Public Health England

Protecting and improving the nation's health

Radiotherapy Data Set (RTDS) v5.0
Requirements Specification

National Information Standard (SCCI0111)

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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SCCI Standardisation Committee for Care Information

This information standard (SCCI0111) has been approved for publication by NHS England under section 250 of the Health and Social Care Act 2012.

Assurance that this information standard meets the requirements of the Act and is appropriate for the use specified in the specification document has been provided by the Standardisation Committee for Care Information (SCCI), a sub-group of the National Information Board.

This information standard comprises the following documents:

- Requirements Specification (this document)
- Change Specification
- Implementation Guidance

An Information Standards Notice (SCCI0111 Amd 13/2015) has been issued as a notification of use and implementation timescales. Please read this alongside the documents for the standard.

The controlled versions of these documents can be found on the HSCIC website.

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Reviewer:
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Name	Organisation	Version	Date
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The following must approve this document:

Name	Organisation	Version	Date
Dr Jem Rashbass	Director, National Disease Registration, Public Health England	v1.0	03/11/2015

Contents

1. Background

The Radiotherapy Data Set (RTDS) standard (SCCI0111) is an existing standard that has required all NHS acute trust providers of radiotherapy services in England to collect and submit standardised data monthly against a nationally defined data set since 2009.

The purpose of the standard is to collect consistent and comparable data across all NHS acute trust providers of radiotherapy services in England in order to provide intelligence for service planning, commissioning, clinical practice and research and the operational provision of radiotherapy services across England.

RTDS has provided and will continue to provide intelligence to underpin the strategic objectives for radiotherapy services defined in the National Radiotherapy Implementation Group report "Radiotherapy Services in England" (2012)[1] and NHS England/Cancer Research UK "Vision for Radiotherapy 2014 – 2024".[2]

The main recommendations of these reports are synthesised in the *Achieving World Class Cancer Outcomes Strategy,*[3] which indicates the main areas where data and information can underpin the monitoring and outcomes of key dimensions of the future development of radiotherapy in England.

'Radiotherapy can cure cancers, can assist in alleviating symptoms and is cost effective. It is second only to surgery in its effectiveness in treating cancer, and experts suggest around 4 in 10 patients whose cancer is cured receive radiotherapy. Thirty eight per cent of cancer patients in England currently have radiotherapy as part of their treatment. International benchmarks suggest this should be closer to 50 per cent.

'Recent advances in radiotherapy using cutting-edge imaging and computing technology have helped target radiation doses more precisely. As a result, they enable better outcomes, with improved quality of life for patients and reduced NHS Costs in the long term through patients suffering fewer side

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[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213151/Radiotherapy-Services-in-England-2012.pdf

[2] http://www.cancerresearchuk.org/sites/default/files/policy_feb2014_radiotherapy_vision2014-2024_final.pdf

[3] http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf

effects. Historically the NHS has not adopted new techniques into clinical practice in a consistent and equitable way across England. In 2014, NHS England and Cancer Research UK jointly published a Vision for Radiotherapy. This recommended that all patients should receive advanced and innovative radiotherapy that had been shown to be clinically and cost effective.'

The management and delivery of the national Radiotherapy Data Set (RTDS) until 31 March 2016 will lie with the National Clinical Analysis and Specialised Applications Team (NATCANSAT), which is based at The Clatterbridge Cancer Centre NHS Foundation Trust.

Public Health England (PHE) will take over full responsibility for RTDS with effect from 1 April 2016.

Since PHE is responsible for the national collection of the Cancer Outcomes and Services Data Set COSD SCCI1521 and the Systemic Anti-Cancer Therapy data set SACT ISB1533, both of which are national cancer information standards, it was determined that RTDS should not be commissioned outside PHE and should be managed by the National Cancer Registration Service (NCRS), allowing greater integration of the management, collection, quality assurance and analysis of radiotherapy data alongside the other major national cancer data sets.

Clinical input into the analysis of radiotherapy data will be secured through the National Cancer Intelligence Network's site-specific clinical reference groups and NHS England's Radiotherapy clinical reference group.

2. Purpose of the Standard

The purpose of the standard is to collect consistent and comparable data across all NHS acute providers of radiotherapy services in England in order to provide intelligence for service planning, commissioning, clinical research and the operational provision of radiotherapy services across England. The primary change in this release signals that the system for data extraction, submission and quality assurance will change from NATCANSAT to the NCRS in PHE. PHE will be the data controller and none of the previous tools or submission methods used by NATCANSAT will continue to be used beyond April 2016.

PHE will receive, validate, quality assure and integrate the data received from across the NHS acute trust providers of radiotherapy to produce a timely and definitive analytical resource. This will be linked vitally by PHE to data captured from other national cancer data sets (Cancer Outcomes and Services Data Set COSD SCCI1521 and the Systemic Anti-Cancer Therapy data set SACT ISB1533 to support key service metrics to track progress in the provision of radiotherapy and other cancer services. The added benefits of integrating the data collection and analytical functions will be cancer site-specific analyses of outcomes by patient and treatment variables, allowing for a better understanding and appreciation of the specific role of radiotherapy in improving outcomes compared with other treatment modalities.

Cancer data collection by the NCRS within PHE is covered by section 251 of the NHS Act 2006, which allows the Secretary of State for Health to make regulations to set aside the common law duty of confidentiality for defined medical purposes. These permissions are subject to annual review by the Confidentiality Advisory Group (CAG) of the Health Research Authority, which advises the Minister. The NCRS permission to receive, hold and process patient identifiable data without individual consent under these regulations was renewed in November 2014 (PIAG 03(a)/2001). The CAG has received formal, advance notification of the change in control and processing of the RTDS and this will be included in their review of PIAG 03(a)/2001 scheduled for November 2015.

PHE needs the confidential data in the RTDS to ensure secure linkage of the details of radiotherapy plans and treatments to personal data already managed by PHE. This will ensure a full pathway of information on patients' diagnosis, treatment and care. The full pathway data will allow clinical teams to understand better how radiotherapy treatment contributes to patient outcomes alongside other treatment modalities.

3. Scope

3.1 In scope

There is no change of scope planned in this release and so it remains:

All radiotherapy of the following types:

- teletherapy
- brachytherapy given using automated remote afterloading machines
- all other brachytherapy given for the treatment of malignant disease

delivered in England to patients in NHS facilities, or in private facilities where delivery is funded by the NHS, from 1 April 2016.

3.2 Out of scope

Brachytherapy delivered using other than automated remote afterloading, for the treatment of non-malignant disease.

Radiotherapy delivered using unsealed sources.

Radiotherapy delivered outside of England.

Radiotherapy delivered in a non-NHS setting and not funded by the NHS.

Non-therapeutic exposures delivered using a radiotherapy machines (eg imaging).

Non-patient exposures (eg dosimetry exposures, blood or tissues, animals).

4. Requirements - Radiotherapy Service Providers

4.1 Requirements

Since there are no planned changes to the format or content of the data set apart from two minor format changes to coding items, the requirements for providers working with their Oncology Management Systems (OMS) in this release remain largely unchanged. The data set will retain the current format, however the current NHS standard for the transmission of data sets is XML. The ability to transmit the data to PHE in XML format will be consulted on for introduction from April 2017 with a view to the current upload function being discontinued from April 2019.

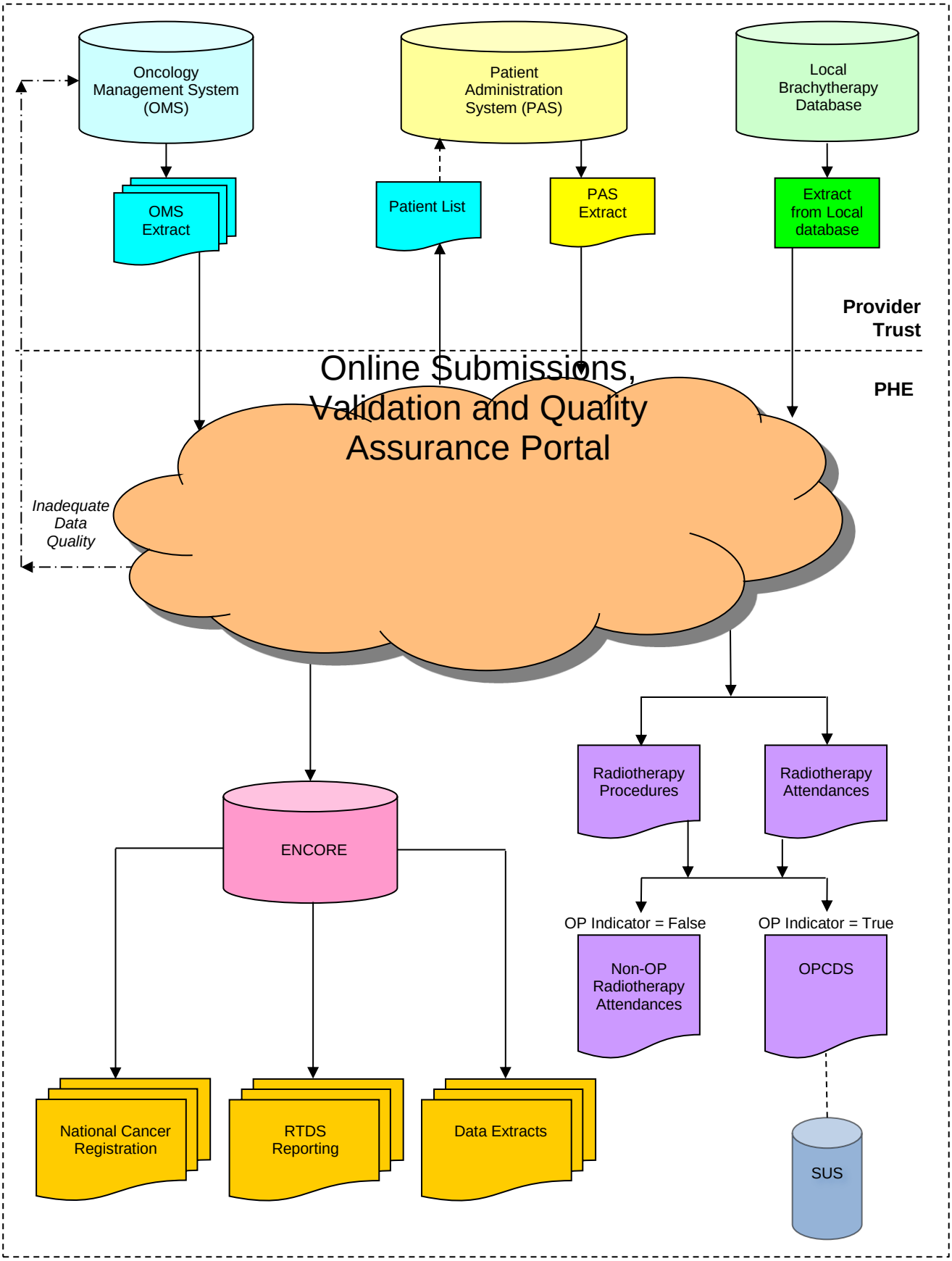
The RTDS data set requires data to be generated from the proprietary or in-house OMS and stored in five tables in a relational SQL database. These require the inclusion of appropriate patient identifiers to allow for linkage and interoperability with the other data standards. A series of reports from the OMS and /or Verify & Record database tables need to be extracted using the proprietary executive information software recommended by the OMS supplier or the in-house system to populate the data items.

All providers of radiotherapy services to NHS patients in England **MUST** collect each of the required data items (see section 8), using the appropriate format and coding, for every patient receiving teletherapy, brachytherapy given using automated remote afterloading machines and all other brachytherapy given for the treatment of malignant disease.
The Radiotherapy Data Set **MUST** be submitted to Public Health England by the 15th working day of each month or a quality assured return which meets the ‘critical’ QA criteria by the 20th day of the month in line with the submissions schedule in section 7.

Data will be generated from the hospital OMS and patient administration system (PAS) using the PHE extraction methods, which will replace the data normalization functions of the NATCANSAT toolkit currently used by providers. The methods of extraction and submission are currently being developed but will be fully tested and operational by January 2016.

The data will then be validated, quality assured, collated and reported on by the NCRS within PHE using an online submissions and reporting portal.

The main change to the data collection and submission is that the data is to be submitted to PHE and not NATCANSAT.


Oncology Management System (OMS)
Patient Administration System (PAS)
Local Brachytherapy Database
OMS Extract
Patient List
PAS Extract
Extract from Local database
Provider Trust
PHE
Online Submissions, Validation and Quality Assurance Portal
Inadequate Data Quality
ENCORE
Radiotherapy Procedures
Radiotherapy Attendances
OP Indicator = False
OP Indicator = True
Non-OP Radiotherapy Attendances
OPCDS
National Cancer Registration
RTDS Reporting
Data Extracts
SUS

4.2 Conformance criteria

Criterion	Measure	Response
Timeliness	Returns MUST be submitted in line with the submission schedule in section 7	A complete return of the data set is required for every month where treatments were delivered. RTDS benefits from being a complete data source for analytical purposes, so late submissions, although not sanctioned, are accepted and uploaded to the database at the next available monthly cycle. Providers who do not submit a monthly return by the date specified would be subject to an escalation policy that will be agreed with the Radiotherapy Information Strategy Group and the project sponsor.
Completeness and Consistency	Returns MUST contain records for every treatment delivered.	Submissions are assessed for completeness upon receipt by NCRS. Submissions which appear to have missing data are queried with the submitter. Missing data is identified using the following criteria: • working days of the month omitted • a different number of radiotherapy machines than the previous month • a significantly different number of records than the previous month In addition, occasional audits of submissions against patient records and scheduling records are used to identify systematic omissions.
Quality Assurance	Quality assurance tests (see section 10) are run on submissions on receipt during the data assembly process. Submissions MUST pass all of the critical tests. Submissions SHOULD pass all of the quality assurance tests.	Submissions that fail any of the critical tests highlighted in section 10 are rejected. Quality assurance reports are provided to submitters including details of their performance. NCRS will maintain communication with submitters to advise priorities for quality improvement.

Providers of radiotherapy services to NHS patients in England **MUST** collect each of the required data items for the RTDS data set (see section 8) and the required data from the Outpatient section of the Commissioning Data Set CDS ISB 0092 (outlined below and see section 9), using the appropriate format and coding, for every patient receiving teletherapy, brachytherapy given using automated remote after loading machines and all other brachytherapy given for the treatment of malignant disease.

From 1 April 2016, the Radiotherapy Data Set should be submitted to PHE by the 15th working day of each month or a quality assured return which meets the 'critical' quality assurance criteria by the 20th day of the month. (See section 7 – RTDS Submissions Schedule).

The items in the data standard are already collected in radiotherapy facilities, and there are no new items proposed for version 5.0. Data is extracted directly from radiotherapy equipment software (verify and record systems, or radiotherapy management systems) for production of the standard.

In advance of v5.0 of the standard becoming operational in April 2016, and during the period September 2015 to December 2016 PHE will provide technical support to all radiotherapy providers who may require it to consolidate the extraction and submission process. This process and the consequent submissions will be compared to the existing data extraction, submission, quality assurance and reporting methods that are required using the NATCANSAT toolkit. The aim of this technical support will be to implement and stabilise data extracted from the Oncology Management Systems (OMS) in use at each site into the data format required for RTDS with effect from 1 April 2016.

Data will be generated from the hospital oncology management and patient administration systems using agreed and tested extract processes.

The data will then be validated, quality assured, collated and reported on by the NCRS within PHE using an online submissions and reporting portal (see nww.api.encore.nhs.uk).

Each radiotherapy attendance is reported using the standard Commissioning Data Set (CDS) plus an additional 'radiotherapy tail' (see section 9.19). Attendance specific information is taken from the Oncology Management Systems (OMS) at each radiotherapy facility, and combined with demographic and other 'non-attendance specific' information taken from the Patient Administration System (PAS) to generate the required file. This avoids duplication of entry of radiotherapy attendances into PAS and OMS.

All radiotherapy attendances should be reported to PHE using the radiotherapy attendance record and RTDS.

The Outpatient Commissioning Data Set (OPCDS) can be generated from the Radiotherapy Attendance Record by filtering records with ‘Yes’ in the outpatient attendance indicator field.

The Commissioning Data Set (CDS) for admitted patients receiving radiotherapy should be generated through PAS in the normal way.

5. Requirements – Oncology System Suppliers

5.1 Requirements

System suppliers MUST ensure that the Oncology Management systems are capable of recording the data required for the information standard.

System suppliers MUST support data extraction required for RTDS, this MAY be by the provision of standard reporting for extraction, or MAY be by the provision of user definable reporting.

System suppliers SHOULD liaise with NCRS regarding any changes to systems which may have an impact on RTDS.

New system suppliers MUST liaise with NCRS before implementation of extraction of RTDS from systems.

5.2 Conformance criteria

Criterion	Measure	Response
Overall	System suppliers are required to demonstrate that every field in the data set can be recorded and exported at the correct level of aggregation, using appropriate codes and formats.	This should be tested by auditing real patient data against the expected outputs from the information standard. Real patient data should include patients with multiple concurrent and consecutive prescriptions for treatment.
Aggregation	Oncology Management Systems (OMSs) must contain records stored at each level of aggregation as required by the RTDS (Patient, Attendance, Episode, Prescription, Exposure).	System suppliers must provide an indication of a level of aggregation in the OMS, which is equivalent to: Patient, Attendance, Episode, Prescription, and Exposure.
Data Items	OMSs must contain matching fields that will store defined data to support a defined extract. Each data item must be at the correct level of aggregation.	System suppliers must provide an indication of a field in the OMS that is equivalent to each of the fields specified in the defined extract, and which is held at the correct level of aggregation.
Coding	OMSs must include every coded field, populated with a list of values which can be directly and unequivocally mapped to the codes in the NHS Data Model and Dictionary.	System suppliers must provide a list of codes used in their system in the fields which are equivalent to those in the OMS extract, and which are coded in the RTDS. Each list of codes must include details of its direct or unequivocal mapping to the codes in the NHS Data Model and Dictionary.
Formats	OMSs must include each field so that data can be entered and exported with the correct format (eg date).	System suppliers must demonstrate that each field can be exported in the format specified in the OMS extract definition.
The key words MUST, SHOULD and MAY follow definitions in rfc21194.		

[4] https://www.ietf.org/rfc/rfc2119.txt

6. Requirements – PHE

Each of the data items submitted by providers will be subject to validation and quality assurance checks. A list of these checks is included in Section 10. The Requirements Specification and the Implementation Guidance will be available to all providers and maintained to continue to inform and underpin the extraction, submission and validation process.

When a file is uploaded through the submissions portal an instant report will be provided to the submitter. This will allow the provider to correct any errors that are identified or to re-submit the file within the agreed timetable.

Record level detail will be provided to providers to allow errors to be located on local systems and rectified.

PHE will produce regular information reports on the data received from the Radiotherapy providers. The range of reports will include:

National Reports
Number of Linacs in Use
Age Profile of Linacs
Attendances per m pop by Network
Attendances per m pop by Provider
Linacs per m pop
Machine Attendances per Linac
Opening Hours by Provider
Percentage of IMRT Episodes by Provider
Attendances
Attendances by Machine Type per Provider
Attendances by Network of Patient
Attendances by Network of Patient
Attendances by PCT in Network of Patient with Provider
Attendances by Provider
Attendances by Provider in Network
Attendances for Provider by CCG
Attendances for Provider by PCT
Episodes
Episodes by Network of Patient
Episodes by PCT
Episodes by PCT in Network of Patient
Episodes by Provider
Episodes by Provider in Network

Machine Attendances

Machine Attendances by Machine
Machine Attendances by Machine Identifier and Day of Week
Machine Attendances by Machine Identifier in Network of Provider

Prescriptions

Prescriptions by Network of Patient
Prescriptions by Provider
Prescriptions by Provider in Network

Productivity

HRG Preparation Code
HRG Treatment Code
OPCS Codes
Working Day Profile of Linear Accelerator
IMRT by Provider

7. RTDS Submissions Schedule 2016/17

Data month	Submission date for quality assurance	Submission deadline
April 2016	20/05/16	27/05/16
May 2016	21/06/16	28/06/16
June 2016	21/07/16	26/07/16
July 2016	19/08/16	26/08/16
August 2016	21/09/16	28/09/16
September 2016	21/10/16	28/10/16
October 2016	21/11/16	28/11/16
November 2016	21/12/16	30/12/16
December 2016	21/01/17	28/01/17
January 2017	22/02/17	01/03/17
February 2017	21/03/17	28/03/17
March 2017	21/04/17	28/04/17

8. Radiotherapy Data Set

V5.0 Summary of Format Changes		
Description	Current Format	Required Format
radiotherapy Diagnosis (ICD-10 Code)	an6	min an4 max an6
radiotherapy Anatomical Treatment Site (OPCS-4 Code)	an6	an4

RADIOTHERAPY ATTENDANCE RECORD – formed of the OPCDS v6.2 plus

8.1 DATA GROUP: RADIOTHERAPY ATTENDANCE: To carry the details of whether the Radiotherapy Attendance requires an Outpatient Attendance Record.

A radiotherapy attendance is one visit by a patient to receive radiotherapy, normally once a weekday. The attendances may involve treatment being given on different machines and to several areas

No	Name	Format	Values	NHS Data Model and Dictionary Definition
M	OUTPATIENT ATTENDANCE INDICATOR (RADIOTHERAPY DATASET)	Alpha (1)	Y – Yes N - No	An indication of whether the Radiotherapy Attendance requires and Out-patient Attendance record for the purposes of the Radiotherapy Data Set

8.2 DATA GROUP: RADIOTHERAPY EPISODE
To carry the details of the Episode of radiotherapy being given at this attendance.

No	Name	Format	Size	Definition	Codes	Values	New or Existing	Source Dataset	Notes
RE1	RADIOTHERAPY EPISODE IDENTIFIER	Alphanumeric	an50	Any identifier that is unique for each radiotherapy episode.			Existing	RTDS	
RE2	DECISION TO TREAT DATE (RADIOTHERAPY TREATMENT EPISODE)	Date	ccyy-mm-dd	The date on which it was decided that the PATIENT required a specific Planned Cancer Treatment. This is the date that the consultation between the PATIENT and the clinician took place and a Planned Cancer Treatment was agreed			Existing	COSD	This is the date the clinician and patient agree that this course of radiotherapy needs to be given.
RE3	EARLIEST CLINICALLY APPROPRIATE DATE	Date	ccyy-mm-dd	This is the first date that the patient would have been available to start radiotherapy			Existing	RTDS	Same as the Decision to Treat Date unless there was an elective delay for clinical or social reasons. Also known as “Ready to Start”date
RE4	RADIOTHERAPY PRIORITY	Alphanumeric	an1	The priority for this course of therapy as classified by the requesting clinician	E U R D		Existing	RTDS	https://www.rcr.ac.uk/docs/oncology/pdf/BFCO(08)6_Interruptions.pdf
RE5	TREATMENT START DATE (RADIOTHERAPY TREATMENT EPISODE)	Date	ccyy-mm-dd	The start of a stay, an episode, period covered by a plan or other time period. This may be used to calculate the length of the period, or to classify by financial year or other time-based criterion.			Existing	RTDS	Date of First Fraction of radiotherapy in this episode.
RE6	RADIOTHERAPY DIAGNOSIS (ICD)	Alphanumeric	Min an4/Max an6	This is the PATIENT DIAGNOSIS for: i. Patients with cancer, the primary tumour diagnosis code or ii non-cancer diagnoses, the main condition being treated during			Existing		

				the episode of radiotherapy *Note: The definition of this field is different from that of the Primary Diagnosis in CDS.*					
No	**Name**	**Format**	**Size**	**Definition**	**Codes**	**Values**	**New or Existing**	**Source Dataset**	**Notes**
RE7	RADIOTHERAPY INTENT	Alphanumeric	an2	The intent of the delivered beam radiation	01 02 03	Palliative Anti-Cancer Other	Existing	Cancer Waiting times	Code 01 to be used for palliative Code 02 to be used for radical

8.3 DATA GROUP: RADIOTHERAPY PRESCRIPTION
To carry the details of each Prescription of radiotherapy being given at this attendance.
Multiple Occurrences of this group are allowed

No	**Name**	**Format**	**Size**	**Definition**	**Codes**	**Values**	**New or Existing**	**Source Dataset**	**Notes**
RP1	PRESCRIPTION IDENTIFIER	Alphanumeric	an50	Any identifier that is unique for each radiotherapy prescription.			Existing	RTDS	
RP2	RADIOTHERAPY TREATMENT REGION	Alphanumeric	an2	The specific area to be treated with radiotherapy.	P - Primary PR - Primary & Regional Nodes R – Regional Nodes A – Non-anatomically specific primary site O – Prophylactic (to non primary site) M – Prophylactic (to non-primary site metastasis		Existing	RTDS	
RP3	ANATOMICAL TREATMENT SITE (RADIOTHERAPY)	Alphanumeric	an4	The part of the body to which the RADIOTHERAPY ACTUAL DOSE is	OPCS4 'Z' code for anatomical		Existing	RTDS	Only to be complete for entries A, O or M in 'Treatment Region field

				administered.	site				
No	**Name**	**Format**	**Size**	**Definition**	**Codes**	**Values**	**New or Existing**	**Source Dataset**	**Notes**
RP4	NUMBER OF TELETHERAPY FIELDS	Numeric	n2	The prescribed number of fields of a Teletherapy Treatment Course.			Existing	RTDS	The number of fields prescribed in this prescription.
RP5	RADIOTHERAPY PRESCRIBED DOSE	Numeric	maxn3. maxn2	The total prescribed absorbed radiation dose in Gray			Existing	RTDS	ICRU50 ref pt - prescribed dose in Gy for the whole prescription. recording-and-reporting-photon-beam-therapy-report-62
RP6	PRESCRIBED FRACTIONS	Numeric	n3	The prescribed number of Fractions or hyperfractionation of a Teletherapy Treatment Course			Existing	RTDS	
RP7	RADIOTHERAPY ACTUAL DOSE	Numeric	maxn3. maxn2	The total actual absorbed radiation dose given in Grays.			Existing	RTDS	ICRU50 ref pt – the total actual adsorbed dose in Gy for the whole prescription. http://www.icru.org/home/reports/prescribing-recording-and-reporting-photon-beam-therapy-report-62 This item may be omitted from all but the ultimate fraction for this prescription.
RP8	ACTUAL FRACTIONS	Numeric	n2	The total number of Fractions or hyperfractionation of a Teletherapy Treatment Course administered			Existing	RTDS	The total number of fractions or hyperfractions for the whole prescription. This item may be omitted from all but the ultimate fraction for this prescription.

No	Name	Format	Size	Definition	Codes	Values	New or Existing	Source Dataset	Notes
RP9	RADIOTHERAPY TREATMENT MODALITY	Alphanumeric	an1	Identifies each record as a 'Teletherapy' or 'Brachytherapy' record	05 06	Tele therapy Brachy therapy	Existing	RTDS	Identifies prescription as a Teletherapy or Brachytherapy data set

8.4 CDS DATA GROUP: RADIOTHERAPY EXPOSURE
To carry the details of each radiotherapy exposure delivered at this attendance.
Multiple Occurrences of this group are allowed

No	Name	Format	Size	Definition	Codes	Values	New or Existing	Source Dataset	Notes
RX1	RADIOTHERAPY FIELD IDENTIFIER	Alphanumeric	an50				Existing	RTDS	An identifier that is unique for each radiotherapy exposure.
RX2	MACHINE IDENTIFIER	Alphanumeric	an12	A unique code ascribed to the radiotherapy equipment used to treat this exposure.	R A-9 A-9 0-1 0-1 LA/CO/KV/OT 1-9 1-9 1-9 1-9		Existing	RTDS	Five character site code & two character equipment type code & sequence number for this machine issued by NATCANSAT.
RX6	RADIOISOTOPE	Alphanumeric	an6	The type of radioactive source used to deliver radiotherapy with brachytherapy			Existing		To record the isotope in standard scientific notation (eg: I123 or Ir192)
RX3	RADIOTHERAPY BEAM TYPE	Alphanumeric	2an	The prescribed type of beam of a Teletherapy Treatment Course.	T1 T2 T3	Photons Electrons Other	Existing	RTDS	
No	**Name**	**Format**	**Size**	**Definition**	**Codes**	**Values**	**New or Existing**	**Source Dataset**	**Notes**

RX4	RADIOTHERAPY BEAM ENERGY	Numeric	maxn3. maxn3	The prescribed energy of a Teletherapy Treatment Course.			Existing	RTDS	Beam energy in MeV/MV/MVp. Please record kVp energies as decimals (eg 250kV = 0.25MV). Only for multi-modality machines.
RX5	TIME OF EXPOSURE	Time	Hh:mm :ss (8)	Time when the exposure was initiated			Existing	RTDS	

9. Commissioning Data Set (CDS)

Based on CDS6.2 Outpatient section

9.1 CDS DATA GROUP: PATIENT PATHWAY:
To carry the details of the Patient Pathway.
One optional occurrence of this Group is permitted

No	Name	Format	Size	Definition	Codes	Values	New or Existing	Source Dataset	Notes
PP1	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	Numeric	n12	The unique booking reference number assigned by the Choose and Book system when a PATIENT accepts an APPOINTMENT DATE OFFERED of an APPOINTMENT OFFER where the offer was made via the Choose and Book system.			Existing	CDS	Please submit either the Unique Booking Reference Number or the Patient Pathway Identifier (below)
PP2	PATIENT PATHWAY IDENTIFIER	Alphanumeric	an20	An identifier, which together with the ORGANISATION CODE of the issuer, uniquely identifies a PATIENT PATHWAY.			Existing	CDS	Please submit either the Unique Booking Reference Number (above) or the Patient Pathway Identifier
PP3	ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	Alphanumeric	an5 (max)	This is the ORGANISATION CODE of the ORGANISATION issuing the PATIENT PATHWAY IDENTIFIER.			Existing	CDS	
PP4	REFERRAL TO TREATMENT PERIOD STATUS	Alphanumeric	an2	The status of an ACTIVITY (or anticipated ACTIVITY) for the 18 week REFERRAL TO TREATMENT PERIOD decided by the lead CARE PROFESSIONAL.	10 11 12 20 21	first Active Monitoring end CONSULTANT or NHS Allied Health Professional Service Subsequent ACTIVITY further ACTIVITIES anticipated Transfer to another Health Care Provider -	Existing	CDS	

						subsequent ACTIVITY by another Health Care Provider anticipated Start of First Definitive Treatment			
					30	Start of Active Monitoring initiated by the PATIENT			
					31	Start of Active Monitoring initiated by the CARE PROFESSIONAL			
					32	Did not attend - the PATIENT did not attend the first CARE ACTIVITY after the referral[1] Decision not to treat			
					33	PATIENT declined offered treatment PATIENT died before treatment			
					34	After treatment - First Definitive Treatment occurred previously			
					35	Active Monitoring			
					36	not yet referred			
					90	not applicable			
					91	not yet known			
					92				

					98 99				
No	**Name**	**Format**	**Size**	**Definition**	**Codes**	**Values**	**New or Existing**	**Source Dataset**	**Notes**
PP7	WAITING TIME MEASUREMENT TYPE	Alphanumeric	an2	The type of waiting time measurement methodology which may be applied during a PATIENT PATHWAY. The methodology applied may be for one part of a PATIENT PATHWAY, such as the measurement of a REFERRAL TO TREATMENT PERIOD, or other parts of the PATIENT PATHWAY according to Department of Health policy.	01 02 09	Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement Allied Health Professional Referral To Treatment Measurement Other Referral To Treatment Measurement Type	New in CDS v6.2	CDS	Record 01 Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement
PP5	REFERRAL TO TREATMENT PERIOD START DATE	Date	ccyy-mm-dd	One of the following: • the REFERRAL REQUEST RECEIVED DATE of a SERVICE REQUEST for a particular condition • the ACTIVITY DATE of ACTIVITY when a PATIENT has rebooked following the PATIENT not attending an appointment or admission. See REFERRAL TO TREATMENT PERIOD for guidance on DNA. • the ACTIVITY DATE of a CARE ACTIVITY when a decision to treat or refer for diagnostic tests was made following a period of active monitoring and the REFERRAL TO			Existing	CDS	

				TREATMENT PERIOD STATUS is '*active monitoring end*' • the REFERRAL REQUEST RECEIVED DATE of a SERVICE REQUEST when a decision has been made to refer the PATIENT directly to another consultant for a separate condition (the REFERRAL TO TREATMENT PERIOD STATUS for the first CARE ACTIVITY with the other CONSULTANT is '*consultant referral*').					
No	**Name**	**Format**	**Size**	**Definition**	**Codes**	**Values**	**New or Existing**	**Source Dataset**	**Notes**
PP6	REFERRAL TO TREATMENT PERIOD END DATE	Date	ccyy-mm-dd	REFERRAL TO TREATMENT PERIOD END DATE will be one of the following: • the ACTIVITY DATE: when the PATIENT is admitted for First Definitive Treatment. If the start of a PATIENT's treatment is cancelled (by the Health Care Provider or PATIENT) after admission, the REFERRAL TO TREATMENT PERIOD will continue. for First Definitive Treatment undertaken in an outpatient setting. for First Definitive Treatment undertaken by an NHS Allied Health Professional Service (Referral To Treatment			Existing	CDS	

				Measurement). when the decision not to treat is made, with no further action at this time communicated to the PATIENT. This will include Discharge After Patient Did Not Attend and discharge back to primary care for treatment. when the PATIENT declines offered treatment. when the PATIENT did not attend for the first ACTIVITY during a REFERRAL TO TREATMENT PERIOD. See REFERRAL TO TREATMENT PERIOD for guidance on PATIENTS who do not attend. the clinical decision is made (and agreed with the PATIENT) that Active Monitoring will begin. If a PATIENT subsequently requires further treatment this decision would start a new REFERRAL TO TREATMENT PERIOD as part of the same PATIENT PATHWAY. This includes any treatment that is planned for a specific date in the future as ongoing monitoring. a clinical decision is made and has been communicated to the PATIENT, and subsequently their GENERAL PRACTITIONER and/or other referring CARE PROFESSIONAL without undue delay, to add the PATIENT to a transplant list. **or**					

				• the PERSON DEATH DATE. In the event that a PATIENT is booked into the wrong clinic and needs to be re-referred to the right one, this will not end the REFERRAL TO TREATMENT PERIOD or restart it. The start of the REFERRAL TO TREATMENT PERIOD is still the original REFERRAL REQUEST RECEIVED DATE.					

9.2 CDS DATA GROUP: PATIENT WITHHELD IDENTITY:
Must be used where the Commissioning Data Set record has been anonymised.
http://www.datadictionary.nhs.uk/web_site_content/cds_supporting_information/security_issues_and_patient_confidentiality.asp?shownav=1
One occurrence of this Group is permitted.

No	Name	Format	Size	Definition	Codes	Values	New or Existing	Source Dataset	Notes
PI4	NHS NUMBER STATUS INDICATOR CODE	Alphanumeric	an2		01 02 03 04 05 06 07 08	Number present and verified Number present but not traced Trace required Trace attempted - No match or multiple match found Trace needs to be resolved - (NHS Number or patient detail conflict) Trace in progress Number not present and trace not required Trace postponed (baby under six weeks old)	Existing	CDS	Indicates the status of the NHS number
PI8	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	Alphanumeric	an3	The ORGANISATION CODE derived from the PATIENT's POSTCODE OF USUAL ADDRESS, where they reside within the boundary of a relevant organisation			Existing	CDS	

No	Name	Format	Size	Definition	Codes	Values	New or Existing	Source Dataset	Notes
P19	WITHHELD IDENTITY REASON	Alphanumeric	an2		01 02 03 97	Record anonymised for legal/statutory reasons Record anonymised at request of Caldicott Guardian Record anonymised at request of PATIENT Record anonymised for other reason			

9.3 CDS DATA GROUP: PATIENT VERIFIED IDENTITY:
To carry the identity of the Patient. Must be used where the NHS NUMBER STATUS INDICATOR CODE Code Value = 01 (Number present and verified)
http://www.datadictionary.nhs.uk/web_site_content/cds_supporting_information/security_issues_and_patient_confidentiality.asp?shownav=1
One occurrence of this Group is permitted.

No	Name	Format	Size	Definition	Codes	Values	New or Existing	Source Dataset	Notes
PI1	LOCAL PATIENT IDENTIFIER	Alphanumeric	an10 (max)	This number is used to identify a PATIENT uniquely within a Health Care Provider. It may be different from the PATIENT's casenote number and may be assigned automatically by the computer system.			Existing	CDS	Data item can be used to link records from PAS and OMS
PI2	ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	Alphanumeric	an5 (max)	This is the ORGANISATION CODE of the ORGANISATION that assigned the LOCAL PATIENT IDENTIFIER.			Existing	CDS	3 digit Organisation code
PI3	NHS NUMBER	Numeric	an10	A number used to identify a person uniquely within the NHS in England and Wales			Existing	CDS	Data item can be used to link records from PAS and OMS
No	Name	Format	Size	Definition	Codes	Values	New or Existing	Source Dataset	Notes

PI4	NHS NUMBER STATUS INDICATOR CODE	Alphanumeric	an2		01 02 03 04 05 06 07 08	Number present and verified Number present but not traced Trace required Trace attempted - No match or multiple match found Trace needs to be resolved - (NHS Number or patient detail conflict) Trace in progress Number not present and trace not required Trace postponed (baby under six weeks old)	Existing	CDS	Indicates the status of the NHS number
PI7	POSTCODE OF USUAL ADDRESS	Alphanumeric	an8 (max)	This is the usual ADDRESS nominated by the PATIENT, with ADDRESS ASSOCIATION TYPE of 'Main Permanent Residence' or 'Other Permanent Residence'. For CDS functionality see ADDRESS FORMAT CODE.			Existing	CDS	
PI8	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	Alphanumeric	an3	The ORGANISATION CODE derived from the PATIENT's POSTCODE OF USUAL ADDRESS, where they reside within the boundary of a relevant organisation			Existing	CDS	
PC1	PERSON BIRTH DATE	Date	ccyy-mm-dd	The date on which a person was born or is officially deemed to have been born.			Existing	CDS	Data item can be used in conjunction with others to link records from PAS and OMS

9.4 CDS DATA GROUP: PATIENT UNVERIFIED IDENTITY:
To carry the identity of the Patient. Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE NOT included in the above
http://www.datadictionary.nhs.uk/web_site_content/cds_supporting_information/security_issues_and_patient_confidentiality.asp?shownav=1
One occurrence of this Group is permitted.

No	Name	Format	Size	Definition	Codes	Values	New or Existing	Source Dataset	Notes
PI1	LOCAL PATIENT IDENTIFIER	Alphanumeric	an10 (max)	This number is used to identify a PATIENT uniquely within a Health Care Provider. It may be different from the PATIENT's casenote number and may be assigned automatically by the computer system.			Existing	CDS	Data item can be used to link records from PAS and OMS
PI2	ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	Alphanumeric	an5 (max)	This is the ORGANISATION CODE of the ORGANISATION that assigned the LOCAL PATIENT IDENTIFIER.			Existing	CDS	3 digit Organisation code
PI3	NHS NUMBER	Numeric	n10	A number used to identify a person uniquely within the NHS in England and Wales			Existing	CDS	Data item can be used to link records from PAS and OMS
PI4	NHS NUMBER STATUS INDICATOR CODE	Alphanumeric	an2		01 02 03 04 05 06 07 08	Number present and verified Number present but not traced Trace required Trace attempted - No match or multiple match found Trace needs to be resolved - (NHS Number or patient detail conflict) Trace in progress Number not present and trace not required Trace postponed (baby under six weeks old)	Existing	CDS	Indicates the status of the NHS number
PI5	PATIENT NAME - PERSON NAME STRUCTURED Or PATIENT NAME - PERSON NAME UNSTRUCTURED	Alphanumeric	an70 (max)	This is the PERSON NAME where the PERSON NAME CLASSIFICATION equals classification '*a. Preferred Name*' of the PATIENT. NAME FORMAT			Existing	CDS	

				CODE indicates whether it is a PERSON NAME STRUCTURED or PERSON NAME UNSTRUCTURED.					
PI6	PATIENT USUAL ADDRESS - ADDRESS STRUCTURED (Label format Postal Address) **OR** PATIENT USUAL ADDRESS - ADDRESS UNSTRUCTURED (Character string)	Alphanumeric	an175 (max)	This is the usual ADDRESS nominated by the PATIENT, with ADDRESS ASSOCIATION TYPE of 'Main Permanent Residence' or 'Other Permanent Residence'. For CDS functionality see ADDRESS FORMAT CODE.			Existing	CDS	
PI7	POSTCODE OF USUAL ADDRESS	Alphanumeric	an8 (max)	This is the usual ADDRESS nominated by the PATIENT, with ADDRESS ASSOCIATION TYPE of 'Main Permanent Residence' or 'Other Permanent Residence'. For CDS functionality see ADDRESS FORMAT CODE.			Existing	CDS	
PI8	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	Alphanumeric	an3	This is the ORGANISATION CODE of the ORGANISATION that the PATIENT resides in.	5 A-9 A-9		Existing	CDS	
PC1	PERSON BIRTH DATE	Date	ccyy-mm-dd	The date on which a person was born or is officially deemed to have been born.			Existing	CDS	Data item can be used in conjunction with others to link records from PAS and OMS

9.5 CDS DATA GROUP: PATIENT CHARACTERISTICS:
To carry the characteristics of the Patient.
One occurrence of this Group is permitted

No	Name	Format	Size	Definition	Codes	Values	New or Existing	Source Dataset	Notes
PC2	PERSON GENDER CODE CURRENT	Alphanumeric	an1	A PERSON's gender currently.	0 1 2 9	Not Known Male Female Not specified	Existing	CDS	The classification is phenotypical rather than genotypical, i.e. it does not provide codes for medical or scientific purposes Data item can be used to link records from PAS and OMS
No	**Name**	**Format**	**Size**	**Definition**	**Codes**	**Values**	**New or Existing**	**Source Dataset**	**Notes**
PC3	CARER SUPPORT INDICATOR	Alphanumeric	an2	An indication of whether or not carer support is available to the PATIENT at their normal residence.	01 02	Yes No	Existing	CDS	
PC4	ETHNIC CATEGORY	Alphanumeric	an2	The ethnicity of a PERSON, as specified by the PERSON.	A B C D E F G H J K L M N P R S Z	British Irish Any other White background White and Black Caribbean White and Black African White and Asian Any other mixed background Indian Pakistani Bangladeshi Any other Asian background Caribbean African Any other Black background Chinese			

						Any other ethnic group Not stated			

9.6 CDS DATA GROUP: CARE EPISODE - Person Group (Consultant):
To carry the details of the responsible Consultant.
One occurrence of this Group is permitted

No	Name	Format	Size	Definition	Codes	Values	New or Existing	Source Dataset	Notes
CO1	CONSULTANT CODE	Alphanumeric	an8	A default code is used in the CONSULTANT CODE field to show that a RADIOGRAPHER is the responsible professional. Note that the radiographer's own code is not used.			Existing	CDS	Record **H9999998** – *Other health care professional*
CO2	CARE PROFESSIONAL MAIN SPECIALTY CODE	Numeric	n3	This is the specialty in which the CONSULTANT is contracted or recognised			Existing	CDS	Record **960** – Allied Health Care Professional
CO3	ACTIVITY TREATMENT FUNCTION CODE	Alphanumeric	an6	This is the TREATMENT FUNCTION under which the PATIENT is treated.			Existing	CDS	Record **800** - Clinical Oncology
CO4	LOCAL SUB-SPECIALTY CODE	Alphanumeric	an8	A unique identifier for a LOCAL SUB-SPECIALTY.			New in CDS v6.2	CDS	*Omit*

9.7 CDS DATA GROUP: CARE EPISODE - CLINICAL DIAGNOSIS (ICD):
To carry the details of the ICD Diagnosis Scheme and the Diagnoses.

No	Name	Format	Size	Definition	Codes	Values	New or Existing	Source Dataset	Notes
CD1	DIAGNOSIS SCHEME IN USE	Alphanumeric	an2	This denotes the Coding Scheme basis of the Diagnosis			Existing	CDS	Record **02 -** ICD10
CD2	PRIMARY DIAGNOSIS (ICD)	Alphanumeric	an6 (max)	The main condition treated or investigated during the relevant episode of healthcare, and where there is no definitive diagnosis, the main symptom, abnormal findings or			Existing	CDS	

				problem					
CD4	PRESENT ON ADMISSION INDICATOR	Alphanumeric	an1	An indication of whether a PATIENT DIAGNOSIS was already present when the PATIENT started a Hospital Provider Spell.	Y N	PATIENT DIAGNOSIS already present PATIENT DIAGNOSIS not already present			*Not yet approved - Omit (Default Y-patients receiving radiotherapy will always have a diagnosis)*
No	**Name**	**Format**	**Size**	**Definition**	**Codes**	**Values**	**New or Existing**	**Source Dataset**	**Notes**
CD3	SECONDARY DIAGNOSIS (ICD)	Alphanumeric	an6 (max)				Existing	CDS	*Omit (not required)*
CD5	PRESENT ON ADMISSION INDICATOR	Alphanumeric	an1	An indication of whether a PATIENT DIAGNOSIS was already present when the PATIENT started a Hospital Provider Spell.	Y N	PATIENT DIAGNOSIS already present PATIENT DIAGNOSIS not already present			*Omit (not required)*

9.8 CDS DATA GROUP: CARE EPISODE - CLINICAL DIAGNOSIS (READ):
To carry the details of the READ Diagnosis Scheme and the Diagnoses.

No	Name	Format	Size	Definition	Codes	Values	New or Existing	Source Dataset	Notes
CD6	DIAGNOSIS SCHEME IN USE	Alphanumeric	an2				Existing	CDS	*Omit (ICD10 codes to be used)*
CD7	PRIMARY DIAGNOSIS (READ)	Alphanumeric	an6				Existing	CDS	*Omit (ICD10 codes to be used))*
CD8	SECONDARY DIAGNOSIS (READ) Multiple Secondary Diagnoses may be recorded.	Alphanumeric	an6				Existing	CDS	*Omit (ICD10 codes to be used)*

9.9 CDS DATA GROUP: CARE ATTENDANCE - Activity Characteristics:
To carry the details of the Care Attendance or missed or cancelled appointment.

No	Name	Format	Size	Definition	Codes	Values	New or Existing	Source Dataset	Notes
AC1	ATTENDANCE IDENTIFIER	Alphanumeric	an12 (max)	A sequential number or time of day used to enable an attendance to be uniquely identified.			Existing	CDS	
AC2	ADMINISTRATIVE CATEGORY CODE	Alphanumeric	an2	This records category of PATIENT for this event whether NHS or private health care.	01 02 03 04		Existing	CDS	*01=NHS, 02=PP, 03=Amenity, 04=Cat II*
AC3	ATTENDED OR DID NOT ATTEND CODE	Alphanumeric	an1	This indicates whether or not an APPOINTMENT for a CARE CONTACT took place.			Existing	CDS	Record **5** – Attended (where the event triggering the attendance record is the administration of a radiotherapy exposure) Record Did Not Attend also
AC4	FIRST ATTENDANCE CODE	Numeric	an1	Indicates whether a PATIENT is making a FIRST ATTENDANCE or follow-up attendance or contact ()	1 2		Existing	CDS	***1****=yes for first visit,* ***2****= subsequent / follow up* where this is a subsequent event in an OP series but the first in radiotherapy 2 should be recorded
AC5	MEDICAL STAFF TYPE SEEING PATIENT	Alphanumeric	an2	A classification of the type of medical staff seeing the PATIENT	1		Existing	CDS	Record **03** Lead care Professional Record **04** – Care Professional team
AC6	OPERATION STATUS CODE	Alphanumeric	an1	Used once for each record to record states of knowledge regarding the operative procedure.			Existing	CDS	Record **8** – No Operative procedure carried out
AC7	OUTCOME OF ATTENDANCE CODE	Alphanumeric	an1	This records the outcome of an OUT-PATIENT ATTENDANCE CONSULTANT.	1 2 3		Existing	CDS	***1****=discharged,* ***2****= another appointment given;****3*** *Appointment to*

									be made at a later date
AC8	APPOINTMENT DATE	Date	ccyy-mm-dd	Date when PATIENT is to be seen by or be in contact with one or more CARE PROFESSIONALS.			Existing	CDS	*format CCYY-MM-DD*
AC11	APPOINTMENT TIME	Time	hh:mm:ss	TIME is the time (using a 24 hour clock) at which an event, or the action in an event, takes place.			New in CDS v6.2	CDS	*Omit (recorded in detail in RTDS)*
No	**Name**	**Format**	**Size**	**Definition**	**Codes**	**Values**	**New or Existing**	**Source Dataset**	**Notes**
AC12	EXPECTED DURATION OF APPOINTMENT	Numeric	n3	EXPECTED DURATION OF APPOINTMENT is the expected duration in minutes of an APPOINTMENT when booked, prior to the attendance of the PATIENT.			New in CDS v6.2	CDS	*Omit (not required)*
AC9	AGE AT CDS ACTIVITY DATE	Numeric	n3	The number of completed years between the PERSON BIRTH DATE of the PATIENT and the CDS ACTIVITY DATE.			Existing	CDS	Derived from APPOINTMENT DATE minus PERSON BIRTH DATE If DOB is absent a default value of 999 is inserted.
AC10	OVERSEAS VISITOR STATUS CLASSIFICATION AT CDS ACTIVITY DATE	Alphanumeric	an1	A classification of OVERSEAS VISITOR STATUS.	1 2 3 4	Exempt from payment - subject to Reciprocal Healthcare Agreement Exempt from payment – other To pay hotel fees only To pay all fees	New in CDS v6.2	CDS	*Omit (not required)*
AC13	EARLIEST REASONABLE OFFER DATE	Date	ccyy-mm-dd	EARLIEST REASONABLE OFFER DATE is the date of the earliest of the Reasonable Offers made to a PATIENT for an APPOINTMENT or Elective Admission.			New in CDS v6.2	CDS	*Omit (not required)*
AC14	EARLIEST CLINICALLY APPROPRIATE DATE	Date	ccyy-mm-dd	EARLIEST CLINICALLY APPROPRIATE DATE is the earliest DATE that it was clinically appropriate for an ACTIVITY to take place.			New in CDS v6.2	CDS	*Omit (recorded in RTDS)*

AC15	CONSULTATION MEDIUM USED	Alphanumeric	an2	CONSULTATION MEDIUM USED identifies the communication mechanism used to relay information between the CARE PROFESSIONAL and the PERSON who is the subject of the consultation, during a CARE ACTIVITY.	01 02 03 04	Face to face communication Telephone Telemedicine web camera Talk type for a person unable to speak	New in CDS v6.2	CDS	*Omit (Default 01)*
No	**Name**	**Format**	**Size**	**Definition**	**Codes**	**Values**	**New or Existing**	**Source Dataset**	**Notes**
AC16	MULTI-PROFESSIONAL CONSULTATION (NATIONAL TARIFF PAYMENT SYSTEM)	Alphanumeric	an1	An indication of whether a PATIENT was seen by a single or multiple CARE PROFESSIONALS during a Clinic Attendance Consultant or Clinic Attendance Non-Consultant,. NATIONAL TARIFF PAYMENT SYSTEM	1 2 3	Uni-Professional Multi-Professional Consultation Multi-Disciplinary Consultation	New in CDS v6.2	CDS	
AC17	REHABILITATION ASSESSMENT TEAM TYPE	Alphanumeric	an1	An indication of whether the CARE PROFESSIONAL TEAM undertaking a Rehabilitation Assessment, is specialised or non-specialised. This information is recorded for the purposes of NATIONAL TARIFF PAYMENT SYSTEM	1 2	Specialised Rehabilitation Team Non-specialised Rehabilitation Team			

9.10 CDS DATA GROUP: CARE ATTENDANCE - Service Agreement Details:
To carry the details of the Service Agreement for the Care Attendance.

SA1	COMMISSIONING SERIAL NUMBER	Alphanumeric	an6 (max)	A number used to uniquely identify a NHS SERVICE AGREEMENT by an ORGANISATION acting as commissioner of patient care services.			Existing	CDS	
SA2	NHS SERVICE AGREEMENT LINE NUMBER	Alphanumeric	an10 (max)	A number (alphanumeric) to provide a unique identifier for a line within a NHS SERVICE AGREEMENT.			Existing	CDS	
SA3	PROVIDER REFERENCE NUMBER	Alphanumeric	an17 (max)	A convention agreed locally between a provider and Commissioner for use within a CDS			Existing	CDS	

				message.					
SA4	COMMISSIONER REFERENCE NUMBER	Alphanumeric	an17 (max)	A number (alphanumeric) allocated by the commissioner to a REFERRAL REQUEST			Existing	CDS	
SA5	ORGANISATION CODE (CODE OF PROVIDER)	Alphanumeric	an5 (max)	This is the ORGANISATION CODE of the ORGANISATION acting as a Health Care Provider.			Existing	CDS	
SA6	ORGANISATION CODE (CODE OF COMMISSIONER)	Alphanumeric	an5 (max)	This is the ORGANISATION CODE of the ORGANISATION commissioning health care			Existing	CDS	

9.11 CDS DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Activity Group (OPCS):
To carry the details of the OPCS coded Clinical Activities undertaken

No	Name	Format	Size	Definition	Codes	Values	New or Existing	Source Dataset	Notes
CA1	PROCEDURE SCHEME IN USE	Alphanumeric	an2	Used in the Clinical Activity Group of the CDS to denote the scheme basis of an Intervention, Operation or A&E Treatment.	01 02 03 04 05	A&E OPCS-4 READ4 READ5 Read3	Existing	CDS	Record **02** OPCS-4
CA2	PRIMARY PROCEDURE (OPCS)	Alphanumeric	an4	A unique identifier for a CLINICAL CLASSIFICATION			Existing	CDS	
CA2a	PROCEDURE DATE(of Primary Procedure)	Date	ccyy-mm-dd	The date of the occurrence of the CLINICAL INTERVENTION.					
CA7	PROFESSIONAL REGISTRATION ISSUER CODE	Alphanumeric	an2	A code which identifies the PROFESSIONAL REGISTRATION BODY or Representative Body.	02 03 08 09	General Dental Council General Medical Council Health and Care Professions Council Nursing and Midwifery Council			*Omit*
CA8	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER	Alphanumeric	an12	The registration identifier allocated by an ORGANISATION.					*Omit*

	(MAIN OPERATING CARE PROFESSIONAL)								
CA9	PROFESSIONAL REGISTRATION ISSUER CODE	Alphanumeric	an2	A code which identifies the PROFESSIONAL REGISTRATION BODY or Representative Body.	02 03 08 09	General Dental Council General Medical Council Health and Care Professions Council Nursing and Midwifery Council			*Omit*
No	**Name**	**Format**	**Size**	**Definition**	**Codes**	**Values**	**New or Existing**	**Source Dataset**	**Notes**
CA10	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)	Alphanumeric	an12 (max)	The registration identifier allocated by an ORGANISATION.	Alphanumeric	12			*Omit*
CA3	(Multiple Procedures may be recorded) PROCEDURE (OPCS)	Alphanumeric	an4	Procedure other than the PRIMARY PROCEDURE (OPCS), carried out and recorded for CDS or HES purposes.			Existing	CDS	
CA3a	(Multiple Procedures may be recorded) PROCEDURE DATE(of Secondary Procedure)	Date	ccyy-mm-dd	The date of the occurrence of the CLINICAL INTERVENTION.					
CA11	PROFESSIONAL REGISTRATION ISSUER CODE	Alphanumeric	an2	A code which identifies the PROFESSIONAL REGISTRATION BODY or Representative Body.	02 03 08 09	General Dental Council General Medical Council Health and Care Professions Council Nursing and Midwifery Council			*Omit*
CA12	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)	Alphanumeric	an12 (max)	The registration identifier allocated by an ORGANISATION.					*Omit*

CA13	PROFESSIONAL REGISTRATION ISSUER CODE	Alphanumeric	an2	A code which identifies the PROFESSIONAL REGISTRATION BODY or Representative Body.	02 03 08 09	General Dental Council General Medical Council Health and Care Professions Council Nursing and Midwifery Council			*Omit*
CA14	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)	Alphanumeric	an12 (Max)	The registration identifier allocated by an ORGANISATION.					*Omit*

9.12 CDS DATA GROUP: CARE ATTENDANCE - Clinical Activity Group (READ):

No	Name	Format	Size	Definition	Codes	Values	New or Existing	Source Dataset	Notes
CA4	PROCEDURE SCHEME IN USE	Alphanumeric	an2	Used in the Clinical Activity Group of the CDS to denote the scheme basis of an Intervention, Operation or A&E Treatment			Existing	CDS	***Omit*** *(OPCS4 codes to be used)*
CA5	PRIMARY PROCEDURE (READ)	Alphanumeric	an7				Existing	CDS	***Omit*** *(OPCS4 codes to be used)*
CA5a	PROCEDURE DATE (of Primary Procedure)	Date	ccyy-mm-dd				Existing	CDS	***Omit*** *(OPCS4 codes to be used)*
CA6	(Multiple Procedures may be recorded) PROCEDURE (READ)	Alphanumeric	an7				Existing	CDS	***Omit*** *(OPCS4 codes to be used)*
CA6a	PROCEDURE DATE (of Secondary Procedure)	Date	ccyy-mm-dd				Existing	CDS	***Omit*** *(OPCS4 codes to be used)*

9.13 CDS DATA GROUP: LOCATION GROUP - Attendance: To carry the details of the location and Site Code of Treatment.
One occurrence of this Group is permitted

No	Name	Format	Size	Definition	Codes	Values	New or Existing	Source Dataset	Notes

LO1	LOCATION CLASS	Alphanumeric	an2	For use within CDS messages of the physical location within which the recorded patient event occurs.	01 02 03 04 05		Existing	CDS	Record **01** – Health Site (General Occurrence)
LO2	SITE CODE (OF TREATMENT)	Alphanumeric	an9 (max)	ORGANISATION SITE where the PATIENT was treated.			Existing	CDS	
LO3	ACTIVITY LOCATION TYPE CODE	Alphanumeric	an6	A physical LOCATION where PATIENTS are seen or where services exist or from which requests for ACTIVITIES are sent			Existing	CDS	*Omit*
LO4	CLINIC CODE	Alphanumeric	an12 (Max)	An identifier for a CLINIC OR FACILITY.			New in CDS v6.2		*Omit (not relevant)*

9.14 CDS DATA GROUP: GP REGISTRATION:
To carry the details of the Patient's Registered GMP.
One occurrence of this Group is permitted.

No	Name	Format	Size	Definition	Codes	Values	New or Existing	Source Dataset	Notes
GP1	GENERAL MEDICAL PRACTITIONER (SPECIFIED)	Alphanumeric	an8	GMC Code of the GENERAL MEDICAL PRACTITIONER (GMP) with whom the PATIENT is registered.		G 0-9,0-9,0-9,0-9,0-9,0-9,0-9	Existing	CDS	Derived from DOCTOR INDEX NUMBER - NHS Prescription Services add leading G and a check digit. Associated with practice.
GP2	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	Alphanumeric	ands6	Code of the practice of the GENERAL MEDICAL PRACTITIONER (GMP) with whom the PATIENT is registered.			Existing	CDS	The ORGANISATION CODE of the GP Practice that the PATIENT is registered with. V81997 - No Registered GP Practice V81998 - GP Practice Code not applicable V81999 - GP Practice Code not known

9.15 CDS DATA GROUP: ACTIVITY CHARACTERISTICS - Referral:
To carry the details of the referral.
One occurrence of this Group is permitted.

No	Name	Format	Size	Definition	Codes	Values	New or Existing	Source Dataset	Notes
RF1	PRIORITY TYPE CODE	Alphanumeric	an1	This is the priority of a request for services	1 2	Routine Urgent	Existing	CDS	
RF2	SERVICE TYPE REQUESTED CODE	Alphanumeric	an1	The terms of reference for the REFERRAL REQUEST	1 2 3	Advice/consultation Specific procedure Other	Existing	CDS	Record **2** – Specific Procedure
RF3	SOURCE OF REFERRAL FOR OUT-PATIENTS	Alphanumeric	an2	A CLASSIFICATION which is used to identify the source of referral of each Consultant Out-Patient Episode.			Existing	CDS	Record **05** – referral from a consultant, other than in A&E Dept
RF4	REFERRAL REQUEST RECEIVED DATE	Date	ccyy-mm-dd	This records the date the REFERRAL REQUEST was received by the Health Care Provider.			Existing	CDS	
RF5	DIRECT ACCESS REFERRAL INDICATOR	Alphanumeric	an1	An indication of whether a PATIENT was referred to a Direct Access Service.	Y N				*Omit(default N)*

9.16 CDS DATA GROUP: REFERRER:
To carry the details of the referrer.
One occurrence of this Group is permitted.

No	Name	Format	Size	Definition	Codes	Values	New or Existing	Source Dataset	Notes
RG 1	REFERRER CODE	Alphanumeric	an8	Code of the PERSON making the referral			Existing	CDS	Consultant Clinical Oncologist's GMC number
RG 2	REFERRING ORGANISATION CODE	Alphanumeric	an6 (max)	ORGANISATION from which the referral is made, such as GP Practice or NHS Trust			Existing	CDS	Record *Clinical Oncologist's Organisation*

9.17 CDS DATA GROUP: MISSED APPOINTMENT OCCURRENCE:
To carry the details of a missed appointment.
One occurrence of this Group is permitted.

No	Name	Format	Size	Definition	Codes	Values	New or Existing	Source Dataset	Notes
DN1	LAST DNA OR PATIENT CANCELLED DATE	Date	ccyy-mm-dd	This date is derived from OFFERED FOR ADMISSION DATE and ADMISSION OFFER OUTCOME			Existing	CDS	**Omit** (only attended records included where data is taken from radiotherapy systems)

9.18 DATA GROUP: RADIOTHERAPY ATTENDANCE
To carry the details of whether the Radiotherapy Attendance requires an Out-Patient Attendance record.
One Occurrence of this group is required.

No	Name	Format	Size	Definition	Codes	Values	New or Existing	Source Dataset	Notes
RT1	OUT-PATIENT ATTENDANCE INDICATOR (RADIOTHERAPY DATA SET)	Alpha	a1	An indication of whether the radiotherapy Attendance requires an Out-Patient Attendance record for the purposes of the Radiotherapy Data Set.	Y N	Yes No	New		NOT A CDS6.2 FIELD A flag to indicate whether the patient was an out-patient for this radiotherapy attendance.

RADIOTHERAPY DATASET – to form a tail for each radiotherapy attendance record

9.19 DATA GROUP: ATTENDANCE IDENTIFICATION To carry the details of the attendance identification, which may be used for Commissioning Data Set (CDS) linkage.									
No	**Name**	**Format**	**Size**	**Definition**	**Codes**	**Values**	**New or Existing**	**Source Dataset**	**Notes**
RT1	ATTENDANCE IDENTIFIER	Alphanumeric	an12	Sequential number or time of day used to enable an attendance to be uniquely identified.			Existing	CDS	
RT2	ORGANISATION CODE	Alphanumeric	an5	A code which identifies an ORGANISATION uniquely.	R A-9 A-9		Existing	CDS	
RT3	APPOINTMENT DATE	Date	ccyy-mm-dd	An arrangement for a PATIENT to be seen by or be in contact with one or more CARE PROFESSIONALS.			Existing	CDS	Date of patient's attendance for radiotherapy

10. Quality Assurance Checks

Critical checks in **Red**: Submissions that fail any of the critical checks will be rejected.

QA Field(s)	Type of Test	Critical	QA Test Name	Validation rule
ACTUAL FRACTIONS	Validation		RTDSPrescriptions ACTUAL FRACTIONS validation	Should only be present For final fraction of a prescription. IF present, must be>=0 and < 101.
ACTUAL FRACTIONS. PRESCRIBED FRACTIONS	Consistency	Critical	ACTUAL FRACTIONSLessThanPRESCRIBED FRACTIONS	Where both values present and numeric, ACTUAL FRACTIONS value must not exceed the
ADMINSTRATIVE CATEGORY	Validation		OPCDS ADMINISTRATIVE CATEGORY validation	01', '02', '03' or '04'
AGE AT CDS ACTIVITY DATE	Validation		OPCDS AGE AT CDS ACTIVITY DATE validation	Between 0 and 120
ALL FIELDS [OPCDS]	Completeness		OPCDS: all fields completed	
ALL FIELDS [OPCDSProcedures]	Completeness		OPCDSProcedures: all fields completed	
ALL FIELDS [RTDSEpisodes]	Completeness		RTDSEpisodes: all Fields completed	
ALL FIELDS [RTDSExposures	Completeness		RTDSExposures: all fields completed	
ALL FIELDS [RTDSPrescriptions]	Completeness		RTDSPrescriptions: all Fields completed	
All OPCDS Fields	Uniqueness	Critical	OPCDS Unique records	Each record in the table differs from all others in at least one field value.
All OPCDSProcedures Fields	Uniqueness	Critical	OPCDSProcedures Unique records	Each record in the table differs from all others in at least one field value.
All RTDSEpisodes Fields	Uniqueness	Critical	RTDSEpisodes Unique records	Each record in the table differs from all others in at least one field value.
All RTDSExposures Fields	Uniqueness	Critical	RTDSExposures Unique records	Each record in the table differs from all others in at least one field value.
All RTDSPrescriptions Fields	Uniqueness	Critical	RTDSPrescriptions Unique records	Each record in the table differs from all others in at least one field value.
ANATOMICAL TREATMENT SITE (RADIOTHERAPY)	Validation		RTDSPrescriptions ANATOMICAL TREATMENT SITE (RADIOTHERAPY) validation	Alphanumeric beginning with 'Z' if RADIOTHERAPY TREATMENT REGION is 'A','O', or 'M', otherwise NULL.
APPOINTMENT DATE [OPCDSProcedures]	Validation	Critical	OPCDSProcedures APPOINTMENT DATE validation	Valid date in the past but after 2008-01-01 in 'yyyy-mm-dd' format.
APPOINTMENT DATE [OPCDS]	Validation	Critical	OPCDS APPOINTMENT DATE validation	Valid date in the past but after 2008-01-01 in 'yyyy-mm-dd' format.
APPOINTMENT DATE [OPCDS], FIRST ATTENDANCE	Consistency		APPOINTMENT DATE where FIRST ATTENDANCE is equal to 01 is earlier than all other appointments	

APPOINTMENT DATE [OPCDS], OUTCOME OF ATTENDANCE	Consistency		APPOINTMENT DATE where OUTCOME OF ATTENDANCE is equal to 01 later than all other appointments	
APPOINTMENT DATE [RTDSEpisodes]	Validation	**Critical**	RTDSEpisodes APPOINTMENT DATE validation	Valid date in the past but after 2008-01-01 in 'yyyy-mm-dd' format.
APPOINTMENT DATE [RTDSExposures]	Validation	**Critical**	RTDSExposures APPOINTMENT DATE validation	Valid date in the past but after 2008-01-01 in 'yyyy-mm-dd' format.
APPOINTMENT DATE [RTDSPrescriptions	Validation	**Critical**	RTDSPrescriptions APPOINTMENT DATE validation	Valid date in the past but after 2008-01-01 in 'yyyy-mm-dd' format.
ATTENDANCE IDENTIFIER (OPCDS). ATTENDANCE IDENTIFIER [OPCDSProcedures]	Connectedness		OPCDSIdsNotInOPCDSPro	Each ATTENDANCE IDENTIFIER occurring in OPCDS table also occurs in the OPCDSProcedures
ATTENDANCE IDENTIFIER (RTDSEpisodes). RADIOTHERAPY EPISODE IDENTIFIER [RTDSEpisodes]. ATTENDANCE IDENTIFIER [RTDSExposures]. RADIOTHERAPY EPISODE IDENTIFIER [RTDSExposures]	Connectedness	**Critical**	RTDSEpisIdsNotInRTDSExpo	Each pair of values of ATTENDANCE IDENTIFIER and RADIOTHERAPY EPISODE IDENTIFIER occurring in RTDSEpisodes table also occur in the RTDSExposures table.
ATTENDANCE IDENTIFIER [RTDSEpisodes]. ATTENDANCE IDENTIFIER [OPCDSProcedures]	Connectedness		RTDSEpisIdsNotInOPCDSPro	Each ATTENDANCE IDENTIFIER occurring in RTDSEpisodes table also occurs in the OPCDSProcedures table.
ATTENDANCE IDENTIFIER [OPCDS]	Validation	**Critical**	OPCDS ATTENDANCE IDENTIFIER validation	Not NULL or an empty string
ATTENDANCE IDENTIFIER [OPCDS]	Uniqueness	**Critical**	OPCDS Unique identifier (or set of identifiers)	Each record has a unique value in the ATTENDANCE IDENTIFIER Field.
ATTENDANCE IDENTIFIER [OPCDS], LOCAL PATIENT IDENTIFIER, APPOINTMENT DATE [OPCDS], TIME OF EXPOSURE	Consistency		APPOINTMENT DATES With 1 ATTENDANCE IDENTIFIEROrAppTotaIT	If there are two or more ATTENDANCE IDENTIFIERS for the same pair of values in LOCAL PATIENT IDENTIFIER and APPOINTMENT DATE, the earliest and latest TIME OF EXPOSURES are more than 5
ATTENDANCE IDENTIFIER [OPCDS]. ATTENDANCE IDENTIFIER [RTDSEpisodes]	Connectedness	**Critical**	OPCDSIdsNotInRTDSEpis	Each ATTENDANCE IDENTIFIER occurring in OPCDS table also occurs in RTDSEpisodes table.
ATTENDANCE IDENTIFIER [OPCDS]. ATTENDANCE IDENTIFIER [RTDSExposures]	Connectedness	**Critical**	OPCDSIdsNotInRTDSEpo	Each ATTENDANCE IDENTIFIER occurring in OPCDS table also occurs in RTDSExposures table.
ATTENDANCE IDENTIFIER [OPCDS]. ATTENDANCE IDENTIFIER [RTDSPrescriptions]	Connectedness	**Critical**	OPCDSIdsNotInRTDSPres	Each ATTENDANCE IDENTIFIER occurring in OPCDS table also occurs in RTDSPrescriptions table.
ATTENDANCE IDENTIFIER [OPCDSProcedures].ORDER NUMBER	Uniqueness	**Critical**	OPCDSProcedures Unique identifier (or set of identifiers)	Each record in the table has a unique pair of values in the ATTENDANCE IDENTIFIER and ORDER
ATTENDANCE IDENTIFIER [OPCDSProcedures]	Validation	**Critical**	OPCDSProcedures ATTENDANCE IDENTIFIER validation	Not NULL or an empty string
ATTENDANCE IDENTIFIER [OPCDSProcedures], ATTENDANCE IDENTIFIER [RTDSExposures]	Connectedness	**Critical**	OPCDSProIdsNotInRTDSExpo	Each ATTENDANCE IDENTIFIER occurring in OPCDSProcedures table also occurs in the RTDSExposures table.

ATTENDANCE IDENTIFIER [OPCDSProcedures], ATTENDANCE IDENTIFIER [RTDSPrescriptions]	Connectedness	**Critical**	OPCDSProIdsNotInRTDSPres	Each ATTENDANCE IDENTIFIER occurring in OPCDSProcedures table also occurs in the RTDSPrescriptions table.
ATTENDANCE IDENTIFIER [OPCDSProcedures]. ATTENDANCE IDENTIFIER [RTDSEpisodes]	Connectedness	**Critical**	OPCDSProIdsNotInRTDSEpis	Each ATTENDANCE IDENTIFIER occurring in OPCDSProcedures table also occurs in the RTDSEpisodes table.
ATTENDANCE IDENTIFIER [OPCDSProcedures]. ATTENDANCE IDENTIFIER [OPCDS]	Connectedness	**Critical**	OPCDSProIdsNotInOPCDS	Each ATTENDANCE IDENTIFIER occurring in OPCDSProcedures table also occurs in the OPCDS table
ATTENDANCE IDENTIFIER [RTDSEpisodes]	Validation	**Critical**	RTDSEpisodes ATTENDANCE IDENTIFIER validation	Not NULL or an empty string
ATTENDANCE IDENTIFIER [RTDSEpisodes]. ATTENDANCE IDENTIFIER [OPCDS]	Connectedness	**Critical**	RTDSEpisIDsNotInOPCDS	Each ATTENDANCE IDENTIFIER occurring in RTDSEpisodes table also occurs in the OPCDS table.
ATTENDANCE IDENTIFIER [RTDSEpisodes]. RADIOTHERAPY EPISODE IDENTIFIER [RTDSEpisodes]	Uniqueness	**Critical**	RTDSEpisodes Unique identifier (or set of identifiers)	Each record in the table has a unique pair of values in the ATTENDANCE IDENTIFIER and RADIOTHERAPY EPISODE IDENTIFIER Fields.
ATTENDANCE IDENTIFIER [RTDSEpisodes]. RADIOTHERAPY EPISODE IDENTIFIER [RTDSEpisodes]. ATTENDANCE IDENTIFIER [RTDSPrescriptions]. RADIOTHERAPY EPISODE IDENTIFIER [RTDSPrescriptions]	Connectedness	**Critical**	RTDSEpisIdsNotInRTDSPres	Each pair of values of ATTENDANCE IDENTIFIER and RADIOTHERAPY EPISODE IDENTIFIER occurring in RTDSEpisodes table also occur in the RTDSPrescriptions table.
ATTENDANCE IDENTIFIER [RTDSExposures], RADIOTHERAPY EPISODE IDENTIFIER [RTDSExposures],ATTENDANCE IDENTIFIER [RTDSEpisodes]. RADIOTHERAPY EPISODE IDENTIFIER [RTDSEpisodes].	Connectedness	**Critical**	RTDSExpoIdsNotInRTDSEpis	Each pair of values of ATTENDANCE IDENTIFIER and RADIOTHERAPY EPISODE IDENTIFIER occurring in RTDSExposures table also occur in the RTDSEpisodes table.
ATTENDANCE IDENTIFIER [RTDSExposures]	Validation	**Critical**	RTDSExposures ATTENDANCE IDENTIFIER validation	Not NULL or an empty string
ATTENDANCE IDENTIFIER [RTDSExposures], ATTENDANCE IDENTIFIER [OPCDS]	Connectedness	**Critical**	RTDSExpoIDsNotInOPCOS	Each ATTENDANCE IDENTIFIER occurring in RTDSExposures table also occurs in the OPCDS table.
ATTENDANCE IDENTIFIER [RTDSExposures], ATTENDANCE IDENTIFIER [OPCDSProcedures]	Connectedness		RTDSExpoIdsNotInOPCDSPro	Each ATTENDANCE IDENTIFIER occurring in RTDSExposures table also occurs in the OPCDSProcedures table.
ATTENDANCE IDENTIFIER [RTDSExposures], RADIOTHERAPY FIELD IDENTIFIER,MACHINE IDENTIFIER	Uniqueness	**Critical**	RTDSExposures Unique identifier (or set of identifiers)	Each record in the table has a unique triplet of values in the ATTENDANCE IDENTIFIER. RADIOTHERAPY FIELD IDENTIFIER and MACHINE IDENTIFIER Fields.
ATTENDANCE IDENTIFIER [RTDSExposures].PRESCRIPTION IDENTIFIER [RTDSExposures]. ATTENDANCE IDENTIFIER [RTDSPrescriptions], PRESCRIPTION	Connectedness	**Critical**	RTDSExpoIdsNotInRTDSPres	Each pair of values of ATTENDANCE IDENTIFIER and PRESCRIPTION IDENTIFIER occurring in RTDSExposures table also occur in the RTDSPrescriptions table.

IDENTIFIER [RTDSPrescriptions].				
ATTENDANCE IDENTIFIER [RTDSPrescriptions]	Validation	**Critical**	RTDSPrescriptions ATTENDANCE IDENTIFIER validation	Not NULL or an empty string
ATTENDANCE IDENTIFIER [RTDSPrescriptions], ATTENDANCE IDENTIFIER [OPCDS]	Connectedness	**Critical**	RTDSPresIDsNotInOPCDS	Each ATTENDANCE IDENTIFIER occurring in RTDSPrescriptions table also occurs in the OPCDS table.
ATTENDANCE IDENTIFIER [RTDSPrescriptions], PRESCRIPTION IDENTIFIER [RTDSPrescriptions],	Uniqueness	**Critical**	RTDSPrescriptions Unique identifier (or set of identifiers)	Each record in the table has a unique pair of values in
ATTENDANCE IDENTIFIER [RTDSPrescriptions], PRESCRIPTION IDENTIFIER [RTDSPrescriptions], ATTENDANCE IDENTIFIER [RTDSExposures]. PRESCRIPTION IDENTIFIER [RTDSExposures]	Connectedness	**Critical**	RTDSPresIdsNotInRTDSExpo	Each pair of values of ATTENDANCE IDENTIFIER and PRESCRIPTION IDENTIFIER occurring in RTDSPrescriptions table also occur in the RTDSExposures table.
ATTENDANCE IDENTIFIER [RTDSPrescriptions]. ATTENDANCE IDENTIFIER [OPCDSProcedures]	Connectedness		RTDSPresIdsNotInOPCDSPro	Each ATTENDANCE IDENTIFIER occurring in RTDSPrescriptions table also occurs in the OPCDSProcedures table.
ATTENDANCE IDENTIFIER [RTDSPrescriptions]. RADIOTHERAPY EPISODE IDENTIFIER [RTDSPrescriptions]. ATTENDANCE IDENTIFIER [RTDSEpisodes], RADIOTHERAPY EPISODE IDENTIFIER [RTDSEpisodes].	Connectedness	**Critical**	RTDSPresIdsNotInRTDSEpis	Each pair of values of ATTENDANCE IDENTIFIER and RADIOTHERAPY EPISODE IDENTIFIER occurring in RTDSPrescriptions table also occur in the RTDSEpisodes table.
ATTENDED OR DID NOT ATTEND	Validation		OPCDS ATTENDED OR DID NOT ATTEND validation	1' or '5'
COMMISSIONER REFERENCE NUMBER	Validation		OPCDS COMMISSIONER REFERENCE NUMBER validation	No test criteria currently applied.
COMMISSIONING SERIAL NUMBER	Validation		OPCDS COMMISSIONING SERIAL NUMBER validation	No test criteria currently applied.
CONSULTANT CODE	Validation		OPCDS CONSULTANT CODE validation	H9998898'
DECISION TO TREAT DATE (RADIOTHERAPY TREATMENT COURSE)	Validation		RTDSEpisodes DECISION TO TREAT DATE (RADIOTHERAPY TREATMENT COURSE) validation	Valid date in the past but after 2008-01-01 in 'yyyy-mm-dd' format.
DECISION TO TREAT DATE (RADIOTHERAPY TREATMENT COURSE), REFERRAL REQUEST RECEIVED DATE	Consistency		DECISION TO TREAT DATE on or before REFERRAL REQUEST RECEIVED DATE	
DECISION TO TREAT DATE (RADIOTHERAPY TREATMENT COURSE). EARLIEST CLINICALLY APPROPRIATE DATE	Consistency		DECISION TO TREAT DATE on or before EARLIEST CLINICALLY APPROPRIATE DATE	
DECISION TO TREAT DATE (RADIOTHERAPY TREATMENT COURSE). EARLIEST CLINICALLY APPROPRIATE DATE	Consistency		If RADIOTHERAPY PRIORITY equals 'D', DECISION TO TREAT DATE before EARLIEST CLINICALLY APPROPRIATE DATE	

DECISION TO TREAT DATE (RADIOTHERAPY TREATMENT COURSE). EARLIEST CLINICALLY APPROPRIATE DATE	Consistency		If RADIOTHERAPY PRIORITY is not 'D'. DECISION TO TREAT DATE equal to EARLIEST CLINICALLY APPROPRIATE DATE	
DIAGNOSIS SCHEME IN USE	Validation		OPCDS DIAGNOSIS SCHEME IN USE validation	02'
EARLIEST CLINICALLY APPROPRIATE DATE	Validation		RTDSEpisodes EARLIEST CLINICALLY APPROPRIATE DATE validation	Valid date in the past but after 2008-01-01 in 'yyyy-mm-dd' format.
EARLIEST CLINICALLY APPROPRIATE DATE, APPOINTMENT DATE [RTDSEpisodes]	Consistency		EARLIEST CLINICALLY APPROPRIATE DATE on or before APPOINTMENT	
FIRST ATTENDANCE	Validation		OPCDS FIRST ATTENDANCE validation	01' or '02'
FIRST ATTENDANCE. RADIOTHERAPY EPISODE IDENTIFIER	Consistency		FIRST ATTENDANCE equal to 01 for at most one record per episode.	
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTIRATION)	Validation		OPCDS GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION) validation	First character in the ranges 'A' to 'H' or 'J' to 'N' or First character is one of 'P', 'W' or 'Y' or whole code is V81997, V81998 or V81999.
GENERAL MEDICAL PRACTITIONER (SPECIFIED)	Validation		OPCDS GENERAL MEDICAL PRACTITIONER (SPECIFIED) validation	Length=8. either First character is 'G' or 'S' and remainder numeric or First character is 'Z' with second character 'E', 'N', 'S' or 'W'.
LOCAL PATIENT IDENTIFIER	Validation	**Critical**	OPCDS LOCAL PATIENT IDENTIFIER validation	Not NULL or an empty string
LOCATION CLASS	Validation		OPCDS LOCATION CLASS validation	01'
MACHINE IDENTIFIER	Validation	**Critical**	RTDSExposures MACHINE IDENTIFIER validation	Value present on list of National Machine identifiers
MAIN SPECIALTY CODE	Validation		OPCDS MAIN SPECIALTY CODE validation	960 or 800
MEDICAL STAFF TYPE SEEING PATIENT	Validation		OPCDS MEDICAL STAFF TYPE SEEING PATIENT validation	
NHS NUMBER	Validation	**Critical**	OPCDS NHS NUMBER validation	Length: 10. can be converted to number, with no "." or "e" characters present in string.
NHS NUMBER STATUS INDICATOR	Validation		OPCDS NHS NUMBER STATUS INDICATOR validation	Single digit '1' to '8', with or without Leading '0'
NHS SERVICE AGREEMENT LINE NUMBER	Validation		OPCDS NHS SERVICE AGREEMENT LINE NUMBER validation	No test criteria currently applied.
NUMBER OF TELETHERAPY FIELDS	Validation	**Critical**	RTDSPrescriptions NUMBER OF TELETHERAPY FIELDS validation	> 0 and <= 100 for linear accelerators, >=0 and <=100 for other machine types.
NUMBER OF TELETHERAPY FIELDS. CountOfTIME OF EXPOSURES	Consistency		NUMBER OF TELETHERAPY FIELDS greater than or equal to the count of the TIME OF EXPOSUREs associated with same prescription.	
OPERATION STATUS	Validation		OPCDS OPERATION STATUS validation	1
ORGANISATION CODE (CODE OF PROVIDER) [OPCDS]	Validation	**Critical**	OPCDS ORGANISATION CODE (CODE OF PROVIDER) validation	On list of RTDS centres
ORGANISATION CODE (CODE OF PROVIDER) [OPCDSProcedures]	Validation	**Critical**	OPCDSProcedures ORGANISATION CODE (CODE OF PROVIDER)	On list of RTDS centres
ORGANISATION CODE (CODE OF PROVIDER) [RTDSEpisodes]	Validation	**Critical**	RTDSEpisodes ORGANISATION CODE (CODE OF PROVIDER) validation	On list of RTDS centres

ORGANISATION CODE (CODE OF PROVIDER) [RTDSExposures]	Validation	**Critical**	RTDSExposures ORGANISATION CODE (CODE OF PROVIDER) validation	On list of RTDS centres
ORGANISATION CODE (CODE OF PROVIDER) [RTDSPrescriptions]	Validation	**Critical**	RTDSPrescriptions ORGANISATION CODE (CODE OF PROVIDER)	On list of RTDS centres
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	Validation	**Critical**	OPCDS ORGANISATION CODE (LOCAL PATIENT IDENTIFIER) validation	Length <: 8, not NULL or an empty string
ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	Validation		OPCDS ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) validation	No test criteria currently applied.
ORGANISATION CODE (PCT OF RESIDENCE)	Validation		OPCDS ORGANISATION CODE (PCT OF RESIDENCE) validation	Either length=3 with leading ‘5’, ‘T’, ‘7’, leading ‘S’ and trailing ‘9’ or ‘Q99’ or ‘X98’: or length=2 with leading ‘K’ or Length >4 with Leading ‘ZC0’ and trailing ‘0’.
ORGANISATION CODE [CODE OF COMMISSIONER]	Validation		OPCDS ORGANISATION CODE (CODE OF COMMISSIONER) validation	Length=5, Leading character ‘5’
OUTCOME OF ATTENDANCE	Validation		OPCDS OUTCOME OF ATTENDANCE validation	1', '2' or '3', with or without leading '0'
OUTCOME OF ATTENDANCE	Consistency		OUTCOME OF ATTENDANCE equals 01 for at most one record per episode	
PATIENT NAME	Validation		OPCDS PATIENT NAME validation	No test criteria currently applied.
PATIENT PATHWAY IDENTIFIER	Validation		OPCDS PATIENT PATHWAY IDENTIFIER validation	No test criteria currently applied.
PATIENT USUAL ADDRESS	Validation		OPCDS PATIENT USUAL ADDRESS validation	No test criteria currently applied.
PERSON BIRTH DATE	Validation	**Critical**	OPCDS PERSON BIRTH DATE validation	Valid date in the past in ‘yyyy-mm-dd’ format.
PERSON BIRTH DATE, ALL DATES [OPCDS]	Consistency		PERSON BIRTH DATE before all other OPCDS dates	
PERSON BIRTH DATE, ALL DATES [OPCDSProcedures]	Consistency		PERSON BIRTH DATE before all other OPCDSProcedures dates	
PERSON BIRTH DATE, ALL DATES [RTDSEpisodes]	Consistency		PERSON BIRTH DATE before all other RTDSEpisodes dates	
PERSON BIRTH DATE, ALL DATES [RTDSExposures]	Consistency		PERSON BIRTH DATE before all other RTDSExposures dates	
PERSON BIRTH DATE, ALL DATES [RTDSPrescriptions]	Consistency		PERSON BIRTH DATE before all other RTDSPrescriptions dates	
PERSON GENDER CURRENT	Validation	**Critical**	OPCDS PERSON GENDER CURRENT validation	0’,’1’, ‘2’ or ‘9’
POSTCODE OF USUAL ADDRESS	Validation	**Critical**	OPCDS POSTCODE OF USUAL ADDRESS validation	Length> 5, valid postcode with single space (see NHS Data Dictionary) or beginning ‘ZZ99’ with space then 3 further characters.
PRESCRIBED FRACTIONS	Validation	**Critical**	RTDSPrescriptions PRESCRIBED FRACTIONS validation	Numeric, greater than 0 and less than 100
PRESCRIPTION IDENTIFIER [RTDSExposures]	Validation	**Critical**	RTDSExposures PRESCRIPTION IDENTIFIER validation	Not NULL or an empty string
PRESCRIPTION IDENTIFIER [RTDSPrescriptions]	Validation	**Critical**	RTDSPrescriptions PRESCRIPTION IDENTIFIER validation	Not NULL or an empty string
PRIMARY DIAGNOSIS (ICD)	Validation	**Critical**	OPCDS PRIMARY DIAGNOSIS (ICD) validation	On list of ICD-10 codes selected for relevance to Radiotherapy practice.
PRIMARY PROCEDURE (OPCS)	Validation		OPCDS PRIMARY PROCEDURE (OPCS) validation	Length=4 or 5, First character a letter, the rest numeric
PRIORITY TYPE	Validation		OPCDS PRIORITY TYPE validation	1' or '2'

PROCEDURE (OPCS)	Validation		OPCDSProcedures PROCEDURE (OPCS) validation	Length=4 or 5, First character a letter, the rest numeric
PROCEDURE DATE	Validation		OPCDS PROCEDURE DATE validation	Valid date in the past but after 2008-01-01 in 'yyyy-mm-dd' format.
PROCEDURE DATE	Validation		OPCDSProcedures PROCEDURE DATE validation	Valid date in the past but after 2008-01-01 in 'yyyy-mm-dd' format.
PROCEDURE SCHEME IN USE	Validation		OPCDS PROCEDURE SCHEME IN USE validation	No test criteria currently applied.
RADIOTHERAPY ACTUAL DOSE	Validation		RTDSPrescriptions RADIOTHERAPY ACTUAL DOSE validation	Should only be present for final fraction of a
RADIOTHERAPY ACTUAL DOSE, RADIOTHERAPY PRESCRIBED DOSE	Consistency		RADIOTHERAPY ACTUAL DOSE less than or equal to RADIOTHERAPY	RADIOTHERAPY ACTUAL DOSE should be no
RADIOTHERAPY EPISODE IDENTIFIER [RTDSEpisodes]	Validation	**Critical**	RTDSEpisodes RADIOTHERAPY EPISODE IDENTIFIER validation	
RADIOTHERAPY EPISODE IDENTIFIER [RTDSEpisodes], LOCAL PATIENT IDENTIFIER. DECISION TO TREAT DATE (RADIOTHERAPY TREATMENT COURSE), RADIOTHERAPY TREATMENT MODALITY	Consistency		RADIOTHERAPY EPISODE IDENTIFIER Unique For LOCAL PATIENT IDENTIFIER	Each RADIOTHERAPY EPISODE IDENTIFIER is associated with a unique set of values in LOCAL PATIENT IDENTIFIER. DECISION TO TREAT DATE (RADIOTHERAPY TREATMENT RADIOTHERAPY TREATMENT MODALITY.COURSE) and
RADIOTHERAPY EPISODE IDENTIFIER [RTDSExposures]	Validation	**Critical**	RTDSExposures RADIOTHERAPY EPISODE IDENTIFIER validation	Not NULL or an empty string
RADIOTHERAPY EPISODE IDENTIFIER [RTDSPrescriptions]	Validation	**Critical**	RTDSPrescriptions RADIOTHERAPY EPISODE IDENTIFIER validation	
RADIOTHERAPY FIELD IDENTIFIER	Validation	**Critical**	RTDSExposures RADIOTHERAPY FIELD IDENTIFIER validation	Not NULL or an empty string
RADIOTHERAPY PRESCRIBED DOSE	Validation	**Critical**	RTDSPrescriptions RADIOTHERAPY PRESCRIBED DOSE validation	Numeric, greater than or equal to 0 and less than 100
RADIOTHERAPY PRIORITY	Validation		RTDSEpisodes RADIOTHERAPY PRIORITY validation	U', 'R', 'D' or 'E'
RADIOTHERAPY TREATMENT MODALITY	Validation	**Critical**	RTDSPrescriptions RADIOTHERAPY TREATMENT MODALITY validation	05' or '06'
RADIOTHERAPY TREATMENT REGION	Consistency		IF RADIOTHERAPY TREATMENT REGION has value in ('A', 'O', 'M'), ANATOMICAL TREATMENT SITE (RADIOTHERAPY) is completed.	
RADIOTHERAPY TREATMENT REGION	Validation		RTDSPrescriptions RADIOTHERAPY TREATMENT REGION validation	P', 'PR' ,'R', 'A', 'O' or 'M'
REFERRAL REQUEST RECEIVED DATE	Validation		OPCDS PROVIDER REFERENCE NUMBER validation	No test criteria currently applied.
REFERRAL REQUEST RECEIVED DATE, APPOINTMENT DATE	Consistency		REFERRAL REQUEST RECEIVED DATE on or before APPOINTMENT DATE	
REFERRAL TO TREATMENT PERIOD END DATE	Validation		OPCDS REFERRAL REQUEST RECEIVED DATE validation	Valid date in the past but after 2008-01-01 in 'yyyy-mm-dd' format.
REFERRAL TO TREATMENT PERIOD START DATE	Validation		OPCDS REFERRAL TO TREATMENT PERIOD END DATE validation	No test criteria currently applied.
REFERRAL TO TREATMENT STATUS	Validation		OPCDS REFERRAL TO TREATMENT PERIOD START DATE validation	No test criteria currently applied.
REFERRER CODE	Validation		OPCDS REFERRAL TO TREATMENT STATUS validation	No test criteria currently applied.
REFERRING ORGANISATION CODE	Validation		OPCDS REFERRER CODE validation	Length: 8, First character 'C', remaining characters numeric.

SERVICE TYPE REQUESTED	Validation		OPCDS REFERRING ORGANISATION CODE validation	Length <= 8, not beginning with '0', '1', '2', '3', '7' or '9', or is V81997, V81998, or V81999.
SERVICE TYPE REQUESTED	Validation		OPCDS SOURCE OF REFERRAL FOR OUTPATIENTS validation	No test criteria currently applied.
SITE CODE OF TREATMENT	Validation		OPCDS SERVICE TYPE REQUESTED validation	2'
SOURCE OF REFERRAL FOR OUT-PATIENTS	Validation		OPCDS SITE CODE (OF TREATMENT) validation	Length <: 8. not beginning with '0', '1', '2', '3', '7' or '9'
TELETHERAPY BEAM ENERGY	Validation	**Critical**	RTDSExposures TELETHERAPY BEAM ENERGY validation	For linacs ('LA' in MACHINE IDENTIFIER),> O and <30, or kV machines ('KV' in MACHINE IDENTIFIER). >= O and < 30, otherwise non-negative numeric value or NULL
TELETHERAPY BEAM TYPE	Validation	**Critical**	RTDSExposures TELETHERAPY BEAM TYPE validation	For linacs or kV machines ('LA' or 'KV' in MACHINE IDENTIFIER), allowed values are 'Ti'. 'T2' or 'T3', otherwise these along with '0' and NULL allowed.
TELETHERAPY BEAM TYPE	Consistency			
TIME OF EXPOSURE	Validation	**Critical**	RTDSExposures TIME OF EXPOSURE validation	Valid 24-hr time values with ':' as separator, hour and minutes required, seconds optional.
TREATMENT FUNCTION CODE	Validation		OPCDS TREATMENT FUNCTION CODE validation	800'
TREATMENT START DATE (RADIOTHERAPY TREATMENT COURSE)	Validation		RTDSEpisodes TREATMENT START DATE (RADIOTHERAPY TREATMENT COURSE) validation	Valid date in the past but after 2008-01-01 in 'yyyy-mm-dd' format.
TREATMENT START DATE (RADIOTHERAPY TREATMENT COURSE). APPOINTMENT DATE	Consistency		TREATMENT START DATE before APPOINTMENT DATE	
TREATMENT START DATE. DECISION TO TREAT DATE. REFERRAL REQUEST RECEIVED DATE. EARLIEST CLINICALLY APPROPRIATE DATE	Consistency		TREATMENT START DATE is on or after DECISION TO TREAT DATE, REFERRAL REQUEST RECEIVED DATE and EARLIEST CLINICALLY	
UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	Validation		OPCDS UNIQUE BOOKING REFERENCE NUMBER (CON VERTED)	No test criteria currently applied.

11. RTDS Glossary

Term	Acronym/ abbreviation	Definition
4D Adaptive radiotherapy	4D ART	The ability to take account of the tumour shape in the three physical dimensions plus the fourth dimension of change with time. It can work well for tumours in areas of the body that may move during treatment, for example due to breathing.
Brachytherapy	BT	Brachytherapy is the delivery of radiation using sealed sources which are placed close to the site that is to be treated. Isotopes used in brachytherapy can be applied directly to the tumour by surface applicators inserted into body cavities and tubular organs via specially designed delivery systems (intracavitary and intraluminal therapy) or inserted directly into a tumour (interstitial radiotherapy).
Cancer Outcomes and Services Data set	COSD	The COSD is the national standard for reporting cancer in the NHS in England. It replaced the previous National Cancer Dataset and includes the former Cancer Registration data set and additional site specific data items relevant to the different tumour types.
Chemoradiation		Chemoradiation is when chemotherapy and radiotherapy is given together. Chemotherapy may be given intravenously via a pump or orally during part of the radiotherapy course. Radiotherapy and chemotherapy treatments may also be alternated between each other.
Extensible markup language	XML	Extensible markup language (XML) is a set of rules for encoding documents in machine-readable form.
External Beam Radiotherapy	EBR	Radiation therapy given ‘from a distance’. This includes most conventional radiotherapy given using linear accelerators. Includes electrically generated and radioisotope beams.
Image Guided Brachytherapy	IGBT	Image guided brachytherapy (IGBT) uses cross sectional image data to create 3D models. This allows clinicians to more precisely plan and deliver the radiation to the target while sparing surrounding health tissues.

Image Guided Radiotherapy	IGRT	IGRT is any imaging at pre-treatment and delivery, the result of which is acted upon, that improves or verifies the accuracy of radiotherapy. IGRT encompasses the whole range of imaging from simple to more complex imaging that allows direct visualisation of the tumour and surrounding tissue. Using scanning during treatment enables verification of tumour position in relation to adjacent soft tissue organs.
Intensity Modulated Radiotherapy	IMRT	IMRT is a high precision form of radiotherapy. It moulds (conforms) the shape and dose of the radiation precisely to the volume of tumour tissue that needs to be treated, reducing exposure to healthy surrounding tissue. Doses can also be varied to different areas at variable risk of harbouring tumour deposits.
Intra-operative Radiotherapy	IORT	IORT applies therapeutic levels of radiation to a target area while the area is exposed during surgery.
Linear Accelerator	LA	A radiotherapy machine capable of generating high energy penetrating X-ray and electron beams for the delivery of radiotherapy.
Magnetic Imaging Resonance	MRI	MRI is a medical imaging technique, which makes use of the property of nuclear magnetic resonance (NMR) to image nuclei of atoms inside the body. This allows greater clarity of soft tissue structures.
Molecular Radiotherapy	MRT	MRT is the treatment of disease with radiopharmaceuticals. It delivers high radiation doses to a specific target and spares health organs from serious side-effects.
National Cancer Intelligence Network	NCIN	NCIN uses the information collected about cancer patients for analysis, publication and research. NCIN is one of a number of health intelligence networks operated by PHE.
National Cancer Registration Service	NCRS	The NCRS is the national cancer registration service for England collecting cancer data from all NHS Providers of cancer care in England. It is part of PHE.
Oncology Management System	OMS	A database associated with a radiotherapy machine, which verifies treatment to be delivered against preset criteria and tolerances, and records the details of treatment delivered.
Patient Administration System	PAS	A database that stores demographic, clinical, administrative details of patient attending a hospital.

Positron Emission Tomography	PET	PET scanning is a nuclear medicine imaging technique that produces a three-dimensional image or picture of functional processes in the body.
Proton Beam Radiotherapy		Proton Beam Radiotherapy uses a high-energy beam of protons rather than high energy X-rays to deliver a dose of radiotherapy. Proton beam treatment directs the radiation dose to precisely the depth where it is needed, with minimal damage to surrounding tissue. The treatment is therefore particularly suitable to complex childhood cancers.
Public Health England	PHE	Executive agency of the Department of Health.
Radiotherapy Data Set	RTDS	The data standard.
Stereotactic Body radiotherapy/ Stereotactic Ablative radiotherapy	SBRT/SABR	SBRT or SABR refers to the precise irradiation of an image defined extra cranial lesion associated with the use of high radiation dose in a small number of fractions.
Stereotactic Radiosurgery	SRS	SRS refers to the precise irradiation of an image defined lesion, similar to SABR, but given as a single fraction. It has become the standard treatment for a number of cranial treatments.