sedative agent)
97 PATIENT has status epilepticus requiring treatment with continuous intravenous infusion
99 No Defined Critical Care Activity (PATIENT is not receiving any of the critical care interventions listed above (Excluding code 21). For example, PATIENT is on the Intensive Care Unit ready for discharge and is receiving normal care. This is the default code.

CRITICAL CARE UNIT FUNCTION

Change to Attribute: Changed Description

~~The principal type of Critical Care clinical service provided within the WARD to which a PATIENT was admitted to during a CRITICAL CARE PERIOD.~~The principal type of Critical Care clinical service provided within the WARD to which a PATIENT was admitted during a CRITICAL CARE PERIOD.

Further detail on CRITICAL CARE UNIT FUNCTIONS is described on CRITICAL CARE PERIOD.

Note:

- National Code descriptions have been updated to remove National Code headings and add prefixes where required. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.
- Facilities are described by the category of PATIENT predominantly treated, as follows:
  - Adult Facilities (PATIENTS more than 19 years old on admission predominate)
  - Children and Young People Facilities (PATIENTS aged greater than or equal to 29 days to less than 19 years predominate)
  - Neonatal Facilities (PATIENTS aged less than 29 days on admission predominate)

- Other settings

National Codes:

01	Non-specific, general adult critical care PATIENTS predominate
02	Surgical adult PATIENTS (unspecified specialty)
03	Medical adult PATIENTS (unspecified specialty)
05	Neurosciences adult PATIENTS predominate
06	Cardiac surgical adult PATIENTS predominate
07	Thoracic surgical adult PATIENTS predominate
08	Burns and plastic surgery adult PATIENTS predominate
09	Spinal adult PATIENTS predominate
10	Renal adult PATIENTS predominate
11	Liver adult PATIENTS predominate
12	Obstetric and gynaecology adult critical care PATIENTS predominate
90	Adult: Non standard LOCATION using a WARD area
04	Paediatric Intensive Care Unit (Paediatric critical care PATIENTS predominate)
16	WARD for children and young people
17	High Dependency Unit for children and young people
18	Renal Unit for children and young people
19	Burns Unit for children and young people
92	Non standard LOCATION using the operating department for children and young people
13	Neonatal Intensive Care Unit (Neonatal critical care PATIENTS predominate)
14	Facility for Babies (Neonates) on a Neonatal Transitional Care WARD
15	Facility for Babies (Neonates) on a Maternity WARD
91	Other settings: non standard LOCATION using the operating department

---

DATA ABSENT REASON

Change to Attribute: New Attribute

The reason why the normally expected content of a CODED CLINICAL ENTRY is missing.

This attribute is also known by these names:

Context	Alias
plural	DATA ABSENT REASONS

DATA ABSENT REASON

Change to Attribute: New Attribute

DATA ABSENT REASON

Data Elements:

DATA ABSENT REASON (FHIR R4)

DISCHARGED TO NHS AT HOME SERVICE INDICATOR

Change to Attribute: New Attribute

An indication of whether a PATIENT was discharged from a Hospital Provider Spell to an NHS At Home Service.

National Codes:

Y	Yes - Discharged to NHS At Home Service
N	No - Not discharged to NHS At Home Service

This attribute is also known by these names:

Context	Alias
plural	DISCHARGED TO NHS AT HOME SERVICE INDICATORS

DISCHARGED TO NHS AT HOME SERVICE INDICATOR

Change to Attribute: New Attribute

DISCHARGED TO NHS AT HOME SERVICE INDICATOR

Data Elements:

DISCHARGED TO NHS AT HOME SERVICE INDICATOR

EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR

Change to Attribute: New Attribute

An indication of whether a follow up CARE CONTACT is required at the end of the eMED3 Fit Note Applicable Period.

National Codes:

Y	Yes - a follow up CARE CONTACT is required at the end of the eMED3 Fit Note Applicable Period
N	No - a follow up CARE CONTACT is not required at the end of the eMED3 Fit Note Applicable Period

This attribute is also known by these names:

Context	Alias
plural	EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATORS

EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR

Change to Attribute: New Attribute

EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR

Data Elements:

EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR

NHS SERVICE AGREEMENT IDENTIFIER

Change to Attribute: New Attribute

The unique identifier of an NHS SERVICE AGREEMENT.

The NHS SERVICE AGREEMENT IDENTIFIER is issued by the ORGANISATION acting as commissioner of a SERVICE.

NHS SERVICE AGREEMENT NUMBER will be replaced with NHS SERVICE AGREEMENT IDENTIFIER, which is the most recent approved national information standard to describe the required definition.

This attribute is also known by these names:

Context	Alias
plural	NHS SERVICE AGREEMENT IDENTIFIERS

NHS SERVICE AGREEMENT IDENTIFIER

Change to Attribute: New Attribute

NHS SERVICE AGREEMENT IDENTIFIER

Data Elements:

NHS SERVICE AGREEMENT IDENTIFIER

NHS SERVICE AGREEMENT LINE IDENTIFIER

Change to Attribute: New Attribute

A unique identifier for an NHS SERVICE AGREEMENT LINE.

NHS SERVICE AGREEMENT LINE NUMBER will be replaced with NHS SERVICE AGREEMENT LINE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.

This attribute is also known by these names:

Context	Alias
plural	NHS SERVICE AGREEMENT LINE IDENTIFIERS

NHS SERVICE AGREEMENT LINE IDENTIFIER

Change to Attribute: New Attribute

NHS SERVICE AGREEMENT LINE IDENTIFIER

Data Elements:

NHS SERVICE AGREEMENT LINE IDENTIFIER

NHS SERVICE AGREEMENT LINE NUMBER

Change to Attribute: Changed Description

A number (alphanumeric) to provide a unique identifier for a line within a NHS SERVICE AGREEMENT.

NHS SERVICE AGREEMENT LINE NUMBER will be replaced with NHS SERVICE AGREEMENT LINE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.

NHS SERVICE AGREEMENT NUMBER

Change to Attribute: Changed Description

A number used to uniquely identify a NHS SERVICE AGREEMENT by an ORGANISATION acting as commissioner of patient care services.

NHS SERVICE AGREEMENT NUMBER will be replaced with NHS SERVICE AGREEMENT IDENTIFIER, which is the most recent approved national information standard to describe the required definition.

OUT-PATIENT ATTENDANCE OUTCOME

Change to Attribute: New Attribute

The outcome of a Care Professional Out-Patient Attendance.

National Codes:

1	PATIENT discharged from the care of the CARE PROFESSIONAL without Personalised Out-Patient Follow Up
2	PATIENT given a Timed Out-Patient Follow Up Appointment while at the out-patient attendance without Personalised Out-Patient Follow Up
3	PATIENT to be given a Timed Out-Patient Follow Up Appointment at a later date without Personalised Out-Patient Follow Up
4	PATIENT moved to a Personalised Out-Patient Follow Up Pathway
5	PATIENT discharged to a Personalised Out-Patient Follow Up Pathway

This attribute is also known by these names:

Context	Alias
plural	OUT-PATIENT ATTENDANCE OUTCOMES

OUT-PATIENT ATTENDANCE OUTCOME

Change to Attribute: New Attribute

OUT-PATIENT ATTENDANCE OUTCOME

Data Elements:

OUT-PATIENT ATTENDANCE OUTCOME

PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR

Change to Attribute: New Attribute

An indication of whether a PATIENT is on a Patient Initiated Out-Patient Follow-Up Pathway.

National Codes:

Y Yes - PATIENT is on a Patient Initiated Out-Patient Follow-Up Pathway
N No - PATIENT is not on a Patient Initiated Out-Patient Follow-Up Pathway

This attribute is also known by these names:

Context	Alias
plural	PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATORS

PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR

Change to Attribute: New Attribute

PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR

Data Elements:

PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR AT CDS ACTIVITY DATE

PATIENT SUBJECT TO REMOTE MONITORING INDICATOR

Change to Attribute: New Attribute

An indication of whether a PATIENT is subject to Remote Monitoring.

National Codes:

Y Yes - PATIENT is subject to Remote Monitoring
N No - PATIENT is not subject to Remote Monitoring

This attribute is also known by these names:

Context	Alias
plural	PATIENT SUBJECT TO REMOTE MONITORING INDICATORS

PATIENT SUBJECT TO REMOTE MONITORING INDICATOR

Change to Attribute: New Attribute

PATIENT SUBJECT TO REMOTE MONITORING INDICATOR

Data Elements:

PATIENT SUBJECT TO REMOTE MONITORING INDICATOR AT CDS ACTIVITY DATE

PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE

Change to Attribute: New Attribute

The expiry date of a Personalised Out-Patient Follow Up Pathway.

This attribute is also known by these names:

Context	Alias
plural	PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATES

PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE

Change to Attribute: New Attribute

PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE

Data Elements:

PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE

PERSON PROPERTY ASSIGNMENT PERIOD DURATION

Change to Attribute: New Attribute

The duration of a PERSON PROPERTY ASSIGNMENT PERIOD.

PERSON PROPERTY ASSIGNMENT PERIOD DURATION

Change to Attribute: New Attribute

PERSON PROPERTY ASSIGNMENT PERIOD DURATION

Data Elements:

EMED3 FIT NOTE DURATION

PERSON PROPERTY ASSIGNMENT PERIOD TYPE

Change to Attribute: Changed Description

The type of PERSON PROPERTY ASSIGNMENT PERIOD.

National Codes:

01	Care Cluster Assignment Period
02	Mental Health Act Legal Status Classification Assignment Period

?? eMED3 Fit Note Applicable Period

PLANNED ACTIVITY DATE TYPE

Change to Attribute: Changed Description

The type of date that defines the usage with regard to the PLANNED ACTIVITY.

A PLANNED ACTIVITY may have many dates associated with it but may only have one date of a particular type.

National Codes:

01	Planned Discharge Date (Hospital Provider Spell)
02	Estimated Discharge Date (Hospital Provider Spell)
03	Intended Smoking Quit Date
04	NHS Continuing Healthcare Care Package Review Date
??	Personalised Out-Patient Follow Up Pathway Review Date

PRESENT ON ADMISSION INDICATOR

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. This is to allow sufficient time for Health Care Providers to move to using the SNOMED CT-coded Comorbidity data structure to submit this data in CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set / CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set, which is the preferred mechanism of data submission.

National Codes:

Y	PATIENT DIAGNOSIS already present
N	PATIENT DIAGNOSIS not already present

~~**Note:**~~
~~**This data item is included in Commissioning Data Set version 6-2, but should not be submitted until further development by NHS Digital has been undertaken.**~~

PROVIDER REFERENCE IDENTIFIER

Change to Attribute: New Attribute

The reference identifier agreed locally between a Health Care Provider and the Commissioner of a SERVICE PROVIDED UNDER AGREEMENT.

PROVIDER REFERENCE NUMBER will be replaced with PROVIDER REFERENCE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.

This attribute is also known by these names:

Context	Alias
plural	PROVIDER REFERENCE IDENTIFIERS

PROVIDER REFERENCE IDENTIFIER

Change to Attribute: New Attribute

PROVIDER REFERENCE IDENTIFIER

Data Elements:

PROVIDER REFERENCE IDENTIFIER

PROVIDER REFERENCE NUMBER

Change to Attribute: Changed Description

The number convention agreed locally between a provider and Commissioner for use within a Commissioning Data Set message. **PROVIDER REFERENCE NUMBER will be replaced with PROVIDER REFERENCE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.**

REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR

Change to Attribute: New Attribute

An indication of whether a PATIENT was referred by a First Contact Practitioner.

National Codes:

Y	Yes - PATIENT referred by a First Contact Practitioner
N	No - PATIENT not referred by a First Contact Practitioner

This attribute is also known by these names:

Context	Alias
plural	REFERRED BY FIRST CONTACT PRACTITIONER INDICATORS

REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR

Change to Attribute: New Attribute

REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR

Data Elements:

REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR

RESPONSIBLE CARE PROFESSIONAL INDICATOR

Change to Attribute: New Attribute

An indication of whether a CARE PROFESSIONAL belonging to a CARE PROFESSIONAL TEAM delivering a Consultant Led Service or Non-Consultant Led Service has overall clinical responsibility for the care of the PATIENT during an ACTIVITY GROUP.

National Codes:

Y	Yes - the CARE PROFESSIONAL has overall clinical responsibility for the PATIENT
N	No - the CARE PROFESSIONAL does not have overall clinical responsibility for the PATIENT

This attribute is also known by these names:

Context	Alias
plural	RESPONSIBLE CARE PROFESSIONAL INDICATORS

RESPONSIBLE CARE PROFESSIONAL INDICATOR

Change to Attribute: New Attribute

RESPONSIBLE CARE PROFESSIONAL INDICATOR

Data Elements:

RESPONSIBLE CARE PROFESSIONAL INDICATOR

SEX OF PATIENTS

Change to Attribute: Changed Description

The sex of PATIENTS intended to use a WARD indicated in the WARD OPERATIONAL PLANS, with the addition of Home Leave.

Note:

- National Code 9 *'Home Leave'* is **not** valid for the Mental Health Services Data Set.

National Codes:

1	Male
2	Female
8	Not specified
9	Home Leave

SEX OF PATIENTS will be replaced with WARD INTENDED SEX OF PATIENTS, which is the most recent approved national information standard to describe the required definition.

WARD DAY PERIOD AVAILABILITY

Change to Attribute: Changed Description

For WARDS this is the number of day periods in a week for which it is planned to be available. Where a WARD is closed availability will be zero.

National Codes:

0	Zero days
1	One day
2	Two days
3	Three days
4	Four days
5	Five days
6	Six days
7	Seven days

WARD DAY PERIOD AVAILABILITY will be replaced with WARD INTENDED DAY PERIOD AVAILABILITY, which is the most recent approved national information standard to describe the required definition.

WARD INTENDED AGE GROUP

Change to Attribute: New Attribute

The age group of PATIENTS intended to use a WARD, as indicated in the WARD OPERATIONAL PLAN.

National Codes:

1	Neonates
2	Children and/or adolescents
3	Elderly
8	Any age

AGE GROUP INTENDED will be replaced with WARD INTENDED AGE GROUP, which is the most recent approved national information standard to describe the required definition.

This attribute is also known by these names:

Context	Alias
plural	WARD INTENDED AGE GROUPS

WARD INTENDED AGE GROUP

Change to Attribute: New Attribute

WARD INTENDED AGE GROUP

Data Elements:

WARD INTENDED AGE GROUP

WARD INTENDED CLINICAL CARE INTENSITY

Change to Attribute: New Attribute

The level of resources and intensity of care which is intended to be provided in a WARD.

National Codes:

51	Mental Illness intensive care: specially designated ward for PATIENTS needing containment and more intensive management (e.g. Psychiatric Intensive Care Unit (PICU)). This is not to be confused with intensive nursing where PATIENTS may require one to one nursing while on a standard WARD
52	Mental Illness short stay: PATIENTS intended to stay less than a year
53	Mental Illness long stay: PATIENTS intended to stay a year or more
61	Learning Disability PATIENTS in a designated or interim secure unit
62	Learning Disability PATIENTS intending to stay less than a year
63	Learning Disability PATIENTS intending to stay a year or more
41	Only for maternity PATIENTS looked after by CONSULTANTS
43	Only for maternity PATIENTS looked after by GENERAL MEDICAL PRACTITIONERS
42	Joint use for maternity PATIENTS looked after by CONSULTANTS and GENERAL MEDICAL PRACTITIONERS
33	Neonates: maternity: associated with the maternity WARD in that cots are in the maternity WARD nursery or in the WARD itself
32	Neonates: non-maternity: not associated with the maternity WARD and without designated cots for intensive care
31	Neonates: not associated with the maternity WARD and in which there are some designated cots for intensive care
21	Younger physically disabled PATIENTS: spinal units, only those units which are nationally recognised
22	Younger physically disabled PATIENTS: other units
81	Terminally ill/Palliative Care PATIENTS
11	General PATIENTS: for intensive therapy, including high dependency care
12	General PATIENTS: for normal therapy: where resources permit the admission of PATIENTS who might need all but intensive or high dependency therapy
13	General PATIENTS: for limited therapy: where nursing care rather than continuous medical care is provided. Such WARDS can be used only for PATIENTS carefully selected and restricted to a narrow range in terms of the extent and nature of disease

CLINICAL CARE INTENSITY will be replaced with WARD INTENDED CLINICAL CARE INTENSITY, which is the most recent approved national information standard to describe the required definition.

This attribute is also known by these names:

Context	Alias
plural	WARD INTENDED CLINICAL CARE INTENSITIES

WARD INTENDED CLINICAL CARE INTENSITY

Change to Attribute: New Attribute

WARD INTENDED CLINICAL CARE INTENSITY

Data Elements:

WARD INTENDED CLINICAL CARE INTENSITY

WARD INTENDED DAY PERIOD AVAILABILITY

Change to Attribute: New Attribute

The number of day periods in a week that it is intended that a WARD should be available, as indicated in the WARD OPERATIONAL PLAN.

Where a WARD is closed, the WARD INTENDED DAY PERIOD AVAILABILITY will be National Code '*Zero days*'.

National Codes:

0	Zero days
1	One day
2	Two days
3	Three days
4	Four days
5	Five days
6	Six days
7	Seven days

WARD DAY PERIOD AVAILABILITY will be replaced with WARD INTENDED DAY PERIOD AVAILABILITY, which is the most recent approved national information standard to describe the required definition.

This attribute is also known by these names:

Context	Alias
plural	WARD INTENDED DAY PERIOD AVAILABILITIES

WARD INTENDED DAY PERIOD AVAILABILITY

Change to Attribute: New Attribute

WARD INTENDED DAY PERIOD AVAILABILITY

Data Elements:

WARD INTENDED DAY PERIOD AVAILABILITY

WARD INTENDED NIGHT PERIOD AVAILABILITY

Change to Attribute: New Attribute

The number of night periods in a week that it is intended that a WARD should be available, as indicated in the WARD OPERATIONAL PLAN.

Where a WARD is closed, the WARD INTENDED NIGHT PERIOD AVAILABILITY will be National Code '*Zero days*'.

National Codes:

0	Zero nights
1	One night
2	Two nights
3	Three nights
4	Four nights
5	Five nights
6	Six nights
7	Seven nights

WARD NIGHT PERIOD AVAILABILITY will be replaced with WARD INTENDED NIGHT PERIOD AVAILABILITY, which is the most recent approved national information standard to describe the required definition.

This attribute is also known by these names:

Context	Alias
plural	WARD INTENDED NIGHT PERIOD AVAILABILITIES

WARD INTENDED NIGHT PERIOD AVAILABILITY

Change to Attribute: New Attribute

WARD INTENDED NIGHT PERIOD AVAILABILITY

Data Elements:

WARD INTENDED NIGHT PERIOD AVAILABILITY

WARD INTENDED SEX OF PATIENTS

Change to Attribute: New Attribute

The sex of PATIENTS intended to use a WARD, as indicated in the WARD OPERATIONAL PLAN.

National Codes:

1	Male
2	Female
8	Not specified

SEX OF PATIENTS will be replaced with WARD INTENDED SEX OF PATIENTS, which is the most recent approved national information standard to describe the required definition.

WARD INTENDED SEX OF PATIENTS

Change to Attribute: New Attribute

WARD INTENDED SEX OF PATIENTS

Data Elements:

WARD INTENDED SEX OF PATIENTS

WARD NIGHT PERIOD AVAILABILITY

Change to Attribute: Changed Description

For WARDS this is the number of night periods in a week for which it is planned to be available. Where a WARD is closed availability will be zero.

National Codes:

0	Zero nights
1	One night
2	Two nights
3	Three nights
4	Four nights
5	Five nights
6	Six nights
7	Seven nights

WARD NIGHT PERIOD AVAILABILITY will be replaced with WARD INTENDED NIGHT PERIOD AVAILABILITY, which is the most recent approved national information standard to describe the required definition.

ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY CODE

Change to Data Element: Changed Description

Format/Length:	an1
National Codes:	See ANAESTHETIC OR ANALGESIC CATEGORY
~~Default Codes:~~	~~9 - Not known: a validation error~~
Default Codes:	9 - ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY CODE not known

Notes:
ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY CODE is derived from attribute ANAESTHETIC OR ANALGESIC CATEGORY and PERIOD ADMINISTERED which records whether anaesthetic was given during Labour/Delivery, and the type used.

ANAESTHETIC GIVEN POST LABOUR OR DELIVERY CODE

Change to Data Element: Changed Description

Format/Length:	an1
National Codes:	See ANAESTHETIC OR ANALGESIC CATEGORY
~~Default Codes:~~	~~9 - Not known: a validation error~~
Default Codes:	9 - ANAESTHETIC GIVEN POST LABOUR OR DELIVERY CODE not known

Notes:
ANAESTHETIC GIVEN POST LABOUR OR DELIVERY CODE is derived from attribute ANAESTHETIC OR ANALGESIC CATEGORY and PERIOD ADMINISTERED which records whether anaesthetic was given after Delivery, and the type used.

APPOINTMENT BOOKED REASON

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See APPOINTMENT BOOKED REASON
Default Codes:	

Notes:
APPOINTMENT BOOKED REASON is the same as attribute APPOINTMENT BOOKED REASON.

For the Commissioning Data Sets, APPOINTMENT BOOKED REASON refers to the reason that the APPOINTMENT record carried in the Commissioning Data Set message was booked, and not any subsequent APPOINTMENTS made as a result of that Care Professional Out-Patient Attendance.

This data element is also known by these names:

Context	Alias
plural	APPOINTMENT BOOKED REASONS

APPOINTMENT BOOKED REASON

Change to Data Element: New Data Element

APPOINTMENT BOOKED REASON

Attribute:

APPOINTMENT BOOKED REASON

APPOINTMENT DATE

Change to Data Element: Changed Description

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

Notes:
APPOINTMENT DATE is the same as attribute APPOINTMENT DATE.

Usage in the CDS:
~~The Outpatient and Future Outpatient CDS Types use the APPOINTMENT DATE as the "CDS ORIGINATING DATE" as a mandatory requirement of the CDS Exchange Protocol, see CDS ACTIVITY DATE.~~The Outpatient (CDS version 6-2 and CDS version 6-3) and Future Outpatient (CDS version 6-2 only) CDS Types use the APPOINTMENT DATE as the "CDS ORIGINATING DATE" as a mandatory requirement of the CDS Bulk/Net Update Protocols, see CDS ACTIVITY DATE.

~~For the Future Outpatient CDS where no APPOINTMENT DATE is available from the healthcare system, a default date value of 2999-12-31 may be applied. Care must be taken to generate the correct CDS Exchange Protocol when using this default value.~~For the CDS V6-2 Type 021 - Future Outpatient Commissioning Data Set, where no

APPOINTMENT DATE is available from the healthcare system, a default date value of 2999-12-31 may be applied. Care must be taken to generate the correct CDS Bulk/Net Update Protocol when using this default value.

~~When submitting a Referral To Treatment Clock Stop Administrative Event via the CDS V6-2 Type 020 - Outpatient Commissioning Data Set, APPOINTMENT DATE is equivalent to the REFERRAL TO TREATMENT PERIOD END DATE carried in the record.~~When submitting a Referral To Treatment Clock Stop Administrative Event via the CDS V6-2 Type 020 - Outpatient Commissioning Data Set or CDS V6-3 Type 020 - Outpatient Commissioning Data Set , APPOINTMENT DATE is equivalent to the REFERRAL TO TREATMENT PERIOD END DATE carried in the record.

ATTENDANCE STATUS

Change to Data Element: Changed Description

Format/Length:	an1
National Codes:	
Default Codes:	

Notes:
ATTENDANCE STATUS is the same as attribute ATTENDED OR DID NOT ATTEND.

~~**This item is being used for development purposes and has not yet been approved.**~~*Permitted National Codes:*

5	Attended on time or, if late, before the relevant CARE PROFESSIONAL was ready to see the PATIENT
6	Arrived late, after the relevant CARE PROFESSIONAL was ready to see the PATIENT, but was seen
7	PATIENT arrived late and could not be seen
2	APPOINTMENT cancelled by, or on behalf of, the PATIENT
3	Did not attend - no advance warning given
4	APPOINTMENT cancelled or postponed by the Health Care Provider

ATTENDED OR DID NOT ATTEND CODE will be replaced with ATTENDANCE STATUS, which is the most recent approved national information standard to describe the required definition.

CDS ACTIVITY DATE

Change to Data Element: Changed Description

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

Notes:
CDS ACTIVITY DATE is the same as attribute ACTIVITY DATE.

For Commissioning data, every CDS Type has a "CDS Originating Date" contained within the Commissioning Data Set data that must be used to populate the CDS ACTIVITY DATE.

The CDS ACTIVITY DATE is held in the Commissioning Data Set Transaction Header Group and is a mandatory data element for all uses of the Commissioning Data Set for both Bulk Update and Net Change Protocols, see the Commissioning Data Set Submission Protocol supporting information.

For Bulk Update use, see:

- CDS V6-2 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol
- CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol
- CDS V6-2-2 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol
- CDS V6-2-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol
- CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol

For Net Change Use, see:

- CDS V6-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol
- CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol
- CDS V6-2-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol
- CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol
- CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol
  CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol

Note:Note: CDS Type 010 *'Accident and Emergency Attendance'* was retired from 1 November 2020 and is no longer accepted for submission to the Secondary Uses Service.

CDS Type 010 *'Accident and Emergency Attendance'* will no longer be accepted from 01 November 2020.

The CDS ACTIVITY DATE has an associated "CDS Originating Date" specifically identified for each CDS Type as follows:

CDS TYPE	DESCRIPTION	CDS ORIGINATING DATE (used to populate the CDS ACTIVITY DATE)
010	Accident and Emergency Attendance	
010	Accident and Emergency Attendance (Retired 1 November 2020)	
011	Emergency Care Attendance	EMERGENCY CARE ARRIVAL DATE, EMERGENCY CARE ARRIVAL TIME
020	Outpatient (known in the Schema as Care Activity)	APPOINTMENT DATE
021	Future Outpatient (known in the Schema as Future Care Activity)	APPOINTMENT DATE
030	EAL End Of Period Census - STANDARD	DECIDED TO ADMIT DATE
040	EAL End Of Period Census - OLD	NHS SERVICE AGREEMENT CHANGE DATE
050	EAL End Of Period Census - NEW	NHS SERVICE AGREEMENT CHANGE DATE
060	EAL Event During Period - ADD	DECIDED TO ADMIT DATE
070	EAL Event During Period - REMOVE	ELECTIVE ADMISSION LIST REMOVAL DATE
080	EAL Event During Period - OFFER	OFFERED FOR ADMISSION DATE
090	EAL Event During Period - AVAILABLE / UNAVAILABLE	SUSPENSION START DATE
100	EAL Event During Period - OLD SERVICE AGREEMENT	NHS SERVICE AGREEMENT CHANGE DATE
110	EAL Event During Period - NEW SERVICE AGREEMENT	NHS SERVICE AGREEMENT CHANGE DATE
120	Finished Birth Episode	END DATE (EPISODE)
130	Finished General Episode	END DATE (EPISODE)
140	Finished Delivery Episode	END DATE (EPISODE)
150	Other Birth	DELIVERY DATE
160	Other Delivery	DELIVERY DATE
150	Other Birth	

		DELIVERY DATE (CDS V6-2) / DELIVERY TIMESTAMP (CDS V6-3)
160	Other Delivery	DELIVERY DATE (VDS V6-2) / DELIVERY TIMESTAMP (CDS V6-3)
170	Detained and/or Long-Term Psychiatric Census	DETAINED AND (OR) LONG TERM PSYCHIATRIC CENSUS DATE
180	Unfinished Birth Episode	START DATE (EPISODE)
190	Unfinished General Episode	START DATE (EPISODE)
200	Unfinished Delivery Episode	START DATE (EPISODE)

Usage:
The CDS ACTIVITY DATE is validated by the Secondary Uses Service and Commissioning Data Set Interchanges are rejected if the date is not present, invalid or not compatible with the Commissioning Data Set Submission Protocol controls being used.

In particular, when using the Commissioning Data Set Bulk Replacement Update Mechanism, the CDS ACTIVITY DATE and its "CDS Originating Date" are used by the Secondary Uses Service to validate that the CDS Type date applicability falls within the CDS REPORT PERIOD START DATE and the CDS REPORT PERIOD END DATE.

CDS BULK REPLACEMENT GROUP CODE

Change to Data Element: Changed Description

Format/Length:	an3
National Codes:	See CDS BULK REPLACEMENT GROUP CODE
Default Codes:	

Notes:
CDS BULK REPLACEMENT GROUP CODE is the same as attribute CDS BULK REPLACEMENT GROUP CODE.

CDS BULK REPLACEMENT GROUP CODE is not required when the Commissioning Data Set Net Change Update Mechanism is used.

The Commissioning Data Set Bulk Replacement Update Mechanism process identifies previously transferred CDS Types that are to be replaced by the submitted Commissioning Data Set interchange. To do this the CDS BULK REPLACEMENT GROUP CODE must be used together with the following data items:

- CDS REPORT PERIOD START DATE
- CDS REPORT PERIOD END DATE
- CDS INTERCHANGE SENDER IDENTITY
- ~~CDS PRIME RECIPIENT IDENTITY~~

~~For submissions of CDS V6-2, CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set and CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set, the CDS PRIME RECIPIENT IDENTITY is Mandatory for submission in the CDS Type 005B - CDS Transaction Header Group - Bulk Update Protocol and CDS Type 005N - CDS Transaction Header Group - Net Change Protocol. However, it no longer forms part of the key for the process of determining duplicate records within the Secondary Uses Service.~~

~~Note that the CDS PRIME RECIPIENT IDENTITY continues to be used to determine data access requirements within the Secondary Uses Service.~~

It is particularly important when using the Commissioning Data Set Bulk Replacement Update Mechanism for a CDS BULK REPLACEMENT GROUP CODE to contain all the relevant CDS Types for the extracted time period in a single Commissioning Data Set Interchange, e.g. the Finished General Episodes, Finished Delivery Episodes and Finished Birth Episodes in a Finished Episode Group.

For specific National Code usage in different data sets, see CDS BULK REPLACEMENT GROUP CODE.

CDS INTERCHANGE CONTROL REFERENCE

Change to Data Element: Changed Description

Format/Length:	max n7
National Codes:	
Default Codes:	

Notes:
CDS INTERCHANGE CONTROL REFERENCE is the same as attribute CDS INTERCHANGE CONTROL REFERENCE.

For each Interchange submitted, the CDS INTERCHANGE CONTROL REFERENCE must be incremented by 1. The maximum value supported is n7 and wrap around from 9999999 to 1 must be supported.

Usage:
CDS INTERCHANGE CONTROL REFERENCE is a mandatory data element when submitting Commissioning Data Set Interchanges and is used to uniquely identify and if required, to sequence check Commissioning Data Set submissions.

For Commissioning Data Sets 6-2, 6-2-1, 6-2-2 and 6-2-3, the XML schemas allow a maximum of an14 alphanumeric characters. This Format/Length was defined historically, but the Secondary Uses Service has always allowed a maximum of 7 numeric characters with a maximum value of 99999999. In Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements" this anomaly has been corrected. ~~Future XML schemas will be amended to carry the correct format/length of max n7.~~ From Commissioning Data Set version 6-3 onwards, the XML schema has been amended to carry the correct format/length of max n7.

This control reference data may also be presented on Secondary Uses Service (SUS) service messages and audit logs, etc.

CDS XML Schema Interchanges:
All CDS XML Schema interchanges submitted must contain a CDS INTERCHANGE CONTROL REFERENCE.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

CDS MESSAGE REFERENCE

Change to Data Element: Changed Description

Format/Length:	max n7

National Codes:	
Default Codes:	

Notes:
CDS MESSAGE REFERENCE is the same as attribute CDS MESSAGE REFERENCE.

Usage:
Each message within an interchange the CDS MESSAGE REFERENCE is assigned to provide a unique identity (within an interchange).

For Commissioning Data Sets 6-2, 6-2-1, 6-2-2 and 6-2-3, the XML schemas allow a maximum of an14 alphanumeric characters. This Format/Length was defined historically, but the Secondary Uses Service has always allowed a maximum of 7 numeric characters with a maximum value of 99999999. In Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements" this anomaly has been corrected. ~~Future XML schemas will be amended to carry the correct format/length of max n7.~~ From Commissioning Data Set version 6-3 onwards, the XML schema has been amended to carry the correct format/length of max n7.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

CDS PRIME RECIPIENT IDENTITY

Change to Data Element: Changed Description

Format/Length:	an3 or an5
National Codes:	
Default Codes:	TDH00 - Overseas Visitor exempt from charges

Notes:
CDS PRIME RECIPIENT IDENTITY is the same as attribute ORGANISATION CODE.

CDS PRIME RECIPIENT IDENTITY is the mandatory NHS ORGANISATION CODE (or valid Organisation Data Service Default Code) representing the ORGANISATION determined to be the Commissioning Data Set Prime Recipient of the Commissioning Data Set Message as indicated in the Commissioning Data Set Addressing Grid.

CDS PRIME RECIPIENT IDENTITY is only used in Commissioning Data Set version 6-2.

Usage:
~~The CDS PRIME RECIPIENT IDENTITY must be allocated on the first creation and submission of a CDS Type for a PATIENT and **must not change even if the ADDRESS or ORGANISATION CODE (RESIDENCE RESPONSIBILITY) of the PATIENT changes during the lifetime of the Commissioning Data Set record** otherwise duplicate Commissioning Data Set data may be lodged in the Secondary Uses Service database.~~For submissions of CDS Version 6-2, CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set Type 011 and CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set, the CDS PRIME RECIPIENT IDENTITY is Mandatory for submission in the CDS Type 005B - CDS Transaction Header Group - Bulk Update Protocol and CDS Type 005N - CDS Transaction Header Group - Net Change Protocol. However, it no longer forms part of the key for the process of determining duplicate records within the Secondary Uses Service. Note that the CDS PRIME RECIPIENT IDENTITY continues to be used to determine data access requirements within the Secondary Uses Service for Commissioning Data Set version 6-2 submissions.

~~CDS PRIME RECIPIENT IDENTITY is a mandatory data item crucial for the correct indexing of the database and must not be changed during the life of the associated Commissioning Data Set. It does not identify the first or most important recipient of data, i.e. there is no inference of primacy of one recipient over another.~~CDS PRIME RECIPIENT IDENTITY does not identify the first or most important recipient of data, i.e. there is no inference of primacy of one recipient over another.

Organisation Data Service Default Codes for CDS PRIME RECIPIENT IDENTITIES are detailed in the Commissioning Data Set Addressing Grid.

Please note that the following Organisation Data Service Default Codes must not be used in the Commissioning Data Set (CDS) header because they are not default Commissioner codes:

- Q99 - High Level Health Geography/Primary Care Organisation of Residence Not Known
    - for the CDS PRIME RECIPIENT IDENTITY, a valid ORGANISATION CODE (RESIDENCE RESPONSIBILITY) must be reported
- X98 - Primary Care Organisation Not Applicable (Overseas Visitors)
    - for the CDS PRIME RECIPIENT IDENTITY, the Commissioning Data Set Addressing Grid confirms the correct code that should be reported for Overseas Visitors who are exempt from charges.

CDS PRIME RECIPIENT IDENTITY will be replaced with ORGANISATION IDENTIFIER (CDS RECIPIENT), which is the most recent approved national information standard to describe the required definition.

CDS RECORD IDENTIFIER

Change to Data Element: Changed Description

Format/Length:	min an1 max an35
National Codes:	
Default Codes:	

Notes:
CDS RECORD IDENTIFIER is the same as attribute RECORD IDENTIFIER.

CDS RECORD IDENTIFIER may also be referred to as the **CDS-RID**.

When exchanging Commissioning Data Set data, CDS RECORD IDENTIFIER is an optional data element and when used is a unique number generated by the sender and inserted into the Commissioning Data Set data to enable senders and recipients to be able to cross-match and uniquely identify each and every Commissioning Data Set record.

The CDS RECORD IDENTIFIER consists of the following components:

REF	RID COMPONENT	FORMAT	CODES / VALUES
~~1~~	~~CDS SENDER IDENTITY/ORGANISATION IDENTIFIER (CDS SENDER)~~	~~an5~~	~~As generated in the CDS V6-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol or the CDS V6-2 Type 005N - CDS Transaction Header Group - Net Change Protocol~~ ~~Or~~ ~~As generated in the CDS V6-2-1 Type 005B - CDS Transaction Header Group - Bulk Update Protocol or the CDS V6-2-1 Type 005N - CDS Transaction Header Group - Net Change Protocol~~

			~~*Or*~~ ~~As generated in the CDS V6-2-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol or the CDS V6-2-2 Type 005N - CDS Transaction Header Group - Net Change Protocol~~ ~~*Or*~~ ~~As generated in the CDS V6-2-3 Type 005B - CDS Transaction Header Group - Bulk Update Protocol or CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol~~
1	CDS SENDER IDENTITY/ORGANISATION IDENTIFIER (CDS SENDER)	an5	As generated in the CDS V6-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol or the CDS V6-2 Type 005N - CDS Transaction Header Group - Net Change Protocol *Or* As generated in the CDS V6-2-1 Type 005B - CDS Transaction Header Group - Bulk Update Protocol or the CDS V6-2-1 Type 005N - CDS Transaction Header Group - Net Change Protocol *Or* As generated in the CDS V6-2-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol or the CDS V6-2-2 Type 005N - CDS Transaction Header Group - Net Change Protocol *Or* As generated in the CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol or CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol
2	Not Used	an2	Set = Blank
~~3~~	~~CDS INTERCHANGE CONTROL REFERENCE~~	~~max n7~~	~~As generated in the CDS V6-2 Type 001 - CDS Interchange Header~~
4	~~CDS MESSAGE REFERENCE~~	~~max n7~~	~~As generated in the CDS V6-2 Type 003 - CDS Message Header~~
3	CDS INTERCHANGE CONTROL REFERENCE	max n7	As generated in the CDS V6-2 Type 001 - CDS Interchange Header or CDS V6-3 Type 001 - CDS Interchange Header
4	CDS MESSAGE REFERENCE	max n7	As generated in the CDS V6-2 Type 003 - CDS Message Header or CDS V6-3 Type 003 - CDS Message Header

Usage:

The CDS-RID is an optional reference assigned to each record by the Commissioning Data Set sender to aid the identification and cross-referencing of data between the sender and the receiver(s) of the Commissioning Data Set data.

CDS XML Schema Interchanges:

~~The CDS-RID data element is carried in the CDS Message Header (CDS V6-2 Type 003 - CDS Message Header).~~The CDS-RID data element is carried in the CDS Message Header (CDS V6-2 Type 003 - CDS Message Header /CDS V6-2-1 Type 003 - CDS Message Header /CDS V6-2-2 Type 003 - CDS Message Header /CDS V6-2-3 Type 003 - CDS Message Header /CDS V6-3 Type 003 - CDS Message Header).

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

CDS UNIQUE IDENTIFIER

Change to Data Element: Changed Description

Format/Length:	min an1 max an35
National Codes:	
Default Codes:	

Notes:
CDS UNIQUE IDENTIFIER is the same as attribute RECORD IDENTIFIER.

CDS UNIQUE IDENTIFIER provides a unique identity for the life-time of an episode carried in a Commissioning Data Set message.

Note that the CDS UNIQUE IDENTIFIER must be constructed without the use of PATIENT Confidential Information. ~~This includes PATIENT Identifiers such as NHS NUMBER or LOCAL PATIENT IDENTIFIER, as well as any text which may identify the PATIENT DIAGNOSIS of the PATIENT or any PATIENT procedures being undertaken.~~ This includes PATIENT Identifiers such as NHS NUMBER or LOCAL PATIENT IDENTIFIER (EXTENDED), as well as any text which may identify the PATIENT DIAGNOSIS of the PATIENT or any PATIENT procedures being undertaken.

See the Commissioning Data Set Submission Protocol for detailed information.

Once assigned, a Commissioning Data Set record must retain its CDS UNIQUE IDENTIFIER otherwise duplicate Commissioning Data Set records may be generated and stored in the Secondary Uses Service database.

The CDS UNIQUE IDENTIFIER has three components. The recommended constructs are given below.

For All CDS Types EXCEPT the EAL CDS Types:

REF	UID	FORMAT	CODES / VALUES	COMMENT
1	**NHS Organisation Code Type**	an1	A = Pre 1996 ORGANISATION CODE B = Post 1996 NHS ORGANISATION CODE / ORGANISATION IDENTIFIER	Mandatory For all CDS Types
2	**Provider Code**	an5	The NHS ORGANISATION CODE / ORGANISATION IDENTIFIER of the Provider at the time of, or at the start of, the period covered by the activity reported by the CDS Message.	Mandatory for all CDS Types
3a	**Application Specific CDS Identity**	an29	A code of up to **29 alpha-numeric characters** generated by the Sender's application to uniquely identify the CDS within its CDS Type or family of CDS Types	Mandatory for all CDS Types **Except for EAL CDS Types**

~~For EAL End Of Period (EOP) CDS Types only:~~**For EAL End Of Period (EOP) CDS Types only (CDS 6-2 only):**

REF	UID	FORMAT	CODES / VALUES	COMMENT
1	**NHS Organisation Code Type**	an1	A = Pre 1996 ORGANISATION CODE B = Post 1996 NHS ORGANISATION CODE / ORGANISATION IDENTIFIER	Mandatory For all CDS Types
2	**Provider Code**	an5	The NHS ORGANISATION CODE / ORGANISATION IDENTIFIER of the Provider at the time of, or at the start of, the period covered by the activity reported by the CDS Message.	Mandatory for all CDS Types
3b	**Application Specific CDS Identity**	an9	A code of up to **9 alpha-numeric characters** generated by the Sender's application to uniquely identify the EAL End Of period census CDS Types with the same Admission List Entry. Additional data positions must be left blank.	**Mandatory for all EAL EOP CDS Types**
3c	**Filler**	an20	Additional data positions must be left blank.	

~~For EAL Event During Period (EDP) CDS Types only:~~**For EAL Event During Period (EDP) CDS Types only (CDS 6-2 only):**

REF	UID	FORMAT	CODES / VALUES	COMMENT
1	**NHS Organisation Code Type**	an1	A = Pre 1996 ORGANISATION CODE B = Post 1996 NHS ORGANISATION CODE / ORGANISATION IDENTIFIER	**Mandatory For all CDS Types**
2	**Provider Code**	an5	The NHS ORGANISATION CODE / ORGANISATION IDENTIFIER of the Provider at the time of, or at the start of, the period covered by the activity reported by the CDS Message.	**Mandatory for all CDS Types**
3d	**Application Specific CDS Identity**	an9	A code of up to **5 alpha-numeric characters padded with 4 trailing spaces to 9 characters**. Generated by the Sender's application to uniquely identify the EAL Event During Period Census CDS Types with the same Admission List Entry.	**Mandatory for all EAL EDP CDS Types**
3e	**Filler**	an3	A code of **3 alpha-numeric characters** generated by the Sender's application to identify **the event** within the EAL Entry. Even if the events are of different types, they must have different identifiers.	**Mandatory for all EAL EDP CDS Types**
3f	**Filler**	an17	Additional data positions must be left blank.	

Usage:
~~CDS UNIQUE IDENTIFIER is a mandatory data item when the Net Change Update Mechanism is used and strongly recommended for use with the Bulk Replacement Update Mechanism.~~

~~***However it is strongly advised that users of the Bulk Replacement Mechanism maintain a correctly generated CDS UNIQUE IDENTIFIER within the Commissioning data.***~~CDS UNIQUE IDENTIFIER is a mandatory data item when the Net Change Update Mechanism is used. ***It is strongly advised that users of the Bulk Replacement Mechanism maintain a correctly generated CDS UNIQUE IDENTIFIER within the Commissioning Data Set data. This will establish a migration path towards the use of the Net Change Mechanism and will also then minimise the risk of creating duplicate Commissioning Data Set data in the Secondary Uses Service database.***

- Note that senders of Commissioning Data Set data remain directly responsible for the integrity of the CDS UNIQUE IDENTIFIER
- It is a mandatory requirement for all submissions using the Net Change Update Mechanism that these two components are constructed correctly to ensure uniqueness of CDS UNIQUE IDENTIFIERS across the NHS.
- ~~The structure of 3b and 3c allows the EAL End of Period Census and the EAL Event During Period Census for the same EAL Entry to be linked.~~
- The structure of 3b and 3c allows the EAL End of Period Census and the EAL Event During Period Census for the same EAL Entry to be linked (CDS 6-2 only).

There are circumstances in patient care application systems where the control of the UID key integrity may be suspect. These issues include:

a) Episode deletion (not resulting in a Commissioning Data Set deletion of previously submitted data sent to the original Commissioner);
b) Episode re-sequencing (not resulting in a corresponding Commissioning Data Set records being sent);
c) Service agreement alterations not resulting in correct adjustments - Old Service Agreement deletion / New Service Agreement addition
d) Re-admissions causing duplicate keys on the Secondary Uses Service database.

Each use of an NHS ORGANISATION CODE within a Commissioning Data Set message must be associated with the release version of the NHS Organisation Code scheme. At present this may be derived locally by NHS IT systems.

The following values have been informally used in many Commissioning Data Set implementations and are recommended to be used:

A or O*	Signifying "OLD" (pre-April 1996) to denote an ORGANISATION CODE issued before, and in use up to the 1996 major re-issue
B or N*	Signifying "NEW" (post-April 1996) to denote an ORGANISATION CODE / ORGANISATION IDENTIFIER issued from April 1996

***** The values of **A and B** must be used in the formatting of the CDS UNIQUE IDENTIFIER.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

COMMISSIONER REFERENCE IDENTIFIER

Change to Data Element: New Data Element

Format/Length:	max an20

National Codes:	
Default Codes:	8 - Not Applicable
	9 - COMMISSIONER REFERENCE IDENTIFIER not known

Notes:
COMMISSIONER REFERENCE IDENTIFIER is the same as attribute COMMISSIONER REFERENCE IDENTIFIER.

COMMISSIONER REFERENCE NUMBER will be replaced with COMMISSIONER REFERENCE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.

This data element is also known by these names:

Context	Alias
plural	COMMISSIONER REFERENCE IDENTIFIERS

COMMISSIONER REFERENCE IDENTIFIER

Change to Data Element: New Data Element

COMMISSIONER REFERENCE IDENTIFIER

Attribute:

COMMISSIONER REFERENCE IDENTIFIER

COMMISSIONER REFERENCE NUMBER

Change to Data Element: Changed Description, linked Attribute

Format/Length:	max an17
National Codes:	
Default Codes:	8 - Not applicable
	9 - COMMISSIONER REFERENCE NUMBER not known

Notes:
COMMISSIONER REFERENCE NUMBER is the same as attribute COMMISSIONER REFERENCE NUMBER.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

COMMISSIONER REFERENCE NUMBER will be replaced with COMMISSIONER REFERENCE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.

COMMISSIONER REFERENCE NUMBER

Change to Data Element: Changed Description, linked Attribute

COMMISSIONER REFERENCE NUMBER

Attribute:

COMMISSIONER REFERENCE NUMBER

COMMISSIONING SERIAL NUMBER

Change to Data Element: Changed Description

Format/Length:	max an6
National Codes:	
Default Codes:	

Notes:
COMMISSIONING SERIAL NUMBER is the same as attribute NHS SERVICE AGREEMENT NUMBER.

From 01/04/2001 this data item will be used to identify PATIENTS treated under Non-Contract Activities. NHS Trusts and NHS Foundation Trusts are required to insert the letters 'OAT' (mandated input as capitals) in the first three characters of the COMMISSIONING SERIAL NUMBER field of the Admitted Patient Care Commissioning Data Set. The remaining three characters will continue to be defined locally, see DSCN 17/2000.

From 01/04/2005 an '=' (equals) as the last significant character in this six character field will indicate an episode that should be excluded from the National Tariff Payment System tariff.

The position of the last character depends on any preceding characters eg 1st character if field is otherwise blank, 4th character if following 'OAT', up to a maximum of 6th position. This provides a general exclusion facility for unusual circumstances or where more specific rules regarding coding in other fields cannot be implemented due to local software restrictions.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

COMMISSIONING SERIAL NUMBER will be replaced with NHS SERVICE AGREEMENT IDENTIFIER, which is the most recent approved national information standard to describe the required definition.

CONSULTATION MECHANISM

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See CONSULTATION MECHANISM
Default Codes:	

Notes:
CONSULTATION MECHANISM is the same as attribute CONSULTATION MECHANISM.

CONSULTATION MEDIUM USED will be replaced with CONSULTATION MECHANISM, which is the most recent approved national information standard to describe the required definition.

This data element is also known by these names:

Context	Alias
plural	CONSULTATION MECHANISMS

CONSULTATION MECHANISM

Change to Data Element: New Data Element

CONSULTATION MECHANISM

Attribute:

CONSULTATION MECHANISM

CONSULTATION MEDIUM USED

Change to Data Element: Changed Description

Format/Length:	an2
National Codes:	See CONSULTATION MEDIUM USED
Default Codes:	

Notes:
CONSULTATION MEDIUM USED is the same as attribute CONSULTATION MEDIUM USED.

For specific National Code usage in different data sets, see CONSULTATION MEDIUM USED.

CONSULTATION MEDIUM USED will be replaced with CONSULTATION MECHANISM, which is the most recent approved national information standard to describe the required definition.

CRITICAL CARE LEVEL

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See CRITICAL CARE LEVEL
Default Codes:	

Notes:
CRITICAL CARE LEVEL is the same as attribute CRITICAL CARE LEVEL.

This data element is also known by these names:

Context	Alias
plural	CRITICAL CARE LEVELS

CRITICAL CARE LEVEL

Change to Data Element: New Data Element

CRITICAL CARE LEVEL

Attribute:

CRITICAL CARE LEVEL

DATA ABSENT REASON (FHIR R4)

Change to Data Element: New Data Element

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
DATA ABSENT REASON (FHIR R4) is the same as attribute DATA ABSENT REASON.

DATA ABSENT REASON (FHIR R4) is the concept from the FHIR Release 4 Value Set 'data-absent-reason' which identifies the reason that a CODED CLINICAL ENTRY data item in an ELECTRONIC HEALTH RECORD is missing.

The FHIR Release 4 Value Set codes can be accessed from the HL7 FHIR website at: data-absent-reason.

This data element is also known by these names:

Context	Alias
plural	DATA ABSENT REASONS (FHIR R4)

DATA ABSENT REASON (FHIR R4)

Change to Data Element: New Data Element

DATA ABSENT REASON (FHIR R4)

Attribute:

DATA ABSENT REASON

DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET)

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See DIAGNOSIS SCHEME IN USE
Default Codes:	

Notes:
DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET) is the same as attribute DIAGNOSIS SCHEME IN USE for the Commissioning Data Sets.

Permitted National Codes:

02	ICD-10

This data element is also known by these names:

Context	Alias

plural	DIAGNOSIS SCHEMES IN USE (COMMISSIONING DATA SET)

DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET)

Change to Data Element: New Data Element

DIAGNOSIS SCHEME IN USE (COMMISSIONING DATA SET)

Attribute:

DIAGNOSIS SCHEME IN USE

DISCHARGED TO NHS AT HOME SERVICE INDICATOR

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See DISCHARGED TO NHS AT HOME SERVICE INDICATOR
Default Codes:	9 - Not known whether the PATIENT was discharged to an NHS At Home Service

Notes:
DISCHARGED TO NHS AT HOME SERVICE INDICATOR is the same as attribute DISCHARGED TO NHS AT HOME SERVICE INDICATOR.

This data element is also known by these names:

Context	Alias
plural	DISCHARGED TO NHS AT HOME SERVICE INDICATORS

DISCHARGED TO NHS AT HOME SERVICE INDICATOR

Change to Data Element: New Data Element

DISCHARGED TO NHS AT HOME SERVICE INDICATOR

Attribute:

DISCHARGED TO NHS AT HOME SERVICE INDICATOR

EMED3 FIT NOTE ASSESSMENT DATE

Change to Data Element: New Data Element

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

Notes:
EMED3 FIT NOTE ASSESSMENT DATE is the same as the attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*eMED3 Fit Note Assessment Date*'.

This data element is also known by these names:

Context	Alias

plural	EMED3 FIT NOTE ASSESSMENT DATES

EMED3 FIT NOTE ASSESSMENT DATE

Change to Data Element: New Data Element

EMED3 FIT NOTE ASSESSMENT DATE

Attribute:

ACTIVITY DATE

EMED3 FIT NOTE CONDITION (SNOMED CT EXPRESSION)

Change to Data Element: New Data Element

Format/Length:	See SNOMED CT EXPRESSION
National Codes:	
Default Codes:	

Notes:
EMED3 FIT NOTE CONDITION (SNOMED CT EXPRESSION) is the same as attribute CLINICAL TERMINOLOGY CODE.

EMED3 FIT NOTE CONDITION (SNOMED CT EXPRESSION) is a structured combination of one or more SNOMED CT® concept identifiers which are used to describe the reason that a CARE PROFESSIONAL issued an eMED3 Fit Note for a PATIENT.

For further information on SNOMED CT EXPRESSIONS, see the SNOMED CT® Glossary at: Expression.

EMED3 FIT NOTE CONDITION (SNOMED CT EXPRESSION)

Change to Data Element: New Data Element

EMED3 FIT NOTE CONDITION (SNOMED CT EXPRESSION)

Attribute:

CLINICAL TERMINOLOGY CODE

EMED3 FIT NOTE DIAGNOSIS (ICD)

Change to Data Element: New Data Element

Format/Length:	See ICD-10 CODE
National Codes:	
Default Codes:	

Notes:
EMED3 FIT NOTE DIAGNOSIS (ICD) is the same as attribute CLINICAL CLASSIFICATION CODE.

EMED3 FIT NOTE DIAGNOSIS (ICD) is the International Classification of Diseases (ICD) code used to describe the reason that a CARE PROFESSIONAL issued an eMED3 Fit Note for a PATIENT.

This data element is also known by these names:

Context	Alias
plural	EMED3 FIT NOTE DIAGNOSES (ICD)

EMED3 FIT NOTE DIAGNOSIS (ICD)

Change to Data Element: New Data Element

EMED3 FIT NOTE DIAGNOSIS (ICD)

Attribute:

CLINICAL CLASSIFICATION CODE

EMED3 FIT NOTE DURATION

Change to Data Element: New Data Element

Format/Length:	max an3
National Codes:	
Default Codes:	999 - eMED3 Fit Note is for an indefinite period

Notes:
EMED3 FIT NOTE DURATION is the same as attribute PERSON PROPERTY ASSIGNMENT PERIOD DURATION.

EMED3 FIT NOTE DURATION is the number of days duration of an eMED3 Fit Note Applicable Period.

EMED3 FIT NOTE DURATION

Change to Data Element: New Data Element

EMED3 FIT NOTE DURATION

Attribute:

PERSON PROPERTY ASSIGNMENT PERIOD DURATION

EMED3 FIT NOTE END DATE

Change to Data Element: New Data Element

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

Notes:
EMED3 FIT NOTE END DATE is the same as attribute PERSON PROPERTY EFFECTIVE END DATE.

EMED3 FIT NOTE END DATE is the date that the eMED3 Fit Note Applicable Period ended.

This data element is also known by these names:

Context	Alias
plural	EMED3 FIT NOTE END DATES

EMED3 FIT NOTE END DATE

Change to Data Element: New Data Element

EMED3 FIT NOTE END DATE

Attribute:

PERSON PROPERTY EFFECTIVE END DATE

EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR
Default Codes:	

Notes:
EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR is the same as attribute EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR.

This data element is also known by these names:

Context	Alias
plural	EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATORS

EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR

Change to Data Element: New Data Element

EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR

Attribute:

EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR

EMED3 FIT NOTE RECORDED DATE

Change to Data Element: New Data Element

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

Notes:
EMED3 FIT NOTE RECORDED DATE is the same as the attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*eMED3 Fit Note Recorded Date*'.

This data element is also known by these names:

Context	Alias
plural	EMED3 FIT NOTE RECORDED DATES

EMED3 FIT NOTE RECORDED DATE

Change to Data Element: New Data Element

EMED3 FIT NOTE RECORDED DATE

Attribute:

ACTIVITY DATE

EMED3 FIT NOTE START DATE

Change to Data Element: New Data Element

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

Notes:
EMED3 FIT NOTE START DATE is the same as attribute PERSON PROPERTY EFFECTIVE START DATE.

EMED3 FIT NOTE START DATE is the date that the eMED3 Fit Note Applicable Period commenced.

This data element is also known by these names:

Context	Alias
plural	EMED3 FIT NOTE START DATES

EMED3 FIT NOTE START DATE

Change to Data Element: New Data Element

EMED3 FIT NOTE START DATE

Attribute:

PERSON PROPERTY EFFECTIVE START DATE

LAST PATIENT CANCELLED DATE

Change to Data Element: New Data Element

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

Notes:
LAST PATIENT CANCELLED DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is '*Last Patient Cancelled Date*'.

For the CDS V6-3 Type 020 - Outpatient Commissioning Data Set, the LAST PATIENT CANCELLED DATE is the last APPOINTMENT which the PATIENT cancelled, on or prior to the APPOINTMENT DATE carried in that CDS V6-3 Type 020 - Outpatient Commissioning Data Set record.

This data element is also known by these names:

Context	Alias
plural	LAST PATIENT DID NOT ATTEND DATES

LAST PATIENT CANCELLED DATE

Change to Data Element: New Data Element

LAST PATIENT CANCELLED DATE

Attribute:

ACTIVITY DATE

LAST PATIENT DID NOT ATTEND DATE

Change to Data Element: New Data Element

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

Notes:
LAST PATIENT DID NOT ATTEND DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is '*Last Patient Did Not Attend Date*'.

For the CDS V6-3 Type 020 - Outpatient Commissioning Data Set, the LAST PATIENT DID NOT ATTEND DATE is the last APPOINTMENT which the PATIENT failed to attend without advance warning, on or prior to the APPOINTMENT DATE carried in that CDS V6-3 Type 020 - Outpatient Commissioning Data Set record.

This data element is also known by these names:

Context	Alias
plural	LAST PATIENT DID NOT ATTEND DATES

LAST PATIENT DID NOT ATTEND DATE

Change to Data Element: New Data Element

LAST PATIENT DID NOT ATTEND DATE

Attribute:

ACTIVITY DATE

LATEST CLINICALLY APPROPRIATE DATE

Change to Data Element: New Data Element

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

Notes:

LATEST CLINICALLY APPROPRIATE DATE is the same as attribute ACTIVITY DATE.

LATEST CLINICALLY APPROPRIATE DATE is the latest date that it was clinically appropriate for an ACTIVITY to take place.

For the Commissioning Data Sets, LATEST CLINICALLY APPROPRIATE DATE is the latest date by which the PATIENT should next be reviewed for the purposes of follow up consultation, Clinical Investigation or further management, in order to maintain a reasonable margin of clinical safety, as judged by the responsible CARE PROFESSIONAL.

This data element is also known by these names:

Context	Alias
plural	LATEST CLINICALLY APPROPRIATE DATES

LATEST CLINICALLY APPROPRIATE DATE

Change to Data Element: New Data Element

LATEST CLINICALLY APPROPRIATE DATE

Attribute:

ACTIVITY DATE

MULTI-PROFESSIONAL OR MULTI-DISCIPLINARY INDICATION CODE (NATIONAL TARIFF PAYMENT SYSTEM)

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See MULTI-PROFESSIONAL OR MULTI-DISCIPLINARY INDICATION CODE
Default Codes:	9 - Not known whether attendance was uni-professional, multi-professional or multi-disciplinary

Notes:

MULTI-PROFESSIONAL OR MULTI-DISCIPLINARY INDICATION CODE (NATIONAL TARIFF PAYMENT SYSTEM) is the same as attribute MULTI-PROFESSIONAL OR MULTI-DISCIPLINARY INDICATION CODE.

This data item is included in Commissioning Data Set version 6-3, but should not be submitted until further development by the Department of Health and Social Care has been undertaken.

This data element is also known by these names:

Context	Alias
plural	MULTI-PROFESSIONAL OR MULTI-DISCIPLINARY CONSULTATION INDICATION CODES (NATIONAL TARIFF PAYMENT SYSTEM)

MULTI-PROFESSIONAL OR MULTI-DISCIPLINARY INDICATION CODE (NATIONAL TARIFF PAYMENT SYSTEM)

Change to Data Element: New Data Element

MULTI-PROFESSIONAL OR MULTI-DISCIPLINARY INDICATION CODE (NATIONAL TARIFF PAYMENT SYSTEM)

Attribute:

MULTI-PROFESSIONAL OR MULTI-DISCIPLINARY INDICATION CODE

NHS SERVICE AGREEMENT IDENTIFIER

Change to Data Element: New Data Element

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
NHS SERVICE AGREEMENT IDENTIFIER is the same as attribute NHS SERVICE AGREEMENT IDENTIFIER.

Where a PATIENT is receiving Non-Contract Activity treatment, Health Care Providers submitting the Commissioning Data Sets should populate the first 3 characters of the NHS SERVICE AGREEMENT IDENTIFIER with the letters 'OAT' (in capital letters). The remaining characters continue to be locally-populated as required.

Where the ACTIVITY in the Commissioning Data Set record should be excluded from the National Tariff Payment System tariff, an '=' (equals sign) should be entered as the last character in the NHS SERVICE AGREEMENT IDENTIFIER. The position of the last character depends on any preceding characters; for example where the field is otherwise blank, the '=' sign would be the first character. Where the first three characters are 'OAT' as above, the '=' sign is entered as the 4th character. The '=' sign provides a general exclusion from National Tariff Payment System processing by the Secondary Uses Service which should be used for unusual circumstances, or where more specific rules regarding population of other data fields used in the Healthcare Resource Group Payment Grouper cannot be implemented due to local system restrictions.

COMMISSIONING SERIAL NUMBER will be replaced with NHS SERVICE AGREEMENT IDENTIFIER, which is the most recent approved national information standard to describe the required definition.

NHS SERVICE AGREEMENT IDENTIFIER

Change to Data Element: New Data Element

NHS SERVICE AGREEMENT IDENTIFIER

Attribute:

NHS SERVICE AGREEMENT IDENTIFIER

NHS SERVICE AGREEMENT LINE IDENTIFIER

Change to Data Element: New Data Element

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
NHS SERVICE AGREEMENT LINE IDENTIFIER is the same as attribute NHS SERVICE AGREEMENT LINE IDENTIFIER.

NHS SERVICE AGREEMENT LINE NUMBER will be replaced with NHS SERVICE AGREEMENT LINE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.

This data element is also known by these names:

Context	Alias
plural	NHS SERVICE AGREEMENT LINE IDENTIFIERS

NHS SERVICE AGREEMENT LINE IDENTIFIER

Change to Data Element: New Data Element

NHS SERVICE AGREEMENT LINE IDENTIFIER

Attribute:

NHS SERVICE AGREEMENT LINE IDENTIFIER

NHS SERVICE AGREEMENT LINE NUMBER

Change to Data Element: Changed Description

Format/Length:	max an10
National Codes:	
Default Codes:	

Notes:
NHS SERVICE AGREEMENT LINE NUMBER is the same as attribute NHS SERVICE AGREEMENT LINE NUMBER.

NHS SERVICE AGREEMENT LINE NUMBER may be used to identify a specific NHS SERVICE AGREEMENT reference where the main identifier refers to a general omnibus agreement.

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

NHS SERVICE AGREEMENT LINE NUMBER will be replaced with NHS SERVICE AGREEMENT LINE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.

ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)

Change to Data Element: Changed Description

Format/Length:	min an3 max an5
National Codes:	
Default Codes:	

Notes:
ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER) is the same as attribute ORGANISATION IDENTIFIER.

ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER) is the ORGANISATION IDENTIFIER of the ORGANISATION issuing the PATIENT PATHWAY IDENTIFIER.

Where Choose and Book has been used, the ORGANISATION IDENTIFIER X09 should be used.

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, and is of the following Commissioning Data Set Types:

- ~~CDS V6-2 Type 020 - Outpatient Commissioning Data Set~~
- ~~CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set~~
- ~~CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set~~
- ~~CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set~~
- ~~CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) Commissioning Data Set~~
- ~~CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) Commissioning Data Set~~
- ~~CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) Commissioning Data Set~~
- CDS V6-2 Type 020 - Outpatient Commissioning Data Set / CDS V6-3 Type 020 - Outpatient Commissioning Data Set
- CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set / CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set
- CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set / CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set
- CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set
- CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) Commissioning Data Set
- CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) Commissioning Data Set
- CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) Commissioning Data Set

then ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) will be replaced with ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER), which is the most recent approved national information standard to describe the required definition.

ORGAN SYSTEM SUPPORTED

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See ORGAN SYSTEM SUPPORTED
Default Codes:	

Notes:
ORGAN SYSTEM SUPPORTED is the same as attribute ORGAN SYSTEM SUPPORTED.

This data element is also known by these names:

Context	Alias
plural	ORGAN SYSTEMS SUPPORTED

ORGAN SYSTEM SUPPORTED

Change to Data Element: New Data Element

ORGAN SYSTEM SUPPORTED

Attribute:

ORGAN SYSTEM SUPPORTED

OUTPATIENT ATTENDANCE IDENTIFIER

Change to Data Element: Changed Description

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
OUTPATIENT ATTENDANCE IDENTIFIER is the same as attribute ACTIVITY IDENTIFIER.

~~This item is being used for development purposes and has not yet been approved.~~OUTPATIENT ATTENDANCE IDENTIFIER is a unique identifier for each Care Professional Out-Patient Attendance.

Note that the OUTPATIENT ATTENDANCE IDENTIFIER must be constructed without the use of PATIENT Confidential Information. This includes PATIENT Identifiers such as NHS NUMBER or LOCAL PATIENT IDENTIFIER, as well as any text which may identify the PATIENT DIAGNOSIS of the PATIENT or any PATIENT procedures being undertaken.

ATTENDANCE IDENTIFIER will be replaced with OUTPATIENT ATTENDANCE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.

OUT-PATIENT ATTENDANCE OUTCOME

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See OUT-PATIENT ATTENDANCE OUTCOME
Default Codes:	

Notes:
OUT-PATIENT ATTENDANCE OUTCOME is the same as attribute OUT-PATIENT ATTENDANCE OUTCOME.

This data element is also known by these names:

Context	Alias
plural	OUT-PATIENT ATTENDANCE OUTCOMES

OUT-PATIENT ATTENDANCE OUTCOME

Change to Data Element: New Data Element

OUT-PATIENT ATTENDANCE OUTCOME

Attribute:

OUT-PATIENT ATTENDANCE OUTCOME

PATIENT FAMILY NAME

Change to Data Element: New Data Element

Format/Length:	max an35
National Codes:	
Default Codes:	

Notes:
PATIENT FAMILY NAME is the same as attribute PERSON NAME WORD TEXT where the PERSON NAME WORD TYPE is National Code *'Person Family Name'*.

PATIENT FAMILY NAME is the PERSON FAMILY NAME of the PATIENT.

This data element is also known by these names:

Context	Alias
plural	PATIENT FAMILY NAMES

PATIENT FAMILY NAME

Change to Data Element: New Data Element

PATIENT FAMILY NAME

Attribute:

PERSON NAME WORD TEXT

PATIENT FULL NAME

Change to Data Element: New Data Element

Format/Length:	max an70
National Codes:	
Default Codes:	

Notes:
PATIENT FULL NAME is the same as attribute PERSON NAME WORD TEXT.

PATIENT FULL NAME is the preferred PERSON FULL NAME of the PATIENT.

The PATIENT's name and ADDRESS should be withheld from any Commissioning Data Set that contains a valid NHS NUMBER. For further information, see the Security Issues and Patient Confidentiality.

This data element is also known by these names:

Context	Alias
plural	PATIENT FULL NAMES

PATIENT FULL NAME

Change to Data Element: New Data Element

PATIENT FULL NAME

Attribute:

PERSON NAME WORD TEXT

PATIENT GIVEN NAME

Change to Data Element: New Data Element

Format/Length:	max an35
National Codes:	
Default Codes:	

Notes:
PATIENT GIVEN NAME is the same as attribute PERSON NAME WORD TEXT where the PERSON NAME WORD TYPE is National Code *'Person Given Name'*.

PATIENT GIVEN NAME is the PERSON GIVEN NAME of the PATIENT.

This data element is also known by these names:

Context	Alias
plural	PATIENT GIVEN NAMES

PATIENT GIVEN NAME

Change to Data Element: New Data Element

PATIENT GIVEN NAME

Attribute:

PERSON NAME WORD TEXT

PATIENT INITIALS

Change to Data Element: New Data Element

Format/Length:	max an35
National Codes:	
Default Codes:	

Notes:
PATIENT INITIALS is the same as attribute PERSON NAME WORD TEXT where the PERSON NAME WORD TYPE is National Code *'Person Initials'*.

PATIENT INITIALS is the PERSON INITIALS of the PATIENT.

This data element is also known by these names:

Context	Alias
plural	PATIENT INITIALS

PATIENT INITIALS

Change to Data Element: New Data Element

PATIENT INITIALS

Attribute:

PERSON NAME WORD TEXT

PATIENT NAME SUFFIX

Change to Data Element: New Data Element

Format/Length:	max an35

National Codes:
Default Codes:

Notes:
PATIENT NAME SUFFIX is the same as attribute PERSON NAME WORD TEXT where the PERSON NAME WORD TYPE is National Code *'Person Name Suffix'.*

PATIENT NAME SUFFIX is the PERSON NAME SUFFIX of the PATIENT.

This data element is also known by these names:

Context	Alias
plural	PATIENT NAME SUFFIXES

PATIENT NAME SUFFIX

Change to Data Element: New Data Element

PATIENT NAME SUFFIX

Attribute:

PERSON NAME WORD TEXT

PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR AT CDS ACTIVITY DATE

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR
Default Codes:	

Notes:
PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR AT CDS ACTIVITY DATE is the same as attribute PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR.

PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR AT CDS ACTIVITY DATE indicates whether the PATIENT is on a Patient Initiated Out-Patient Follow-Up Pathway at the CDS ACTIVITY DATE.

PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR AT CDS ACTIVITY DATE

Change to Data Element: New Data Element

PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR AT CDS ACTIVITY DATE

Attribute:

PATIENT ON PATIENT INITIATED OUT-PATIENT FOLLOW UP PATHWAY INDICATOR

PATIENT PATHWAY IDENTIFIER

Change to Data Element: Changed Description

Format/Length:	an20
National Codes:	
Default Codes:	

Notes:
PATIENT PATHWAY IDENTIFIER is the same as PATIENT PATHWAY IDENTIFIER.

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, and is of the following Commissioning Data Set Types:

- ~~CDS V6-2 Type 020 - Outpatient Commissioning Data Set~~
- ~~CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set~~
- ~~CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set~~
- **CDS V6-2 Type 020 - Outpatient Commissioning Data Set / CDS V6-3 Type 020 - Outpatient Commissioning Data Set**
- **CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set / CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set**
- **CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set / CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set**
- **CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set**
- **CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) Commissioning Data Set**
- **CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) Commissioning Data Set**
- **CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) Commissioning Data Set**

then either UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) or PATIENT PATHWAY IDENTIFIER must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

PATIENT SUBJECT TO REMOTE MONITORING INDICATOR AT CDS ACTIVITY DATE

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See PATIENT SUBJECT TO REMOTE MONITORING INDICATOR
Default Codes:	

Notes:
PATIENT SUBJECT TO REMOTE MONITORING INDICATOR AT CDS ACTIVITY DATE is the same as attribute PATIENT SUBJECT TO REMOTE MONITORING INDICATOR.

PATIENT SUBJECT TO REMOTE MONITORING INDICATOR AT CDS ACTIVITY DATE indicates whether the PATIENT is subject to Remote Monitoring at the CDS ACTIVITY DATE.

PATIENT SUBJECT TO REMOTE MONITORING INDICATOR AT CDS ACTIVITY DATE

Change to Data Element: New Data Element

PATIENT SUBJECT TO REMOTE MONITORING INDICATOR AT CDS ACTIVITY DATE

Attribute:

PATIENT SUBJECT TO REMOTE MONITORING INDICATOR

PATIENT TITLE

Change to Data Element: New Data Element

Format/Length:	max an35
National Codes:	
Default Codes:	

Notes:
PATIENT TITLE is the same as attribute PERSON NAME WORD TEXT where the PERSON NAME WORD TYPE is National Code *'Person Title'*.

PATIENT TITLE is the PERSON TITLE of the PATIENT.

This data element is also known by these names:

Context	Alias
plural	PATIENT TITLES

PATIENT TITLE

Change to Data Element: New Data Element

PATIENT TITLE

Attribute:

PERSON NAME WORD TEXT

PATIENT USUAL ADDRESS (STRUCTURED (BABY))

Change to Data Element: New Data Element

Format/Length:	max an35
National Codes:	
Default Codes:	

Notes:
PATIENT USUAL ADDRESS (STRUCTURED (BABY)) is the same as attribute ADDRESS, for a baby.

PATIENT USUAL ADDRESS (STRUCTURED (BABY)) is the usual ADDRESS STRUCTURED nominated by the PATIENT, where the ADDRESS ASSOCIATION TYPE is National Code *'Main Permanent Residence'* or *'Other Permanent Residence'*.

For the baby in a birth episode, the PATIENT USUAL ADDRESS (STRUCTURED (BABY)) should usually refer to the mother's usual permanent place of residence, unless different circumstances apply (for example the baby is to be taken into care after birth).

PATIENT USUAL ADDRESS (STRUCTURED (BABY)) requires submission of at least the first two lines of the ADDRESS of the PATIENT. The format refers to the physical layout of the ADDRESS, not the logical layout, and does not require intelligent intervention when splitting the text string into lines. For example:

Flat 1, 21 Arbuthnott Avenue, Pollo (35 characters)
k Estate, Lesser Hinkley, Staffords (35 characters)
hire (4 chars)

If PATIENTS usually resident elsewhere are staying in hotels, hostels or other residential establishments for a short period of time, they should be recorded as staying at their usual permanent place of residence. However if the PATIENTs stay is long term, for example if they are resident at a boarding school, the School ADDRESS must be recorded. University students may nominate either their home ADDRESS or the ADDRESS of their University ACCOMMODATION.

PATIENTS not able to provide a current permanent ADDRESS should be asked for their most recent ADDRESS. If this cannot be established, record the ADDRESS as *'No fixed abode'* or *'Address unknown'*. These PATIENTS are regarded as resident in the local geographical district for commissioning purposes.

The PATIENT's name and ADDRESS should be withheld from any Commissioning Data Set record which contains a valid NHS NUMBER.

This data element is also known by these names:

Context	Alias
plural	PATIENT USUAL ADDRESSES (STRUCTURED (BABY))

PATIENT USUAL ADDRESS (STRUCTURED (BABY))

Change to Data Element: New Data Element

PATIENT USUAL ADDRESS (STRUCTURED (BABY))

Attribute:

ADDRESS

PATIENT USUAL ADDRESS (STRUCTURED (MOTHER))

Change to Data Element: New Data Element

Format/Length:	max an35
National Codes:	
Default Codes:	

Notes:
PATIENT USUAL ADDRESS (STRUCTURED (MOTHER)) is the same as attribute ADDRESS, for the Mother of a baby.

PATIENT USUAL ADDRESS (STRUCTURED (MOTHER)) is the usual ADDRESS STRUCTURED nominated by the PATIENT (mother), where the ADDRESS ASSOCIATION TYPE is National Code *'Main Permanent Residence'* or *'Other Permanent Residence'*.

PATIENT USUAL ADDRESS (STRUCTURED (MOTHER)) requires submission of at least the first two lines of the ADDRESS of the PATIENT (mother). The format refers to the physical layout of the ADDRESS, not the logical layout, and does not require intelligent intervention when splitting the text string into lines. For example:

Flat 1, 21 Arbuthnott Avenue, Pollo (35 characters)
k Estate, Lesser Hinkley, Staffords (35 characters)
hire (4 chars)

If PATIENTS usually resident elsewhere are staying in hotels, hostels or other residential establishments for a short period of time, they should be recorded as staying at their usual permanent place of residence. However if the PATIENTs stay is long term, for example if they are resident at a boarding school, the School ADDRESS must be recorded. University students may nominate either their home ADDRESS or the ADDRESS of their University ACCOMMODATION.

Where PATIENTS do not have the capacity to supply this information, because of mental illness, for example, then the PERSON responsible for the PATIENT such as a parent, guardian or other representative should nominate the PATIENT USUAL ADDRESS (STRUCTURED (MOTHER)).

PATIENTS not able to provide a current permanent ADDRESS should be asked for their most recent ADDRESS. If this cannot be established, record the ADDRESS as *'No fixed abode'* or *'Address unknown'*. These PATIENTS are regarded as resident in the local geographical district for commissioning purposes.

The PATIENT's name and ADDRESS should be withheld from any Commissioning Data Set record which contains a valid NHS NUMBER.

This data element is also known by these names:

Context	Alias
plural	PATIENT USUAL ADDRESSES (STRUCTURED (MOTHER))

PATIENT USUAL ADDRESS (STRUCTURED (MOTHER))

Change to Data Element: New Data Element

PATIENT USUAL ADDRESS (STRUCTURED (MOTHER))

Attribute:

ADDRESS

PATIENT USUAL ADDRESS (STRUCTURED)

Change to Data Element: New Data Element

Format/Length:	max an35
National Codes:	
Default Codes:	

Notes:
PATIENT USUAL ADDRESS (STRUCTURED) is the same as attribute ADDRESS.

PATIENT USUAL ADDRESS (STRUCTURED) is the usual ADDRESS STRUCTURED nominated by the PATIENT, where the ADDRESS ASSOCIATION TYPE is National Code *'Main Permanent Residence'* or *'Other Permanent Residence'*.

PATIENT USUAL ADDRESS (STRUCTURED) requires submission of at least the first two lines of the ADDRESS of the PATIENT. The format refers to the physical layout of the ADDRESS, not the logical layout, and does not require intelligent intervention when splitting the text string into lines. For example:

Flat 1, 21 Arbuthnott Avenue, Pollo (35 characters)
k Estate, Lesser Hinkley, Staffords (35 characters)
hire (4 chars)

If PATIENTS usually resident elsewhere are staying in hotels, hostels or other residential establishments for a short period of time, they should be recorded as staying at their usual permanent place of residence. However if the PATIENTs stay is long term, for example if they are resident at a boarding school, the School ADDRESS must be recorded. University students may nominate either their home ADDRESS or the ADDRESS of their University ACCOMMODATION.

Where PATIENTS do not have the capacity to supply this information, because of mental illness, for example, then the PERSON responsible for the PATIENT such as a parent, guardian or other representative should nominate the PATIENT USUAL ADDRESS (UNSTRUCTURED).

PATIENTS not able to provide a current permanent ADDRESS should be asked for their most recent ADDRESS. If this cannot be established, record the ADDRESS as *'No fixed abode'* or *'Address unknown'*. These PATIENTS are regarded as resident in the local geographical district for commissioning purposes.

For the baby in a birth episode, the PATIENT USUAL ADDRESS (UNSTRUCTURED) should usually refer to the mother's usual permanent place of residence, unless different circumstances apply (for example the baby is to be taken into care after birth).

The PATIENT's name and ADDRESS should be withheld from any Commissioning Data Set record which contains a valid NHS NUMBER.

This data element is also known by these names:

Context	Alias
plural	PATIENT USUAL ADDRESSES (STRUCTURED)

PATIENT USUAL ADDRESS (STRUCTURED)

Change to Data Element: New Data Element

PATIENT USUAL ADDRESS (STRUCTURED)

Attribute:

ADDRESS

PATIENT USUAL ADDRESS (UNSTRUCTURED (BABY))

Change to Data Element: New Data Element

Format/Length:	max an175
National Codes:	
Default Codes:	

Notes:
PATIENT USUAL ADDRESS (UNSTRUCTURED (BABY)) is the same as attribute ADDRESS for a baby.

PATIENT USUAL ADDRESS (UNSTRUCTURED (BABY)) is the usual ADDRESS UNSTRUCTURED nominated by the PATIENT, where the ADDRESS ASSOCIATION TYPE is National Code *'Main Permanent Residence'* or *'Other Permanent Residence*'.

For the baby in a birth episode, the PATIENT USUAL ADDRESS (UNSTRUCTURED (BABY)) should usually refer to the mother's usual permanent place of residence, unless different circumstances apply (for example the baby is to be taken into care after birth).

If PATIENTS usually resident elsewhere are staying in hotels, hostels or other residential establishments for a short period of time, they should be recorded as staying at their usual permanent place of residence. However if the PATIENTs stay is long term, for example if they are resident at a boarding school, the School ADDRESS must be recorded. University students may nominate either their home ADDRESS or the ADDRESS of their University ACCOMMODATION.

PATIENTS not able to provide a current permanent ADDRESS should be asked for their most recent ADDRESS. If this cannot be established, record the ADDRESS as *'No fixed abode'* or *'Address unknown*'. These PATIENTS are regarded as resident in the local geographical district for commissioning purposes.

The PATIENT's name and ADDRESS should be withheld from any Commissioning Data Set record which contains a valid NHS NUMBER.

This data element is also known by these names:

Context	Alias
plural	PATIENT USUAL ADDRESSES (UNSTRUCTURED (BABY))

PATIENT USUAL ADDRESS (UNSTRUCTURED (BABY))

Change to Data Element: New Data Element

PATIENT USUAL ADDRESS (UNSTRUCTURED (BABY))

Attribute:

ADDRESS

PATIENT USUAL ADDRESS (UNSTRUCTURED (MOTHER))

Change to Data Element: New Data Element

Format/Length:	max an175
National Codes:	
Default Codes:	

Notes:
PATIENT USUAL ADDRESS (UNSTRUCTURED (MOTHER)) is the same as attribute ADDRESS for the mother of a baby.

PATIENT USUAL ADDRESS (UNSTRUCTURED (MOTHER)) is the usual ADDRESS UNSTRUCTURED nominated by the PATIENT, where the ADDRESS ASSOCIATION TYPE is National Code *'Main Permanent Residence'* or *'Other Permanent Residence'*.

If PATIENTS usually resident elsewhere are staying in hotels, hostels or other residential establishments for a short period of time, they should be recorded as staying at their usual permanent place of residence. However if the PATIENTs stay is long term, for example if they are resident at a boarding school, the School ADDRESS must be recorded. University students may nominate either their home ADDRESS or the ADDRESS of their University ACCOMMODATION.

Where PATIENTS do not have the capacity to supply this information, because of mental illness, for example, then the PERSON responsible for the PATIENT such as a parent, guardian or other representative should nominate the PATIENT USUAL ADDRESS (UNSTRUCTURED (MOTHER)).

PATIENTS not able to provide a current permanent ADDRESS should be asked for their most recent ADDRESS. If this cannot be established, record the ADDRESS as *'No fixed abode'* or *'Address unknown'*. These PATIENTS are regarded as resident in the local geographical district for commissioning purposes.

The PATIENT's name and ADDRESS should be withheld from any Commissioning Data Set record which contains a valid NHS NUMBER.

This data element is also known by these names:

Context	Alias
plural	PATIENT USUAL ADDRESSES (UNSTRUCTURED (MOTHER))

PATIENT USUAL ADDRESS (UNSTRUCTURED (MOTHER))

Change to Data Element: New Data Element

PATIENT USUAL ADDRESS (UNSTRUCTURED (MOTHER))

Attribute:

ADDRESS

PATIENT USUAL ADDRESS (UNSTRUCTURED)

Change to Data Element: New Data Element

Format/Length:	max an175
National Codes:	
Default Codes:	

Notes:
PATIENT USUAL ADDRESS (UNSTRUCTURED) is the same as attribute ADDRESS.

PATIENT USUAL ADDRESS (UNSTRUCTURED) is the usual ADDRESS UNSTRUCTURED nominated by the PATIENT, where the ADDRESS ASSOCIATION TYPE is National Code *'Main Permanent Residence'* or *'Other Permanent Residence*'.

If PATIENTS usually resident elsewhere are staying in hotels, hostels or other residential establishments for a short period of time, they should be recorded as staying at their usual permanent place of residence. However if the PATIENTs stay is long term, for example if they are resident at a boarding school, the School ADDRESS must be recorded. University students may nominate either their home ADDRESS or the ADDRESS of their University ACCOMMODATION.

Where PATIENTS do not have the capacity to supply this information, because of mental illness, for example, then the PERSON responsible for the PATIENT such as a parent, guardian or other representative should nominate the PATIENT USUAL ADDRESS (UNSTRUCTURED).

PATIENTS not able to provide a current permanent ADDRESS should be asked for their most recent ADDRESS. If this cannot be established, record the ADDRESS as *'No fixed abode'* or *'Address unknown*'. These PATIENTS are regarded as resident in the local geographical district for commissioning purposes.

For the baby in a birth episode, the PATIENT USUAL ADDRESS (UNSTRUCTURED) should usually refer to the mother's usual permanent place of residence, unless different circumstances apply (for example the baby is to be taken into care after birth).

The PATIENT's name and ADDRESS should be withheld from any Commissioning Data Set record which contains a valid NHS NUMBER.

This data element is also known by these names:

Context	Alias
plural	PATIENT USUAL ADDRESSES (UNSTRUCTURED)

PATIENT USUAL ADDRESS (UNSTRUCTURED)

Change to Data Element: New Data Element

PATIENT USUAL ADDRESS (UNSTRUCTURED)

Attribute:

ADDRESS

PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE

Change to Data Element: New Data Element

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

Notes:
PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE is the same as attribute PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE.

This data element is also known by these names:

Context	Alias
plural	PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATES

PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE

Change to Data Element: New Data Element

PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE

Attribute:

PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY EXPIRY DATE

PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY REVIEW DATE

Change to Data Element: New Data Element

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

Notes:
PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY REVIEW DATE is the same as attribute PLANNED ACTIVITY DATE where the PLANNED ACTIVITY DATE TYPE is National Code '*Personalised Out-Patient Follow Up Pathway Review Date*'.

For the CDS V6-3 Type 020 - Outpatient Commissioning Data Set, where a Personalised Out-Patient Follow Up Pathway Review Date is submitted, this should be the next review date after the APPOINTMENT DATE carried in the CDS V6-3 Type 020 - Outpatient Commissioning Data Set record.

This data element is also known by these names:

Context	Alias
plural	PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY REVIEW DATES

PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY REVIEW DATE

Change to Data Element: New Data Element

PERSONALISED OUT-PATIENT FOLLOW UP PATHWAY REVIEW DATE

Attribute:

PLANNED ACTIVITY DATE

PRESENT ON ADMISSION INDICATOR

Change to Data Element: Changed Description

Format/Length:	an1
National Codes:	See PRESENT ON ADMISSION INDICATOR
Default Codes:	8 - Not applicable (indication of this PATIENT DIAGNOSIS on admission not required nationally) 9 - Not known whether the PATIENT DIAGNOSIS was present on admission

Notes:
PRESENT ON ADMISSION INDICATOR is the same as attribute PRESENT ON ADMISSION INDICATOR.

~~**Note:**~~
~~**This data item is included in Commissioning Data Set version 6-2, but should not be submitted until further development by NHS Digital has been undertaken.**~~Note: **PRESENT ON ADMISSION INDICATOR is only required for PATIENTS with a PATIENT DIAGNOSIS relating to a pre-existing pressure ulcer before admission to a Health Care Provider, recorded as an ICD-10 CODE. This is to allow sufficient time for Health Care Providers to move to using the SNOMED CT-coded Comorbidity data structure to submit this data in CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set / CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set, which is the preferred mechanism of data submission.**

PROCEDURE SCHEME IN USE (COMMISSIONING DATA SET)

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See PROCEDURE SCHEME IN USE
Default Codes:	

Notes:
PROCEDURE SCHEME IN USE (COMMISSIONING DATA SET) is the same as attribute PROCEDURE SCHEME IN USE for the Commissioning Data Sets.

Permitted National Codes:

02 OPCS-4

This data element is also known by these names:

Context	Alias
plural	PROCEDURE SCHEMES IN USE (COMMISSIONING DATA SET)

PROCEDURE SCHEME IN USE (COMMISSIONING DATA SET)

Change to Data Element: New Data Element

PROCEDURE SCHEME IN USE (COMMISSIONING DATA SET)

Attribute:

PROCEDURE SCHEME IN USE

PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)

Change to Data Element: Changed Description

Format/Length:	max an32
National Codes:	
Default Codes:	

Notes:
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) is the same as attribute PROFESSIONAL REGISTRATION ENTRY IDENTIFIER.

PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) is the PROFESSIONAL REGISTRATION ENTRY IDENTIFIER of the CARE PROFESSIONAL carrying out a Patient Procedure.

~~Where more than one CARE PROFESSIONAL is involved in the Patient Procedure, the PROFESSIONAL REGISTRATION ENTRY IDENTIFIER of the main/lead CARE PROFESSIONAL should be recorded.~~In Commissioning Data Set versions 6-2 and 6-3, PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) must be accompanied by the PROFESSIONAL REGISTRATION ISSUER CODE, which indicates the body which issued the PROFESSIONAL REGISTRATION of the main/lead CARE PROFESSIONAL.

~~In Commissioning Data Set version 6-2, PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) must be accompanied by the PROFESSIONAL REGISTRATION ISSUER CODE, which indicates the body which issued the PROFESSIONAL REGISTRATION of the main/lead CARE PROFESSIONAL, where it is one of the following:~~

- ~~General Dental Council~~
- ~~General Medical Council~~
- ~~Health and Care Professions Council~~
- ~~Nursing and Midwifery Council.~~

Note: the Format/Length has been updated. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)

Change to Data Element: Changed Description

Format/Length:	max an32
National Codes:	
Default Codes:	

Notes:
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) is the same as attribute PROFESSIONAL REGISTRATION ENTRY IDENTIFIER.

PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) is the PROFESSIONAL REGISTRATION ENTRY IDENTIFIER of the CARE PROFESSIONAL providing anaesthesia during a Patient Procedure.

~~Where more than one CARE PROFESSIONAL is involved in providing anaesthesia during the Patient Procedure, the PROFESSIONAL REGISTRATION ENTRY IDENTIFIER of the main/lead anaesthetist should be recorded.~~**In Commissioning Data Set versions 6-2 and 6-3, PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) must be accompanied by the PROFESSIONAL REGISTRATION ISSUER CODE, which indicates the body which issued the PROFESSIONAL REGISTRATION of the main/lead anaesthetist.**

~~In Commissioning Data Set version 6-2, PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) must be accompanied by the PROFESSIONAL REGISTRATION ISSUER CODE, which indicates the body which issued the PROFESSIONAL REGISTRATION of the main/lead anaesthetist, where it is one of the following:~~

- ~~General Dental Council~~
- ~~General Medical Council~~
- ~~Health and Care Professions Council~~
- ~~Nursing and Midwifery Council.~~

Note: the Format/Length has been updated. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

PROFESSIONAL REGISTRATION ISSUER CODE

Change to Data Element: Changed Description

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:
PROFESSIONAL REGISTRATION ISSUER CODE is the same as attribute PROFESSIONAL REGISTRATION BODY CODE

Notes:

- ~~National Code 04 '*General Optical Council*' is only valid for CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set/ CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set and must not be submitted in other Commissioning Data Set versions~~
- ~~National Code 16 '*General Pharmaceutical Council*' is only valid for CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set and must not be submitted in other Commissioning Data Set versions.~~
- **National Code 04 '*General Optical Council*' is only valid for CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set / CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set / Commissioning Data Sets version 6-3, and must not be submitted in other Commissioning Data Set versions**
- **National Code 16 '*General Pharmaceutical Council*' is only valid for CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set / Commissioning Data Sets version 6-3, and must not be submitted in other Commissioning Data Set versions.**

Permitted National Codes:

02	General Dental Council
03	General Medical Council
04	General Optical Council
08	Health and Care Professions Council

09 Nursing and Midwifery Council
16 General Pharmaceutical Council

PROVIDER REFERENCE IDENTIFIER

Change to Data Element: New Data Element

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
PROVIDER REFERENCE IDENTIFIER is the same as attribute PROVIDER REFERENCE IDENTIFIER.

PROVIDER REFERENCE NUMBER will be replaced with PROVIDER REFERENCE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.

This data element is also known by these names:

Context	Alias
plural	PROVIDER REFERENCE IDENTIFIERS

PROVIDER REFERENCE IDENTIFIER

Change to Data Element: New Data Element

PROVIDER REFERENCE IDENTIFIER

Attribute:

PROVIDER REFERENCE IDENTIFIER

PROVIDER REFERENCE NUMBER

Change to Data Element: Changed Description

Format/Length:	max an17
National Codes:	
Default Codes:	

Notes:
PROVIDER REFERENCE NUMBER is the same as attribute PROVIDER REFERENCE NUMBER

Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

PROVIDER REFERENCE NUMBER will be replaced with PROVIDER REFERENCE IDENTIFIER, which is the most recent approved national information standard to describe the required definition.

REFERRAL TO TREATMENT PERIOD END DATE

Change to Data Element: Changed Description

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

Notes:
REFERRAL TO TREATMENT PERIOD END DATE is the same as attribute REFERRAL TO TREATMENT PERIOD END DATE.

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, and is of the following Commissioning Data Set Types:

- ~~**CDS V6-2 Type 020 - Outpatient Commissioning Data Set**~~
- ~~**CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set**~~
- ~~**CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set**~~
- **CDS V6-2 Type 020 - Outpatient Commissioning Data Set / CDS V6-3 Type 020 - Outpatient Commissioning Data Set**
- **CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set / CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set**
- **CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set / CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set**
- **CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set**
- **CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) Commissioning Data Set**
- **CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) Commissioning Data Set**
- **CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) Commissioning Data Set**

then REFERRAL TO TREATMENT PERIOD END DATE must be present in the Commissioning Data Set PATIENT PATHWAY Data Group, where the REFERRAL TO TREATMENT PERIOD has ended.

REFERRAL TO TREATMENT PERIOD START DATE

Change to Data Element: Changed Description

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

Notes:
REFERRAL TO TREATMENT PERIOD START DATE is the same as attribute REFERRAL TO TREATMENT PERIOD START DATE.

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, and is of the following Commissioning Data Set Types:

- ~~**CDS V6-2 Type 020 - Outpatient Commissioning Data Set**~~
- ~~**CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set**~~
- ~~**CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set**~~
- **CDS V6-2 Type 020 - Outpatient Commissioning Data Set / CDS V6-3 Type 020 - Outpatient Commissioning Data Set**
- **CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set / CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set**
- **CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set / CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set**
- **CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set**
- **CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) Commissioning Data Set**
- **CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) Commissioning Data Set**
- **CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) Commissioning Data Set**

then REFERRAL TO TREATMENT PERIOD START DATE must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

REFERRAL TO TREATMENT PERIOD STATUS

Change to Data Element: Changed Description

Format/Length:	an2
National Codes:	See REFERRAL TO TREATMENT PERIOD STATUS
Default Codes:	

Notes:
REFERRAL TO TREATMENT PERIOD STATUS is the same as attribute REFERRAL TO TREATMENT PERIOD STATUS.

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, and is of the following Commissioning Data Set Types:

- ~~**CDS V6-2 Type 020 - Outpatient Commissioning Data Set**~~
- ~~**CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set**~~
- ~~**CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set**~~
- **CDS V6-2 Type 020 - Outpatient Commissioning Data Set / CDS V6-3 Type 020 - Outpatient Commissioning Data Set**
- **CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set / CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set**
- **CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set / CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set**
- **CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set**
- **CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) Commissioning Data Set**
- **CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) Commissioning Data Set**
- **CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) Commissioning Data Set**

then REFERRAL TO TREATMENT PERIOD STATUS must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

For specific National Code usage, see REFERRAL TO TREATMENT PERIOD STATUS.

REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR
Default Codes:	9 - Not Known whether PATIENT referred by a First Contact Practitioner

Notes:
REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR is the same as attribute REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR.

This data element is also known by these names:

Context	Alias
plural	REFERRED BY FIRST CONTACT PRACTITIONER INDICATORS

REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR

Change to Data Element: New Data Element

REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR

Attribute:

REFERRED BY FIRST CONTACT PRACTITIONER INDICATOR

RESPONSIBLE CARE PROFESSIONAL INDICATOR

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See RESPONSIBLE CARE PROFESSIONAL INDICATOR
Default Codes:	

Notes:
RESPONSIBLE CARE PROFESSIONAL INDICATOR is the same as attribute RESPONSIBLE CARE PROFESSIONAL INDICATOR.

This data element is also known by these names:

Context	Alias
plural	RESPONSIBLE CARE PROFESSIONAL INDICATORS

RESPONSIBLE CARE PROFESSIONAL INDICATOR

Change to Data Element: New Data Element

RESPONSIBLE CARE PROFESSIONAL INDICATOR

Attribute:

RESPONSIBLE CARE PROFESSIONAL INDICATOR

SEX OF PATIENTS CODE

Change to Data Element: Changed Description

Format/Length:	an1
National Codes:	See SEX OF PATIENTS
Default Codes:	

Notes:
SEX OF PATIENTS CODE is the same as attribute SEX OF PATIENTS.

For specific National Code usage in different data sets, see SEX OF PATIENTS.

SEX OF PATIENTS CODE will be replaced with WARD INTENDED SEX OF PATIENTS, which is the most recent approved national information standard to describe the required definition.

UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)

Change to Data Element: Changed Description

Format/Length:	n12
National Codes:	
Default Codes:	

Notes:
UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) is the same as attribute UNIQUE BOOKING REFERENCE NUMBER (CONVERTED).

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, and is of the following Commissioning Data Set Types:

- ~~CDS V6-2 Type 020 - Outpatient Commissioning Data Set~~
- ~~CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set~~
- ~~CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set~~
- **CDS V6-2 Type 020 - Outpatient Commissioning Data Set / CDS V6-3 Type 020 - Outpatient Commissioning Data Set**
- **CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set / CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set**
- **CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set / CDS V6-3 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set**
- **CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set**
- **CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) Commissioning Data Set**
- **CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) Commissioning Data Set**
- **CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) Commissioning Data Set**

then either UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) or PATIENT PATHWAY IDENTIFIER must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:
WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET) is the same as attribute WAITING TIME MEASUREMENT TYPE for the Commissioning Data Sets.

Permitted National Codes:

01 Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement
02 Allied Health Professional Referral To Treatment Measurement
09 Other Referral To Treatment Measurement Type (not listed)

This data element is also known by these names:

Context	Alias
plural	WAITING TIME MEASUREMENT TYPES (COMMISSIONING DATA SET)

WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)

Change to Data Element: New Data Element

WAITING TIME MEASUREMENT TYPE (COMMISSIONING DATA SET)

Attribute:

WAITING TIME MEASUREMENT TYPE

WARD INTENDED AGE GROUP

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See WARD INTENDED AGE GROUP
Default Codes:	

Notes:
WARD INTENDED AGE GROUP is the same as attribute WARD INTENDED AGE GROUP.

INTENDED AGE GROUP will be replaced with WARD INTENDED AGE GROUP, which is the most recent approved national information standard to describe the required definition.

This data element is also known by these names:

Context	Alias
plural	WARD INTENDED AGE GROUPS

WARD INTENDED AGE GROUP

Change to Data Element: New Data Element

WARD INTENDED AGE GROUP

Attribute:

WARD INTENDED AGE GROUP

WARD INTENDED CLINICAL CARE INTENSITY

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See WARD INTENDED CLINICAL CARE INTENSITY
Default Codes:	

Notes:
WARD INTENDED CLINICAL CARE INTENSITY is the same as attribute WARD INTENDED CLINICAL CARE INTENSITY.

INTENDED CLINICAL CARE INTENSITY CODE will be replaced with WARD INTENDED CLINICAL CARE INTENSITY, which is the most recent approved national information standard to describe the required definition.

WARD INTENDED CLINICAL CARE INTENSITY

Change to Data Element: New Data Element

WARD INTENDED CLINICAL CARE INTENSITY

Attribute:

WARD INTENDED CLINICAL CARE INTENSITY

WARD INTENDED DAY PERIOD AVAILABILITY

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See WARD INTENDED DAY PERIOD AVAILABILITY
Default Codes:	

Notes:
WARD INTENDED DAY PERIOD AVAILABILITY is the same as attribute WARD INTENDED DAY PERIOD AVAILABILITY.

WARD DAY PERIOD AVAILABILITY CODE will be replaced with WARD INTENDED DAY PERIOD AVAILABILITY, which is the most recent approved national information standard to describe the required definition.

This data element is also known by these names:

Context	Alias
plural	WARD INTENDED DAY PERIOD AVAILABILITIES

WARD INTENDED DAY PERIOD AVAILABILITY

Change to Data Element: New Data Element

WARD INTENDED DAY PERIOD AVAILABILITY

Attribute:

WARD INTENDED DAY PERIOD AVAILABILITY

WARD INTENDED NIGHT PERIOD AVAILABILITY

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See WARD INTENDED NIGHT PERIOD AVAILABILITY
Default Codes:	

Notes:
WARD INTENDED NIGHT PERIOD AVAILABILITY is the same as attribute WARD INTENDED NIGHT PERIOD AVAILABILITY.

WARD NIGHT PERIOD AVAILABILITY CODE will be replaced with WARD INTENDED NIGHT PERIOD AVAILABILITY, which is the most recent approved national information standard to describe the required definition.

This data element is also known by these names:

Context	Alias
plural	WARD INTENDED NIGHT PERIOD AVAILABILITIES

WARD INTENDED NIGHT PERIOD AVAILABILITY

Change to Data Element: New Data Element

WARD INTENDED NIGHT PERIOD AVAILABILITY

Attribute:

WARD INTENDED NIGHT PERIOD AVAILABILITY

WARD INTENDED SEX OF PATIENTS

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See WARD INTENDED SEX OF PATIENTS
Default Codes:	

Notes:
WARD INTENDED SEX OF PATIENTS is the same as attribute WARD INTENDED SEX OF PATIENTS.

SEX OF PATIENTS CODE will be replaced with WARD INTENDED SEX OF PATIENTS, which is the most recent approved national information standard to describe the required definition.

WARD INTENDED SEX OF PATIENTS

Change to Data Element: New Data Element

WARD INTENDED SEX OF PATIENTS

Attribute:

WARD INTENDED SEX OF PATIENTS

COMMISSIONING DATA SET VERSION 6-3 XML SCHEMA CONSTRAINTS

Change to XML Schema Constraint: New XML Schema Constraint

XML Schema constraints applied to the Commissioning Data Sets V6-3.

The "Allowed Values" column indicates the NHS Data Model and Dictionary National Codes and Default Codes present in the XML Schema:

- **None = The National Codes and Default Codes are included in the XML Schema**
- **Removed = The National Codes and Default Codes are not included in the XML Schema.**

Data Element	XML Schema Format/Length	Allowed Values	Range	Pattern Match	Reason / Comment / XML Choice
ACTIVITY LOCATION TYPE CODE	None	Removed	None	None	National Codes not enumerated in XML schema
ACTIVITY TREATMENT FUNCTION CODE	None	Removed	None	None	National Codes not enumerated in XML schema
ASSESSMENT TOOL (SNOMED CT EXPRESSION)	min an6 max an4000	None	None	None	SNOMED CT EXPRESSION data item constrained to recommended length
CARE PROFESSIONAL MAIN SPECIALTY CODE	None	Removed	None	None	National Codes not enumerated in XML schema
CDS BULK REPLACEMENT GROUP CODE	None	010,020,030,040,060	None	None	Commissioning Data Set version 6-3 only allows these CDS BULK REPLACEMENT GROUP CODES
CDS MESSAGE VERSION NUMBER	None	CDS063	None	None	Message version is hard coded in the XML schema
CDS TYPE CODE	None	020,120,130,140,150,160,180,190,200	None	None	Commissioning Data Set version 6-3 only allows these CDS Types
COMORBIDITY (SNOMED CT EXPRESSION)	min an6 max an4000	None	None	None	SNOMED CT EXPRESSION data item constrained to recommended length
CRITICAL CARE ACTIVITY CODE	None	Removed	None	None	

					National Codes not enumerated in XML schema
DIAGNOSIS (SNOMED CT EXPRESSION)	min an6 max an4000	None	None	None	SNOMED CT EXPRESSION data item constrained to recommended length
EMED3 FIT NOTE CONDITION (SNOMED CT EXPRESSION)	min an6 max an4000	None	None	None	SNOMED CT EXPRESSION data item constrained to recommended length
ETHNIC CATEGORY	max an2	None	None	None	Existing Format/Length means fixed length which is incorrect. Unable to change this as it is used in other data sets. Second character can be for local use. Format/Length amended to max an2
FINDING (SNOMED CT EXPRESSION)	min an6 max an4000	None	None	None	SNOMED CT EXPRESSION data item constrained to recommended length
GENERAL MEDICAL PRACTITIONER (SPECIFIED)	None	Removed	None	None	National Codes and default codes not enumerated in the XML Schema
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)	None	Removed	None	None	National Codes not enumerated in XML schema
OBSERVATION (SNOMED CT EXPRESSION)	min an6 max an4000	None	None	None	SNOMED CT EXPRESSION data item constrained to recommended length
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION IDENTIFIER (CODE OF PROVIDER)	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION IDENTIFIER (LOCAL PATIENT	None	Removed	None	None	Default codes not enumerated in the XML Schema

IDENTIFIER (BABY))					
ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER))	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION IDENTIFIER (REFERRING ORGANISATION)	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION SITE IDENTIFIER (OF TREATMENT)	None	Removed	None	None	Default Codes not enumerated in the XML schema
OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE	None	A,B,C,D,E,F,P,9	None	None	National Code X is not valid in Commissioning Data Set version 6-3
REFERRER CODE	None	Removed	None	None	Default Codes not enumerated in the XML schema
PROCEDURE (SNOMED CT EXPRESSION)	min an6 max an4000	None	None	None	Default Codes not enumerated in the XML schema
SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT EXPRESSION)	min an6 max an4000	None	None	None	SNOMED CT EXPRESSION data item constrained to recommended length

---

For enquiries about this Change Request, please email information.standards@nhs.net

ISO
9001
CERTIFICATION
EUROPE ™