NHS Data Model and Dictionary

Type:	Change Request
Reference:	1690
Version No:	1.0
Subject:	Community Services Data Set Version 1.5
Effective Date:	1 April 2020
Reason for Change:	Change to Information Standards
Publication Date:	15 October 2019

Background:

The Community Services Data Set (CSDS) Version 1.0 was approved by the Standardisation Committee for Care (SCCI) as SCCI1069: Community Services Data Set.

A number of changes have been identified since the last version, and the Community Services Data Set Version 1.5 includes:

- Amendments to National Code values and descriptions
- New tables
- New Data Items
- Retirement of Data Items
- The Community Services Data Set will be submitted centrally via the Strategic Data Collection Service in the Cloud (SDCS Cloud) maintained by NHS Digital, using the XML Schema. This replaces the Bureau Service Portal (BSP) that was previously used.
- Changes to Organisation and Organisation Site Code Data Items to reflect changes to organisation reference data maintained and published by the Organisation Data Service, as defined by SCCI0090: Health and Social Care Organisation Reference Data.

To support the Information Standard, this Change Request updates the NHS Data Model and Dictionary to introduce the Community Services Data Set Version 1.5.

To view a demonstration on "How to Read an NHS Data Model and Dictionary Change Request", visit the NHS Data Model and Dictionary help pages at: http://www.datadictionary.nhs.uk/Flash_Files/changerequest.htm.

Note: if the web page does not open, please copy the link and paste into the web browser.

Summary of changes:

Diagrams

COMMUNITY SERVICES DIAGRAM	Changed Diagram

Data Set

COMMUNITY SERVICES DATA SET	Changed Dataset, Description

Supporting Information

CLINICAL DATA SETS MESSAGE DOCUMENTATION	Changed Description
CLINICAL DATA SETS MESSAGE DOCUMENTATION MENU	Changed Description
COMMUNITY BED-BASED INTERMEDIATE CARE	New Supporting Information
COMMUNITY BED-BASED INTERMEDIATE CARE SERVICE	New Supporting Information
COMMUNITY SERVICES DATA SET OVERVIEW	Changed Dataset, Description
CRISIS RESPONSE INTERMEDIATE CARE	New Supporting Information
CRISIS RESPONSE INTERMEDIATE CARE SERVICE	New Supporting Information
CRISIS RESPONSE INTERMEDIATE CARE WAITING TIME MEASUREMENT	New Supporting Information
CRISIS RESPONSE INTERMEDIATE CARE WITHIN 2 HOURS WAITING TIME MEASUREMENT	New Supporting Information
HOME-BASED INTERMEDIATE CARE	New Supporting Information
HOME-BASED INTERMEDIATE CARE SERVICE	New Supporting Information
INTERMEDIATE CARE	New Supporting Information
INTERMEDIATE CARE SERVICE	New Supporting Information
OTHER INTERMEDIATE CARE WAITING TIME MEASUREMENT	New Supporting Information
OTHER INTERMEDIATE CARE WITHIN 2 DAYS WAITING TIME MEASUREMENT	New Supporting Information
PERSONALISED CARE AND SUPPORT PLAN	New Supporting Information
REABLEMENT INTERMEDIATE CARE	New Supporting Information
REABLEMENT INTERMEDIATE CARE SERVICE	New Supporting Information
STRATEGIC DATA COLLECTION SERVICE IN THE CLOUD	New Supporting Information
XML SCHEMA TRUD DOWNLOAD	Changed Dataset
YOUNG PERSONS TRANSITION PLAN	New Supporting Information

Class Definitions

CARE ACTIVITY	Changed Attributes
CARE PLAN	Changed Attributes
PERSON RELATIONSHIP	Changed Attributes
REFERRAL TO TREATMENT PERIOD	Changed Attributes
REPORTING PERIOD	Changed Attributes
SESSION	Changed Attributes

Attribute Definitions

ACCOMMODATION STATUS CODE

	Changed Dataset, Description
ACTIVITY DATE	Changed Dataset
ACTIVITY DURATION	Changed Dataset
ACTIVITY GROUP TYPE	Changed Description
ACTIVITY IDENTIFIER	Changed Dataset
ACTIVITY LOCATION TYPE CODE	Changed Dataset
ACTIVITY SERVICE REQUEST DATE	Changed Dataset
ACTIVITY TIME	Changed Dataset
ADMINISTRATIVE CATEGORY CODE	Changed Dataset
APPOINTMENT DATE OFFERED	Changed Dataset
ATTENDED OR DID NOT ATTEND	Changed Dataset
BREASTFEEDING STATUS	Changed Dataset
CARE CONTACT CANCELLATION REASON	Changed Dataset
CARE CONTACT SUBJECT	Changed Dataset
CARE PLAN AGREED BY	Changed Dataset
CARE PLAN IDENTIFIER	Changed Dataset
CARE PLAN TYPE FOR COMMUNITY CARE	New Attribute
CARE PROFESSIONAL IDENTIFIER	Changed Dataset
CARE PROFESSIONAL STAFF GROUP FOR COMMUNITY CARE	Changed Dataset, Description
CARE PROFESSIONAL TEAM IDENTIFIER	Changed Dataset
CHILDHOOD IMMUNISATION TYPE	Changed Dataset, Description
CHILD PROTECTION PLAN REASON CODE	Changed Dataset
CLINICAL CLASSIFICATION CODE	Changed Dataset
CLINICAL INVESTIGATION RESULT RECEIVED DATE	Changed Dataset
CLINICAL INVESTIGATION RESULT VALUE	Changed Dataset
CLINICAL TERMINOLOGY CODE	Changed Dataset
COMMUNITY CARE ACTIVITY TYPE renamed from COMMUNITY CARE ACTIVITY TYPE CODE	Changed Dataset, Name
CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR	Changed Dataset, Description
CONSULTATION MEDIUM USED	Changed Dataset
CONSULTATION TYPE	Changed Dataset
DATA SET VERSION NUMBER	Changed Dataset
DEATH LOCATION TYPE CODE	Changed Dataset
DEATH NOT AT PREFERRED LOCATION REASON	Changed Dataset
DIAGNOSIS SCHEME IN USE	Changed Dataset
DISABILITY CODE	Changed Dataset
DISABILITY IMPACT PERCEPTION	Changed Dataset, Description

EDUCATIONAL ASSESSMENT OUTCOME	Changed Dataset
EMPLOYMENT STATUS	Changed Dataset
ETHNIC CATEGORY CODE	Changed Dataset
EVENT DATE	Changed Dataset
EVENT TIME	Changed Dataset
FINDING SCHEME IN USE	Changed Dataset
GROUP SESSION TYPE FOR COMMUNITY CARE renamed from GROUP SESSION TYPE CODE FOR COMMUNITY CARE	Changed Dataset, Name
GROUP THERAPY INDICATOR	Changed Dataset
INVESTIGATION EXAMINATION RESULT	Changed Dataset
JOB ROLE CODE	Changed Dataset
LANGUAGE CODE	Changed Dataset
LOCAL PATIENT IDENTIFIER	Changed Dataset
LOOKED AFTER CHILD INDICATOR	Changed Dataset
NEWBORN BLOOD SPOT TEST OUTCOME STATUS	Changed Dataset
NEWBORN HEARING AUDIOLOGY OUTCOME	Changed Dataset
NEWBORN HEARING SCREENING OUTCOME	Changed Dataset
NHS NUMBER	Changed Dataset
NHS NUMBER STATUS INDICATOR CODE	Changed Dataset
NHS OCCUPATION CODE	Changed Dataset
NHS SERVICE AGREEMENT LINE NUMBER	Changed Dataset
OBSERVATION SCHEME IN USE	Changed Dataset
OBSERVATION VALUE	Changed Dataset
OFFERED FOR ADMISSION DATE	Changed Dataset
ONWARD REFERRAL REASON	Changed Dataset
ORGANISATION CODE	Changed Dataset
ORGANISATION IDENTIFIER	Changed Dataset
ORGANISATION SITE CODE	Changed Dataset
PARENTAL RESPONSIBILITIES INDICATOR	Changed Description
PATIENT PATHWAY IDENTIFIER	Changed Dataset
PERSON AT RISK OF UNEXPECTED DEATH INDICATOR	Changed Dataset, Description
PERSON BIRTH DATE	Changed Dataset
PERSON COUNT	Changed Dataset
PERSON DEATH DATE	Changed Dataset
PERSON PROPERTY EFFECTIVE END DATE	Changed Dataset
PERSON PROPERTY EFFECTIVE START DATE	Changed Dataset
PERSON PROPERTY OBSERVED DATE	Changed Dataset
PERSON PROPERTY RECORDED DATE	Changed Dataset
PERSON SCORE	Changed Dataset
PERSON STATED GENDER CODE	Changed Dataset
POSTCODE	Changed Dataset

PREFERRED DEATH LOCATION DISCUSSED INDICATOR	Changed Dataset, Description
PRESCRIPTION DATE	Changed Dataset
PRIMARY DATA COLLECTION SYSTEM IN USE	Changed Dataset
PRIORITY TYPE	Changed Dataset
PROCEDURE SCHEME IN USE	Changed Dataset
PROFESSIONAL REGISTRATION BODY CODE	Changed Dataset, Description
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER	Changed Dataset
REASON FOR REFERRAL TO COMMUNITY CARE	Changed Dataset, Description
REFERRAL CLOSURE REASON	Changed Dataset
REFERRAL REJECTION REASON	Changed Dataset
REFERRAL REQUEST RECEIVED DATE	Changed Dataset
REFERRAL REQUEST RECEIVED TIME	Changed Dataset
REFERRAL TO TREATMENT PERIOD END DATE	Changed Dataset
REFERRAL TO TREATMENT PERIOD END TIME	New Attribute
REFERRAL TO TREATMENT PERIOD START DATE	Changed Dataset, Description
REFERRAL TO TREATMENT PERIOD START TIME	New Attribute
REFERRAL TO TREATMENT PERIOD STATUS	Changed Dataset
REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH AND COMMUNITY CARE	Changed Dataset
RELATIONSHIP TO PERSON FOR CHILDREN AND YOUNG PEOPLE	Changed Dataset, Description
RELATIONSHIP TO PERSON FOR COMMUNITY	New Attribute
REPORTING PERIOD END DATE	Changed Dataset
REPORTING PERIOD END TIME	New Attribute
REPORTING PERIOD START DATE	Changed Dataset
REPORTING PERIOD START TIME	New Attribute
SAFEGUARDING VULNERABILITY FACTORS INDICATOR	Changed Dataset
SAFEGUARDING VULNERABILITY FACTORS TYPE	Changed Dataset
SAMPLE COLLECTION DATE	Changed Dataset
SERVICE OR TEAM TYPE REFERRED TO FOR COMMUNITY CARE	Changed Dataset, Description
SERVICE REQUEST DATE	Changed Dataset
SERVICE REQUEST IDENTIFIER	Changed Dataset
SERVICE TYPE	Changed Description
SESSION DATE	Changed Dataset
SETTLED ACCOMMODATION INDICATOR	Changed Description
SOURCE OF REFERRAL FOR COMMUNITY	Changed Dataset
SPECIAL EDUCATIONAL NEED TYPE	Changed Dataset
UCUM UNIT OF MEASUREMENT	Changed Dataset

UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	Changed Dataset
WAITING TIME MEASUREMENT TYPE	Changed Dataset, Description
WEEKLY HOURS WORKED	Changed Dataset

Data Elements

ACCOMMODATION STATUS CODE	Changed Dataset
ACCOMMODATION STATUS RECORDED DATE	Changed Dataset
ACTIVITY LOCATION TYPE CODE	Changed Dataset
ADMINISTRATIVE CATEGORY CODE	Changed Dataset
ASSESSMENT TOOL COMPLETION DATE	Changed Dataset
ASSISTIVE TECHNOLOGY FINDING (SNOMED CT)	Changed Dataset, Description
ATTENDED OR DID NOT ATTEND CODE	Changed Dataset
BLOOD SPOT CARD COMPLETION DATE	Changed Dataset
BREASTFEEDING STATUS	Changed Dataset
CARE ACTIVITY IDENTIFIER	Changed Dataset
CARE CONTACT CANCELLATION DATE	Changed Dataset
CARE CONTACT CANCELLATION REASON	Changed Dataset
CARE CONTACT DATE	Changed Dataset
CARE CONTACT IDENTIFIER	Changed Dataset
CARE CONTACT SUBJECT	Changed Dataset
CARE CONTACT TIME	Changed Dataset
CARE PLAN AGREED BY	Changed Dataset
CARE PLAN AGREED DATE	Changed Dataset
CARE PLAN AGREED TIME	Changed Dataset
CARE PLAN CREATION DATE	Changed Dataset
CARE PLAN CREATION TIME	Changed Dataset
CARE PLAN IDENTIFIER	Changed Dataset
CARE PLAN IMPLEMENTATION DATE	Changed Dataset
CARE PLAN LAST UPDATED DATE	Changed Dataset, Description
CARE PLAN LAST UPDATED TIME	Changed Dataset, Description
CARE PLAN TYPE (COMMUNITY CARE)	New Data Element
CARE PROFESSIONAL (JOB ROLE CODE)	Changed Dataset
CARE PROFESSIONAL LOCAL IDENTIFIER	Changed Dataset
CARE PROFESSIONAL STAFF GROUP (COMMUNITY CARE)	Changed Dataset
CARE PROFESSIONAL TEAM LOCAL IDENTIFIER	Changed Dataset
CHILDHOOD IMMUNISATION TYPE (CHILDREN AND YOUNG PEOPLE'S HEALTH SERVICES)	Changed Dataset, Description
CHILD PROTECTION PLAN END DATE	Changed Dataset

CHILD PROTECTION PLAN INDICATION CODE	Changed Description
CHILD PROTECTION PLAN REASON CODE	Changed Dataset
CHILD PROTECTION PLAN START DATE	Changed Dataset
CLINICAL CONTACT DURATION OF CARE ACTIVITY	Changed Dataset
CLINICAL CONTACT DURATION OF CARE CONTACT	Changed Dataset
CLINICAL CONTACT DURATION OF GROUP SESSION	Changed Dataset
CODED ASSESSMENT TOOL TYPE (SNOMED CT)	Changed Dataset
CODED FINDING (CODED CLINICAL ENTRY)	Changed Dataset
CODED OBSERVATION (CLINICAL TERMINOLOGY)	Changed Dataset
CODED PROCEDURE (CLINICAL TERMINOLOGY)	Changed Dataset
COMMUNITY CARE ACTIVITY TYPE renamed from COMMUNITY CARE ACTIVITY TYPE CODE	Changed Dataset, Name
CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR	Changed Dataset
CONSULTATION MEDIUM USED	Changed Dataset
CONSULTATION TYPE	Changed Dataset
DATA SET VERSION NUMBER	Changed Dataset
DATE AND TIME DATA SET CREATED	Changed Dataset
DEATH LOCATION TYPE CODE (ACTUAL)	Changed Dataset
DEATH LOCATION TYPE CODE (PREFERRED)	Changed Dataset
DEATH NOT AT PREFERRED LOCATION REASON	Changed Dataset
DIAGNOSIS DATE	Changed Dataset
DIAGNOSIS SCHEME IN USE	Changed Dataset
DISABILITY CODE	Changed Dataset
DISABILITY IMPACT PERCEPTION	Changed Dataset
DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)	Changed Dataset
EARLIEST CLINICALLY APPROPRIATE DATE	Changed Dataset
EARLIEST REASONABLE OFFER DATE	Changed Dataset
EDUCATIONAL ASSESSMENT OUTCOME	Changed Dataset
EMPLOYMENT STATUS	Changed Dataset
EMPLOYMENT STATUS RECORDED DATE	Changed Dataset
END DATE (GMP PATIENT REGISTRATION)	Changed Dataset
ETHNIC CATEGORY	Changed Dataset
FINDING SCHEME IN USE	Changed Dataset
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	Changed Dataset
GROUP SESSION DATE	Changed Dataset
GROUP SESSION IDENTIFIER	Changed Dataset
GROUP SESSION TYPE (COMMUNITY CARE) renamed from GROUP SESSION TYPE CODE (COMMUNITY CARE)	Changed Dataset, Name
GROUP THERAPY INDICATOR	Changed Dataset
HEALTH VISITOR FIRST ANTENATAL VISIT DATE	

	Changed Dataset, Description
IMMUNISATION DATE	Changed Dataset
IMMUNISATION PROCEDURE (CLINICAL TERMINOLOGY)	Changed Dataset
INFANT PHYSICAL EXAMINATION DATE	Changed Dataset
INFANT PHYSICAL EXAMINATION RESULT (EYES)	Changed Dataset
INFANT PHYSICAL EXAMINATION RESULT (HEART)	Changed Dataset
INFANT PHYSICAL EXAMINATION RESULT (HIPS)	Changed Dataset
INFANT PHYSICAL EXAMINATION RESULT (TESTES)	Changed Dataset
LANGUAGE CODE (PREFERRED)	Changed Dataset
LOCAL PATIENT IDENTIFIER (EXTENDED)	Changed Dataset
LOOKED AFTER CHILD INDICATOR	Changed Dataset
NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (CONGENITAL HYPOTHYROIDISM)	Changed Dataset
NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (CYSTIC FIBROSIS)	Changed Dataset
NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (GLUTARIC ACIDURIA TYPE 1)	Changed Dataset
NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (HOMOCYSTINURIA)	Changed Dataset
NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (ISOVALERIC ACIDURIA)	Changed Dataset
NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (MAPLE SYRUP URINE DISEASE)	Changed Dataset
NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (MEDIUM CHAIN ACYL-COA DEHYDROGENASE DEFICIENCY)	Changed Dataset
NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (PHENYLKETONURIA)	Changed Dataset
NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (SICKLE CELL DISEASE)	Changed Dataset
NEWBORN BLOOD SPOT TEST RESULT RECEIVED DATE	Changed Dataset
NEWBORN HEARING AUDIOLOGY OUTCOME	Changed Dataset
NEWBORN HEARING SCREENING OUTCOME	Changed Dataset
NHS NUMBER	Changed Dataset
NHS NUMBER (MOTHER)	Changed Dataset
NHS NUMBER STATUS INDICATOR CODE	Changed Dataset
NHS NUMBER STATUS INDICATOR CODE (MOTHER)	Changed Dataset
NHS SERVICE AGREEMENT LINE NUMBER	Changed Dataset
NUMBER OF GROUP SESSION PARTICIPANTS	Changed Dataset
OBSERVATION SCHEME IN USE	Changed Dataset
OBSERVATION VALUE	Changed Dataset
OCCUPATION CODE	Changed Dataset
ONWARD REFERRAL DATE	Changed Dataset

ONWARD REFERRAL REASON	Changed Dataset
ORGANISATION CODE (CODE OF COMMISSIONER)	Changed Dataset
ORGANISATION CODE (CODE OF PROVIDER)	Changed Dataset
ORGANISATION CODE (CODE OF SUBMITTING ORGANISATION)	Changed Dataset
ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT) (RETIRED) renamed from ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)	Changed status to Retired, Dataset, Description, Name, linked Attribute
ORGANISATION CODE (GP PRACTICE RESPONSIBILITY) (RETIRED) renamed from ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)	Changed status to Retired, Dataset, Description, Name, linked Attribute
ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION) (RETIRED) renamed from ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION)	Changed status to Retired, Dataset, Description, Name, linked Attribute
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	Changed Dataset
ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	Changed Dataset
ORGANISATION CODE (RECEIVING)	Changed Dataset
ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	Changed Dataset
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	Changed Dataset
ORGANISATION IDENTIFIER (CODE OF PROVIDER)	Changed Dataset
ORGANISATION IDENTIFIER (CODE OF SUBMITTING ORGANISATION)	Changed Dataset
ORGANISATION IDENTIFIER (EDUCATIONAL ESTABLISHMENT)	Changed Dataset, Description
ORGANISATION IDENTIFIER (GP PRACTICE RESPONSIBILITY)	Changed Dataset, Description
ORGANISATION IDENTIFIER (IMMUNISATION RESPONSIBLE ORGANISATION)	Changed Dataset, Description
ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	Changed Dataset
ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	Changed Dataset
ORGANISATION IDENTIFIER (RECEIVING)	Changed Dataset
ORGANISATION IDENTIFIER (REFERRING)	Changed Dataset
ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	Changed Dataset
ORGANISATION SITE IDENTIFIER (OF TREATMENT)	Changed Dataset
OTHER REASON FOR REFERRAL (COMMUNITY CARE)	Changed Dataset
PATIENT PATHWAY IDENTIFIER	Changed Dataset
PERSON AT RISK OF UNEXPECTED DEATH INDICATOR	Changed Dataset
PERSON BIRTH DATE	Changed Dataset
PERSON DEATH DATE	Changed Dataset
PERSON HEIGHT IN METRES	Changed Dataset
PERSON LENGTH IN CENTIMETRES	Changed Dataset
PERSON RELATIONSHIP (MAIN CARER)	Changed Dataset, Description, linked Attribute

PERSON SCORE	Changed Dataset
PERSON STATED GENDER CODE	Changed Dataset
PERSON WEIGHT	Changed Dataset
POSTCODE OF USUAL ADDRESS	Changed Dataset
PREFERRED DEATH LOCATION DISCUSSED INDICATOR	Changed Dataset
PRESCRIPTION DATE (ASSISTIVE TECHNOLOGY)	Changed Dataset
PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY)	Changed Dataset
PRIMARY DATA COLLECTION SYSTEM IN USE	Changed Dataset
PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY)	Changed Dataset
PRIMARY REASON FOR REFERRAL (COMMUNITY CARE)	Changed Dataset
PRIORITY TYPE CODE	Changed Dataset
PROCEDURE DATE (NEWBORN HEARING AUDIOLOGY)	Changed Dataset
PROCEDURE SCHEME IN USE	Changed Dataset
PROFESSIONAL REGISTRATION BODY CODE	Changed Dataset
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER	Changed Dataset
PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY)	Changed Dataset
PROVISIONAL DIAGNOSIS DATE	Changed Dataset
REFERRAL CLOSURE DATE	Changed Dataset
REFERRAL CLOSURE REASON	Changed Dataset
REFERRAL REJECTION DATE	Changed Dataset
REFERRAL REJECTION REASON	Changed Dataset
REFERRAL REQUEST RECEIVED DATE	Changed Dataset
REFERRAL REQUEST RECEIVED TIME	Changed Dataset
REFERRAL TO TREATMENT PERIOD END DATE	Changed Dataset
REFERRAL TO TREATMENT PERIOD END TIME	New Data Element
REFERRAL TO TREATMENT PERIOD START DATE	Changed Dataset
REFERRAL TO TREATMENT PERIOD START TIME	New Data Element
REFERRAL TO TREATMENT PERIOD STATUS	Changed Dataset
REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE)	Changed Dataset
REFERRING ORGANISATION CODE	Changed Dataset
REPLACEMENT APPOINTMENT BOOKED DATE	Changed Dataset
REPLACEMENT APPOINTMENT DATE OFFERED	Changed Dataset
REPORTING PERIOD END DATE	Changed Dataset
REPORTING PERIOD START DATE	Changed Dataset
SAFEGUARDING VULNERABILITY FACTORS INDICATOR	Changed Dataset
SAFEGUARDING VULNERABILITY FACTORS TYPE	Changed Dataset
SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY)	Changed Dataset
SERVICE DISCHARGE DATE	Changed Dataset
SERVICE OR TEAM TYPE REFERRED TO (COMMUNITY CARE)	Changed Dataset
SERVICE REQUEST DATE (NEWBORN HEARING AUDIOLOGY)	Changed Dataset, Description, linked Attribute

SERVICE REQUEST IDENTIFIER	Changed Dataset
SITE CODE (OF TREATMENT)	Changed Dataset
SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT)	Changed Dataset
SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED DATE	Changed Dataset
SOURCE OF REFERRAL FOR COMMUNITY	Changed Dataset
SPECIAL EDUCATIONAL NEED TYPE	Changed Dataset
START DATE (GMP PATIENT REGISTRATION)	Changed Dataset
UCUM UNIT OF MEASUREMENT	Changed Dataset
UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	Changed Dataset
WAITING TIME MEASUREMENT TYPE	Changed Dataset
WEEKLY HOURS WORKED	Changed Dataset, Description

XML Schema Constraint

COMMUNITY SERVICES DATA SET CONSTRAINTS	New XML Schema Constraint

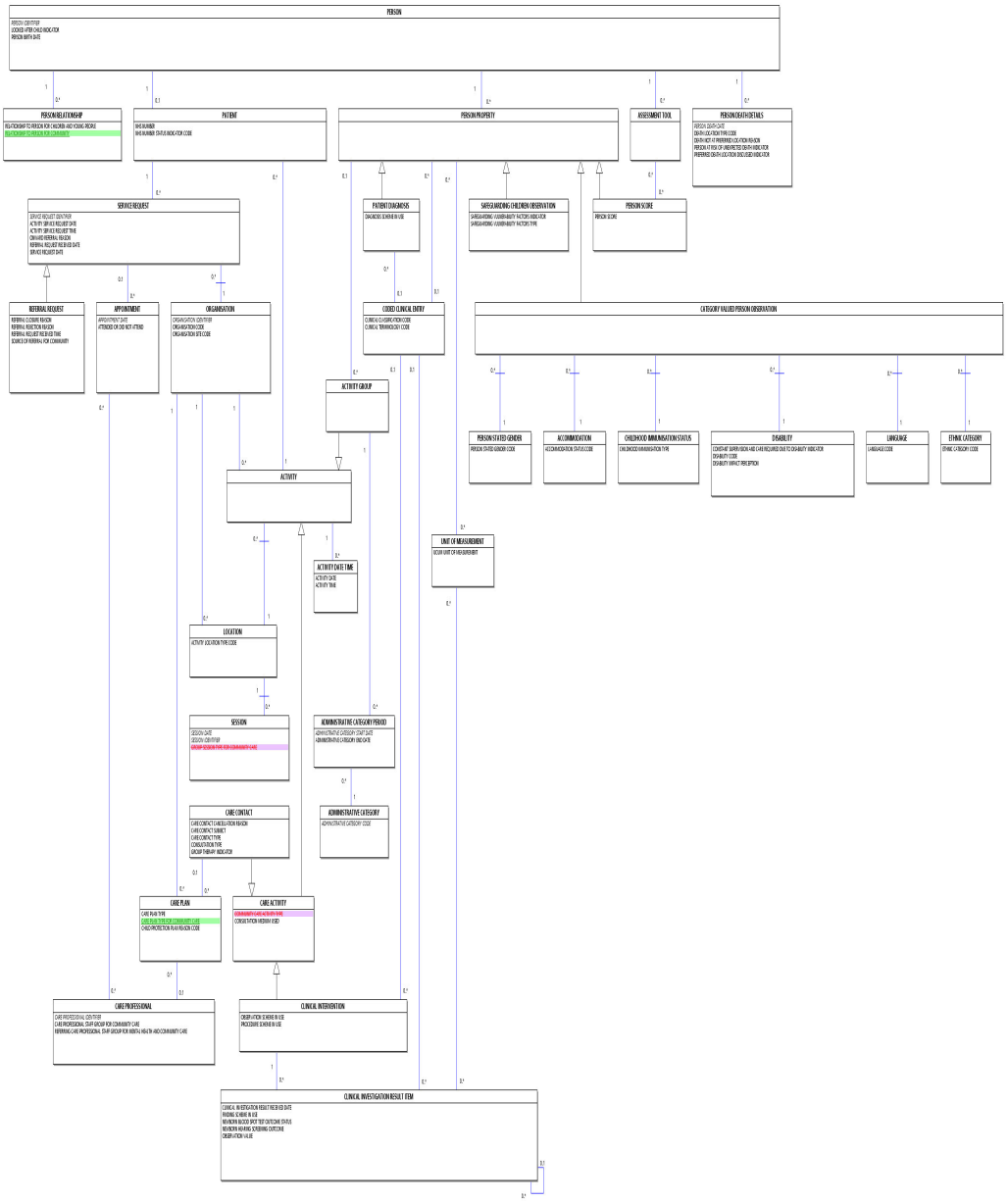
Date: 15 October 2019

Sponsor: Matthew Winn, Chief Executive - Cambridgeshire Community Services NHS Trust, Director Community Health and SRO for Ageing Well - NHS England/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.

COMMUNITY SERVICES DIAGRAM

Change to Diagram: Changed Diagram



COMMUNITY SERVICES DATA SET

Change to Data Set: Changed Dataset, Description

Community Services Data Set Overview

For a "Full Screen" view, click Community Services Data Set.

In the "Full Screen" view, to return to the "Data Set" view, click the browser "back" button.

The Mandatory, Required or Optional (M/R/O) column indicates the recommendation for the inclusion of data.

- M = Mandatory: this data element is mandatory and the technical process (e.g. submission of the data set, production of output etc) cannot be completed without this data element being present
- R = Required: NHS business processes cannot be delivered without this data element
- O = Optional: the inclusion of this data element is optional as required for local purposes.

For guidance on the Data Set constraints, see the Community Services Data Set Constraints.

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

SUBMISSION IDENTIFIER

M/R/O	Data Set Data Elements
M	DATA SET VERSION NUMBER
~~M~~	~~ORGANISATION CODE (CODE OF PROVIDER)~~
~~M~~	~~ORGANISATION CODE (CODE OF SUBMITTING ORGANISATION)~~
M	ORGANISATION IDENTIFIER (CODE OF PROVIDER)
M	ORGANISATION IDENTIFIER (CODE OF SUBMITTING ORGANISATION)
M	PRIMARY DATA COLLECTION SYSTEM IN USE
M	REPORTING PERIOD START DATE
M	REPORTING PERIOD END DATE
M	DATE AND TIME DATA SET CREATED

PATIENT DEMOGRAPHICS

~~Master Patient Index and Risk Indicators:~~ ~~To carry the personal details of the person and the associated mother's NHS number (where applicable).~~ ~~One occurrence of this group is required.~~
Master Patient Index and Risk Indicators: **To carry the personal details of the patient and the associated mother's NHS number (where applicable).** **One occurrence of this group is required for each patient.**

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
~~M~~	~~ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)~~
~~R~~	~~ORGANISATION CODE (RESIDENCE RESPONSIBILITY)~~
~~R~~	~~ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)~~
M	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)
R	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)
R	ORGANISATION IDENTIFIER (EDUCATIONAL ESTABLISHMENT)
R	NHS NUMBER
R	NHS NUMBER STATUS INDICATOR CODE
R	PERSON BIRTH DATE

R	POSTCODE OF USUAL ADDRESS
R	PERSON STATED GENDER CODE
R	ETHNIC CATEGORY
R	LANGUAGE CODE (PREFERRED)
R	PERSON RELATIONSHIP (MAIN CARER)
R	HEALTH VISITOR FIRST ANTENATAL VISIT DATE
R	LOOKED AFTER CHILD INDICATOR
R	SAFEGUARDING VULNERABILITY FACTORS INDICATOR
R	CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR
R	EDUCATIONAL ASSESSMENT OUTCOME
R	PREFERRED DEATH LOCATION DISCUSSED INDICATOR
R	PERSON AT RISK OF UNEXPECTED DEATH INDICATOR
R	DEATH LOCATION TYPE CODE (PREFERRED)
R	PERSON DEATH DATE
R	DEATH LOCATION TYPE CODE (ACTUAL)
R	DEATH NOT AT PREFERRED LOCATION REASON
R	NHS NUMBER (MOTHER)
R	NHS NUMBER STATUS INDICATOR CODE (MOTHER)

~~GP Practice Registration:~~ ~~To carry details of the GP Practice Registration of the person.~~ ~~One occurrence of this group is required.~~	
GP Practice Registration: **To carry details of the GP Practice Registration of the patient.** **One occurrence of this group is required for each change of GP Practice Registration.**	
M/R/O	**Data Set Data Elements**
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)
R	START DATE (GMP PATIENT REGISTRATION)
R	END DATE (GMP PATIENT REGISTRATION)
~~R~~	~~ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)~~
R	ORGANISATION IDENTIFIER (GP PRACTICE RESPONSIBILITY)

~~Accommodation Type:~~ ~~To carry details of the type of accommodation for the person.~~ ~~One occurrence of this group is permitted when accommodation details are recorded.~~	
Accommodation Type: **To carry details of the type of accommodation for the patient.** **One occurrence of this group is permitted for each accommodation status.**	
M/R/O	**Data Set Data Elements**
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ACCOMMODATION STATUS CODE
R	ACCOMMODATION STATUS RECORDED DATE

Care Plan Type:
To carry details of Care Plans created for a patient by the organisation.
One occurrence of this group is permitted for each Care Plan created for the patient.

M/R/O	Data Set Data Elements
M	CARE PLAN IDENTIFIER
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	CARE PLAN TYPE (COMMUNITY CARE)
M	CARE PLAN CREATION DATE
R	CARE PLAN CREATION TIME
R	CARE PLAN LAST UPDATED DATE
R	CARE PLAN LAST UPDATED TIME
R	CARE PLAN IMPLEMENTATION DATE

Care Plan Agreement:
To carry details of any agreements to a Care Plan by a patient, team or organisation.
One occurrence of this group is permitted for each agreement of a Care Plan.

M/R/O	Data Set Data Elements
M	CARE PLAN IDENTIFIER
M	CARE PLAN AGREED BY
R	CARE PLAN AGREED DATE
R	CARE PLAN AGREED TIME

Social and Personal Circumstances:
To carry details of social and personal circumstances of a patient.
One occurrence of this group is permitted for each social and personal circumstance recorded.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT)
M	SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED DATE

Employment Status:
To carry details of the employment status of the patient.
One occurrence of this group is permitted for each employment status.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	EMPLOYMENT STATUS
R	EMPLOYMENT STATUS RECORDED DATE
R	WEEKLY HOURS WORKED

REFERRALS

~~**Service or Team Referral:**~~
~~**To carry details of the Service or Team referral that the person is subject to.**~~
~~**One occurrence of this group is permitted for each referral.**~~

Service or Team Referral:
To carry details of the Service or Team referral that the patient is subject to.
One occurrence of this group is permitted for each referral.

M/R/O	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
~~M~~	~~ORGANISATION CODE (CODE OF COMMISSIONER)~~
M	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)
M	REFERRAL REQUEST RECEIVED DATE
R	REFERRAL REQUEST RECEIVED TIME
O	NHS SERVICE AGREEMENT LINE NUMBER
R	SOURCE OF REFERRAL FOR COMMUNITY
~~R~~	~~REFERRING ORGANISATION CODE~~
R	ORGANISATION IDENTIFIER (REFERRING)
R	REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE)
R	PRIORITY TYPE CODE
R	PRIMARY REASON FOR REFERRAL (COMMUNITY CARE)
R	SERVICE DISCHARGE DATE
R	DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)

~~**Service or Team Type Referred To:**~~
~~**To carry details of the Service or Team that the person has been referred to.**~~
~~**One occurrence of this group is permitted for each service or team that a person has been referred to.**~~

Service or Team Type Referred To:
To carry details of the Service or Team that the patient has been referred to.
One occurrence of this group is permitted for each service or team that a patient has been referred to.

M/R/O	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
R	CARE PROFESSIONAL TEAM LOCAL IDENTIFIER
M	SERVICE OR TEAM TYPE REFERRED TO (COMMUNITY CARE)
R	REFERRAL CLOSURE DATE
R	REFERRAL REJECTION DATE
R	REFERRAL CLOSURE REASON
R	REFERRAL REJECTION REASON

~~**Other Reason for Referral:**~~
~~**To carry details of additional reasons why a person has been referred to a specific service.**~~
~~**One occurrence of this group is permitted for each additional referral reason.**~~

Other Reason for Referral:
To carry details of additional reasons why a patient has been referred to a specific service.
One occurrence of this group is permitted for each additional referral reason.

M/R/O	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER

M	OTHER REASON FOR REFERRAL (COMMUNITY CARE)

~~Referral To Treatment (RTT):~~
~~To carry Referral to Treatment details for the person's referral.~~
~~One occurrence of this group is permitted for Referral to Treatment activity.~~

Referral To Treatment (RTT):
To carry Referral to Treatment details for the patient referral.
One occurrence of this group is permitted for each change in Referral To Treatment Period Status.

M/R/O	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
R	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)
R	PATIENT PATHWAY IDENTIFIER
~~R~~	~~ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)~~
R	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)
R	WAITING TIME MEASUREMENT TYPE
R	REFERRAL TO TREATMENT PERIOD START DATE
R	REFERRAL TO TREATMENT PERIOD START TIME
R	REFERRAL TO TREATMENT PERIOD END DATE
R	REFERRAL TO TREATMENT PERIOD END TIME
R	REFERRAL TO TREATMENT PERIOD STATUS

~~Onward Referral:~~
~~To carry details of any onward referral of the person which has taken place.~~
~~One occurrence of this group is permitted where an onward referral has taken place.~~

Onward Referral:
To carry details of any onward referral of the patient which has taken place.
One occurrence of this group is permitted for each onward referral.

M/R/O	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
M	ONWARD REFERRAL DATE
R	ONWARD REFERRAL REASON
~~R~~	~~ORGANISATION CODE (RECEIVING)~~
R	ORGANISATION IDENTIFIER (RECEIVING)

CARE CONTACT AND ACTIVITIES

~~Care Contact:~~
~~To carry details of any contacts with a person which have taken place as part of a referral.~~
~~One occurrence of this group is permitted for each contact.~~

Care Contact:
To carry details of any contacts with a patient which have taken place as result of a referral.
One occurrence of this group is permitted for each Care Contact.

M/R/O	Data Set Data Elements
M	CARE CONTACT IDENTIFIER
M	SERVICE REQUEST IDENTIFIER
R	CARE PROFESSIONAL TEAM LOCAL IDENTIFIER

M	CARE CONTACT DATE
R	CARE CONTACT TIME
~~R~~	~~ORGANISATION CODE (CODE OF COMMISSIONER)~~
R	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)
R	ADMINISTRATIVE CATEGORY CODE
R	CLINICAL CONTACT DURATION OF CARE CONTACT
R	CONSULTATION TYPE
R	CARE CONTACT SUBJECT
R	CONSULTATION MEDIUM USED
R	ACTIVITY LOCATION TYPE CODE
~~R~~	~~SITE CODE (OF TREATMENT)~~
R	ORGANISATION SITE IDENTIFIER (OF TREATMENT)
R	GROUP THERAPY INDICATOR
R	ATTENDED OR DID NOT ATTEND CODE
R	EARLIEST REASONABLE OFFER DATE
R	EARLIEST CLINICALLY APPROPRIATE DATE
R	CARE CONTACT CANCELLATION DATE
R	CARE CONTACT CANCELLATION REASON
R	REPLACEMENT APPOINTMENT DATE OFFERED
R	REPLACEMENT APPOINTMENT BOOKED DATE

~~**Care Activity:**~~ ~~**To carry details of any activities which have taken place as part of a contact with a person.**~~ ~~**One occurrence of this group is permitted for each activity.**~~	
Care Activity: **To carry details of any activities which have taken place as part of a contact with a patient.** **One occurrence of this group is permitted for each Care Activity.**	
M/R/O	**Data Set Data Elements**
M	CARE ACTIVITY IDENTIFIER
M	CARE CONTACT IDENTIFIER
~~M~~	~~COMMUNITY CARE ACTIVITY TYPE CODE~~
M	COMMUNITY CARE ACTIVITY TYPE
R	CARE PROFESSIONAL LOCAL IDENTIFIER
R	CLINICAL CONTACT DURATION OF CARE ACTIVITY
R	PROCEDURE SCHEME IN USE
R	CODED PROCEDURE (CLINICAL TERMINOLOGY)
R	FINDING SCHEME IN USE
R	CODED FINDING (CODED CLINICAL ENTRY)
R	OBSERVATION SCHEME IN USE
R	CODED OBSERVATION (CLINICAL TERMINOLOGY)
R	OBSERVATION VALUE

R	UCUM UNIT OF MEASUREMENT

GROUP SESSIONS

~~**Group Session:**~~
~~**To carry details of any group sessions which have been provided to a group of people during the reporting period.**~~
~~**One occurrence of this group is permitted where group session activity has taken place.**~~

Group Session:
To carry details of any group sessions which have been provided to a group of people during the reporting period.
One occurrence of this group is permitted for each Group Session activity.

M/R/O	Data Set Data Elements
M	GROUP SESSION IDENTIFIER
M	GROUP SESSION DATE
~~M~~	~~ORGANISATION CODE (CODE OF COMMISSIONER)~~
M	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)
R	CLINICAL CONTACT DURATION OF GROUP SESSION
~~R~~	~~GROUP SESSION TYPE CODE (COMMUNITY CARE)~~
R	GROUP SESSION TYPE (COMMUNITY CARE)
R	NUMBER OF GROUP SESSION PARTICIPANTS
O	ACTIVITY LOCATION TYPE CODE
~~R~~	~~SITE CODE (OF TREATMENT)~~
R	ORGANISATION SITE IDENTIFIER (OF TREATMENT)
R	CARE PROFESSIONAL LOCAL IDENTIFIER
O	NHS SERVICE AGREEMENT LINE NUMBER

SOCIAL CIRCUMSTANCES

Special Educational Need Identified:
To carry details of the child's or young person's Special Educational Need.
One occurrence of this group is permitted for each Special Educational Need identified.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	SPECIAL EDUCATIONAL NEED TYPE

Safeguarding Vulnerability Factor:
To carry details when the child's or young person is subject to any safeguarding concerns.
One occurrence of this group is permitted for each safeguarding concern.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	SAFEGUARDING VULNERABILITY FACTORS TYPE

Child Protection Plan:
To carry details when the child or young person is subject to a child protection plan.
One occurrence of this group is permitted for each child protection plan.

M/R/O	Data Set Data Elements

M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	CHILD PROTECTION PLAN REASON CODE
M	CHILD PROTECTION PLAN START DATE
R	CHILD PROTECTION PLAN END DATE

Assistive Technology to Support Disability Type:
To carry details when assistive technology is used to help support a disabled child or young person.
One occurrence of this group is permitted for each assistive technology type.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ASSISTIVE TECHNOLOGY FINDING (SNOMED CT)
R	PRESCRIPTION DATE (ASSISTIVE TECHNOLOGY)

IMMUNISATIONS

~~**Coded Immunisation:**~~
~~**To carry details of coded immunisation activity for a child or young person.**~~
~~**One occurrence of this group is permitted for each coded immunisation activity.**~~

Coded Immunisation:
To carry details of coded immunisation activity for a patient.
One occurrence of this group is permitted for each coded immunisation activity.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	IMMUNISATION DATE
M	PROCEDURE SCHEME IN USE
M	IMMUNISATION PROCEDURE (CLINICAL TERMINOLOGY)
~~R~~	~~ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION)~~
R	ORGANISATION IDENTIFIER (IMMUNISATION RESPONSIBLE ORGANISATION)

Immunisation:
To carry details of immunisation activity for a child or young person.
One occurrence of this group is permitted for each immunisation activity.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	IMMUNISATION DATE
M	CHILDHOOD IMMUNISATION TYPE (CHILDREN AND YOUNG PEOPLE'S HEALTH SERVICES)
~~R~~	~~ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION)~~
R	ORGANISATION IDENTIFIER (IMMUNISATION RESPONSIBLE ORGANISATION)

DIAGNOSES, TESTS AND OBSERVATIONS

~~**Medical History (Previous Diagnosis):**~~
~~**To carry details of any previous diagnoses for a person, which are stated by the patient or patient proxy or recorded in medical notes.**~~

~~These do not have to have been diagnosed by the organisation submitting the data.~~
~~One occurrence of this group is permitted for each previous diagnosis.~~

Medical History (Previous Diagnosis):
To carry details of any previous diagnoses for a patient, which are stated by the patient or patient proxy or recorded in medical notes.
These do not have to have been diagnosed by the organisation submitting the data.
One occurrence of this group is permitted for each previous diagnosis.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	DIAGNOSIS SCHEME IN USE
M	PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY)
R	DIAGNOSIS DATE

~~Disability Type:~~
~~To carry details of the type of disability affecting a person, based on their perception or the perception of a patient proxy.~~
~~One occurrence of this group is permitted for each disability identified.~~

Disability Type:
To carry details of the type of disability affecting a patient, based on their perception or the perception of a patient proxy.
One occurrence of this group is permitted for each disability identified.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	DISABILITY CODE
R	DISABILITY IMPACT PERCEPTION

~~Newborn Hearing Screening Audiology Referral:~~
~~To carry details of how concerns following Newborn Hearing Screening are followed up.~~
~~One occurrence of this group is permitted if concerns are identified.~~

Newborn Hearing Screening Audiology Referral:
To carry details of how concerns following Newborn Hearing Screening are followed up.
One occurrence of this group is permitted for each newborn hearing audiology test.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
R	NEWBORN HEARING SCREENING OUTCOME
R	SERVICE REQUEST DATE (NEWBORN HEARING AUDIOLOGY)
R	PROCEDURE DATE (NEWBORN HEARING AUDIOLOGY)
R	NEWBORN HEARING AUDIOLOGY OUTCOME

~~Blood Spot Result:~~
~~To carry details of the results of newborn blood spot tests.~~
~~One occurrence of this group is permitted where blood spot results are available.~~

Blood Spot Result:
To carry details of the results of newborn blood spot tests.
One occurrence of this group is permitted for each newborn blood spot test.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
R	BLOOD SPOT CARD COMPLETION DATE
R	NEWBORN BLOOD SPOT TEST RESULT RECEIVED DATE

R	NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (PHENYLKETONURIA)
R	NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (SICKLE CELL DISEASE)
R	NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (CYSTIC FIBROSIS)
R	NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (CONGENITAL HYPOTHYROIDISM)
R	NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (MEDIUM CHAIN ACYL-COA DEHYDROGENASE DEFICIENCY)
R	NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (HOMOCYSTINURIA)
R	NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (MAPLE SYRUP URINE DISEASE)
R	NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (GLUTARIC ACIDURIA TYPE 1)
R	NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (ISOVALERIC ACIDURIA)

~~**Infant Physical Examination (General Medical Practitioner Delivered):**~~
~~**To carry details of the Infant Physical Examination carried out by the General Medical Practitioner.**~~
~~**One occurrence of this group is permitted when an Infant Physical Examination has taken place.**~~

Infant Physical Examination (General Medical Practitioner Delivered):
To carry details of the Infant Physical Examination carried out by the General Medical Practitioner.
One occurrence of this group is permitted for each Infant Physical Examination.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	INFANT PHYSICAL EXAMINATION DATE
R	INFANT PHYSICAL EXAMINATION RESULT (HIPS)
R	INFANT PHYSICAL EXAMINATION RESULT (HEART)
R	INFANT PHYSICAL EXAMINATION RESULT (EYES)
R	INFANT PHYSICAL EXAMINATION RESULT (TESTES)

~~**Provisional Diagnosis:**~~
~~**To carry details of a provisional diagnosis for a person made by the service that the patient was referred to.**~~
~~**One occurrence of this group is permitted for each provisional diagnosis.**~~

Provisional Diagnosis:
To carry details of a provisional diagnosis for a patient made by the service that the patient was referred to.
One occurrence of this group is permitted for each provisional diagnosis.

M/R/O	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
M	DIAGNOSIS SCHEME IN USE
M	PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY)
R	PROVISIONAL DIAGNOSIS DATE

~~**Primary Diagnosis:**~~
~~**To carry details of the primary diagnosis for a person made by the service that the patient was referred to.**~~
~~**One occurrence of this group is permitted for the primary diagnosis. This can change during a reporting period.**~~

Primary Diagnosis:
To carry details of the primary diagnosis for a patient made by the service that the patient was referred to.
One occurrence of this group is permitted for the primary diagnosis. The primary diagnosis can change during a reporting period.

M/R/O	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
M	DIAGNOSIS SCHEME IN USE
M	PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY)
R	DIAGNOSIS DATE

~~**Secondary Diagnosis:**~~
~~**To carry details of a secondary diagnosis for a person made by the service that the patient was referred to.**~~
~~**One occurrence of this group is permitted for each secondary diagnosis.**~~

Secondary Diagnosis:
To carry details of a secondary diagnosis for a patient made by the service that the patient was referred to.
One occurrence of this group is permitted for each secondary diagnosis.

M/R/O	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
M	DIAGNOSIS SCHEME IN USE
M	SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY)
R	DIAGNOSIS DATE

Coded Scored Assessment (Referral):
To carry details of scored assessments that are issued and completed as part of a referral period where a specific service or team is responsible for the patient, but do not take place at a specific contact.
One occurrence of this group is permitted for each coded scored assessment question or dimension captured outside of a contact.

M/R/O	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
M	CODED ASSESSMENT TOOL TYPE (SNOMED CT)
M	PERSON SCORE
R	ASSESSMENT TOOL COMPLETION DATE

~~**Breastfeeding Status:**~~
~~**To carry the child's breastfeeding details as recorded at a contact.**~~
~~**One occurrence of this group is permitted when observed.**~~

Breastfeeding Status:
To carry details of a child's breastfeeding status as recorded at a contact.
One occurrence of this group is permitted containing the most recently recorded breastfeeding status.

M/R/O	Data Set Data Elements
M	CARE ACTIVITY IDENTIFIER
M	BREASTFEEDING STATUS

~~**Observation:**~~
~~**To carry details of observations of a person which take place at a contact.**~~
~~**One occurrence of this group is permitted when an observation is recorded.**~~

Observation:
To carry details of observations of a patient which take place at a contact.
One occurrence of this group is permitted containing the most recently recorded observation(s).

M/R/O	Data Set Data Elements
M	CARE ACTIVITY IDENTIFIER
R	PERSON WEIGHT

R	PERSON HEIGHT IN METRES
R	PERSON LENGTH IN CENTIMETRES

Coded Scored Assessment (Contact): To carry details of scored assessments that are issued and completed as part of a specific contact. One occurrence of this group is permitted for each coded scored assessment question or dimension.	
M/R/O	**Data Set Data Elements**
M	CARE ACTIVITY IDENTIFIER
M	CODED ASSESSMENT TOOL TYPE (SNOMED CT)
M	PERSON SCORE

ANONYMOUS SELF-ASSESSMENT

Anonymous Self-Assessment: To carry details of anonymous assessments that are issued by the Community Health Service. One occurrence of this group is permitted when an anonymous self-assessment is received from a patient.	
M/R/O	**Data Set Data Elements**
M	ASSESSMENT TOOL COMPLETION DATE
M	CODED ASSESSMENT TOOL TYPE (SNOMED CT)
M	PERSON SCORE
R	ACTIVITY LOCATION TYPE CODE
~~R~~	~~ORGANISATION CODE (CODE OF COMMISSIONER)~~
R	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)

STAFF DETAILS

~~Staff Details:~~ ~~To carry details of the staff involved in the treatment of a person.~~ ~~One occurrence of this group is permitted for each staff member.~~	
Staff Details: **To carry details of the staff involved in the treatment of a patient.** **One occurrence of this group is permitted for each staff member.**	
M/R/O	**Data Set Data Elements**
M	CARE PROFESSIONAL LOCAL IDENTIFIER
R	PROFESSIONAL REGISTRATION BODY CODE
R	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER
R	CARE PROFESSIONAL STAFF GROUP (COMMUNITY CARE)
R	OCCUPATION CODE
R	CARE PROFESSIONAL (JOB ROLE CODE)

CLINICAL DATA SETS MESSAGE DOCUMENTATION

Change to Supporting Information: Changed Description

XML Schema Download:

- XML Schema TRUD Download

XML Schema Constraints:

- Cancer Outcomes and Services Data Set XML Schema Constraints
- Diagnostic Imaging Data Set XML Schema Constraints
- HIV and AIDS Reporting Data Set XML Schema Constraints

Data Set Constraints:

- Community Services Data Set Constraints
- Maternity Services Data Set Constraints
- Mental Health Services Data Set Constraints

CLINICAL DATA SETS MESSAGE DOCUMENTATION MENU

Change to Supporting Information: Changed Description

Clinical Data Sets Menu

XML Schema Download:

- XML Schema TRUD Download

XML Schema Constraints:

- Cancer Outcomes and Services
- Diagnostic Imaging
- HIV and AIDS

Data Set Constraints:

- Community Services
- Maternity Services
- Mental Health Services

COMMUNITY BED-BASED INTERMEDIATE CARE

Change to Supporting Information: New Supporting Information

Community Bed-based Intermediate Care is an ACTIVITY GROUP.

Community Bed-based Intermediate Care provides assessments and CLINICAL INTERVENTIONS to PATIENTS in a bed-based setting, such as a community-commissioned Hospital Bed in an acute hospital, community hospital, residential Care Home, Care Home With Nursing, stand-alone Community Bed-based Intermediate Care facility, Independent Sector Healthcare Provider facility, Local Authority facility or other bed-based setting.

Community Bed-based Intermediate Care aims to prevent unnecessary admissions to acute hospitals and premature admissions to long-term care, and to support timely discharge from hospital. For most PATIENTS, CLINICAL INTERVENTIONS last up to 6 weeks.

Community Bed-based Intermediate Care should be delivered within two days of being referred to the Community Bed-based Intermediate Care Service.

- Step up Community Bed-based Intermediate Care:
  - provides care (in a bed-based setting) to help avoid unnecessary hospital admission for PATIENTS who following assessment are at risk of admission to hospital
  - includes PATIENTS who may be in their last years or months of life but are not in their last days of life

- Step down Community Bed-based Intermediate Care:
  - provides care to PATIENTS (in a bed-based setting) following an admission to hospital and who are determined by a "medically optimised for discharge" decision making process to be no longer in need of hospital care
  - includes PATIENTS who may be in their last years or months of life but are not in their last days of life.

For further information on Community Bed-based Intermediate Care, see the:

- age.uk website at: What is intermediate care?
- National Institute for Health and Care Excellence (NICE) website at: Intermediate care including reablement: NICE guideline [NG74].

COMMUNITY BED-BASED INTERMEDIATE CARE SERVICE

Change to Supporting Information: New Supporting Information

A Community Bed-based Intermediate Care Service is a SERVICE.

A Community Bed-based Intermediate Care Service provides Community Bed-based Intermediate Care to PATIENTS.

A Community Bed-based Intermediate Care Service is usually delivered by a Multidisciplinary Team but most commonly by CARE PROFESSIONALS, such as NURSES, Allied Health Professionals or Care Workers (in Care Homes).

This supporting information is also known by these names:

Context	Alias
plural	Community Bed-based Intermediate Care Services

Change to Supporting Information: Changed Dataset, Description

Contextual Overview

The Community Services Data Set (CSDS) is a PATIENT level, output based, secondary uses data set which will deliver robust, comprehensive, nationally consistent and comparable person-centred information for people who are in contact with NHS-funded Community Health Services. As a secondary uses data set it intends to re-use clinical and operational data for purposes other than direct PATIENT care. It defines the data items, definitions and associated value sets to be extracted or derived from local systems.

The data collected in the Community Services Data Set covers all NHS-funded Community Health Services provided by Health Care Providers in England. This includes all SERVICES listed in the SERVICE OR TEAM TYPE REFERRED TO FOR COMMUNITY CARE within the Community Services Data Set, including any SERVICES that have transitioned into new organisational forms as a result of the Transforming Community Services (TCS) programme. This includes acute and Independent Sector Healthcare Providers that provide NHS-funded Community Health Services.

The Community Services Data Set is used by the Department of Health and Social Care, commissioners and Health Care Providers of Community Health Services and PATIENTS, as the data set provides:

- National, comparable, standardised data about Community Health Services that are being delivered, which will support intelligent commissioning decisions and SERVICE provision
- Information on the use of resources to improve the operational management of SERVICES
- Information on outcomes, to help to address health inequalities
- Support for current national outcome indicators for Community Health Services
- Traceability and visibility of Community Health Service expenditure, allowing the implementation of new payment approaches for Community Health Services through the development of defined currencies which are underpinned by consistent data
- Information to improve reference costs for Community Health Services, to ensure that these are reported consistently
- Support for a nationally consistent clinical record for all PATIENTS across England, which can be used to support national research projects
- Information for the future development of Community Health Services.

Data Collection

~~The Community Services Data Set provides the definitions for data:~~The Community Services Data Set provides the definitions for data to provide timely, pseudonymised PATIENT-based data and information for purposes other than direct clinical care, e.g. planning, commissioning, public health, clinical audit, performance improvement, research, clinical governance.

- ~~To be lodged in the data warehouse regularly and routinely~~
- ~~To be assembled, compiled and to flow into a secondary uses data warehouse~~

- ~~To provide timely, pseudonymised PATIENT based data and information for purposes other than direct clinical care, e.g. planning, commissioning, public health, clinical audit, performance improvement, research, clinical governance.~~

Data is expected to be collected from various clinical systems, collated and assembled. This standard is intended to facilitate electronic data recording and reporting but it is not intended to create clinical records for Community Health Services or to enable systems used by Community Health Services to interoperate with other clinical systems.

Submission Information

~~The Community Services Data Set is submitted to NHS Digital using the Community Services Data Set (CSDS) XML Schema.~~The Community Services Data Set is submitted via the Strategic Data Collection Service in the Cloud (SDCS Cloud) maintained by NHS Digital using the Community Services Data Set (CSDS) XML Schema.

Format Information

Data for submission will be formatted into an XML file as per the Technology Reference Data Update Distribution (TRUD) page at: NHS Data Model and Dictionary: DD XML Schemas.

For enquiries regarding the XML Schema, please contact NHS Digital at enquiries@nhsdigital.nhs.uk.

Further Guidance

~~Further information and implementation guidance has been produced by NHS Digital and is available at: Community Services Data Set.~~Further information and implementation guidance has been produced by NHS Digital and is available at:

- Community Services Data Set
- Community Services Data Set user guidance.

CRISIS RESPONSE INTERMEDIATE CARE

Change to Supporting Information: New Supporting Information

Crisis Response Intermediate Care is an ACTIVITY GROUP.

Crisis Response Intermediate Care supports a PATIENT with identified care needs to remain at home when they are at risk of an unplanned hospital admission if unsupported.

Crisis Response Intermediate Care usually involves an assessment and may provide short-term CLINICAL INTERVENTIONS (typically up to 48 hours) if there is an urgent increase in the PATIENT's needs that can be safely managed at home. This includes care in the last days of life.

For further information on Crisis Response Intermediate Care, see the:

- age.uk website at: Crisis response
- National Institute for Health and Care Excellence (NICE) website at: Intermediate care including reablement: NICE guideline [NG74].

CRISIS RESPONSE INTERMEDIATE CARE SERVICE

Change to Supporting Information: New Supporting Information

A Crisis Response Intermediate Care Service is a SERVICE.

A Crisis Response Intermediate Care Service is a community-based SERVICE provided to PATIENTS in their own home or a Care Home within 2 hours of the need for Crisis Response Intermediate Care being identified.

The Crisis Response Intermediate Care Service is delivered by CARE PROFESSIONALS within a community-based Multidisciplinary Team. The Multidisciplinary Team could include: a community NURSE, Physiotherapist, Occupational Therapist, older PEOPLE's mental health NURSE, social care professional, for example, either a Social Worker or community care officer. Other therapy disciplines could work across their own specialist teams to support the Crisis Response Intermediate Care Service, for example, Dietitian, Speech and Language Therapist, Podiatrist.

This supporting information is also known by these names:

Context	Alias
plural	Crisis Response Intermediate Care Services

CRISIS RESPONSE INTERMEDIATE CARE WAITING TIME MEASUREMENT

Change to Supporting Information: New Supporting Information

A Crisis Response Intermediate Care Waiting Time Measurement is a REFERRAL TO TREATMENT PERIOD.

The Crisis Response Intermediate Care Waiting Time Measurement:

- is the duration between the REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME and REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME
- allows monitoring of waiting times for PATIENTS that are deemed not clinically appropriate for the Crisis Response Intermediate Care Within 2 Hours Waiting Time Measurement.

The Crisis Response Intermediate Care Waiting Time Measurement:

- REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME:
    - The PATIENT is identified by a CARE PROFESSIONAL or Social Care Worker as needing support from a Crisis Response Intermediate Care Service (in a community or Urgent Emergency Care (UEC) setting).
- REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME:
    - The CARE CONTACT DATE and CARE CONTACT TIME of the first face-to-face contact between the PATIENT, CARE PROFESSIONAL and Social Care Worker from the Crisis Response Intermediate Care Service.

This supporting information is also known by these names:

Context	Alias
plural	Crisis Response Intermediate Care Waiting Time Measurements

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CRISIS RESPONSE INTERMEDIATE CARE WITHIN 2 HOURS WAITING TIME MEASUREMENT

Change to Supporting Information: New Supporting Information

A Crisis Response Intermediate Care Within 2 Hours Waiting Time Measurement is a REFERRAL TO TREATMENT PERIOD.

A Crisis Response Intermediate Care Within 2 Hours Waiting Time Measurement is measured to ensure there are 120 minutes or less between the REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME and REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME.

The Crisis Response Intermediate Care Within 2 Hours Waiting Time Measurement:

- REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME:
    - The PATIENT is identified by a CARE PROFESSIONAL or Social Care Worker as needing support from a Crisis Response Intermediate Care Service.
- REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME:
    - The CARE CONTACT DATE and CARE CONTACT TIME of the first face-to-face contact between the PATIENT, CARE PROFESSIONAL and Social Care Worker from the Crisis Response Intermediate Care Service.

This supporting information is also known by these names:

Context	Alias
plural	Crisis Response Intermediate Care Within 2 Hours Waiting Time Measurements

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HOME-BASED INTERMEDIATE CARE

Change to Supporting Information: New Supporting Information

Home-based Intermediate Care is an ACTIVITY GROUP.

Home-based Intermediate Care provides clinical assessments and CLINICAL INTERVENTIONS to PATIENTS in their own home or in a Care Home. For most PATIENTS CLINICAL INTERVENTIONS last up to 6 weeks.

Home-based Intermediate Care aims to prevent hospital admissions, support faster recovery from illness, support timely discharge from hospital and maximise independent living.

Home-based Intermediate Care should be delivered within two days of being referred to the Home-based Intermediate Care Service.

- Step up Home-based Intermediate Care:
  - provides care (at home and/or in the community) to help avoid unnecessary hospital admission for PATIENTS who following assessment are at risk of being sent to and/or admitted to hospital
  - includes PATIENTS who may be in their last years or months of life but are not in their last days of life

- Step down Home-based Intermediate Care:
  - provides care to PATIENTS (at home or in their community) following an admission to hospital and who are determined by a "medically optimised for discharge" decision making process to be no longer in need of hospital care
  - includes PATIENTS who may be in their last years or months of life but are not in their last days of life.

For further information on Home-based Intermediate Care, see the:

- age.uk website at: What is intermediate care?
- National Institute for Health and Care Excellence (NICE) website at: Intermediate care including reablement: NICE guideline [NG74].

HOME-BASED INTERMEDIATE CARE SERVICE

Change to Supporting Information: New Supporting Information

A Home-based Intermediate Care Service is a SERVICE.

A Home-based Intermediate Care Service provides Home-based Intermediate Care to PATIENTS in their own home or in a Care Home.

A Home-based Intermediate Care Service is delivered by a Multidisciplinary Team but most commonly by CARE PROFESSIONALS, such as NURSES and Allied Health Professionals or Care Workers (in Care Homes).

This supporting information is also known by these names:

Context	Alias
plural	Home-based Intermediate Care Services

INTERMEDIATE CARE

Change to Supporting Information: New Supporting Information

Intermediate Care is an ACTIVITY GROUP.

Intermediate Care provides care to help PATIENTS achieve what they want to do, which may involve:

- remaining at home when the PATIENT starts to find things more difficult
- recovery after a fall, an acute illness or an operation
- avoiding going into hospital unnecessarily
- returning home more quickly after a hospital stay.

There are four types of Intermediate Care:

- Reablement Intermediate Care
- Crisis Response Intermediate Care
- Home-based Intermediate Care
- Community Bed-based Intermediate Care.

For further information on Intermediate Care, see the National Institute for Health and Care Excellence (NICE) website at: Understanding intermediate care.

INTERMEDIATE CARE SERVICE

Change to Supporting Information: New Supporting Information

An Intermediate Care Service is a SERVICE.

An Intermediate Care Service provides support for a short time to help PATIENTS recover and increase their independence.

There are four types of Intermediate Care Service:

- Reablement Intermediate Care Service
- Crisis Response Intermediate Care Service
- Home-based Intermediate Care Service
- Community Bed-based Intermediate Care Service.

This supporting information is also known by these names:

Context	Alias
plural	Intermediate Care Services

OTHER INTERMEDIATE CARE WAITING TIME MEASUREMENT

Change to Supporting Information: New Supporting Information

An Other Intermediate Care Waiting Time Measurement is a REFERRAL TO TREATMENT PERIOD.

The Other Intermediate Care Waiting Time Measurement:

- is for Intermediate Care other than Crisis Response Intermediate Care, i.e. Reablement Intermediate Care, Home-based Intermediate Care and Community Bed-based Intermediate Care
- allows monitoring of waiting times for PATIENTS that are deemed not clinically appropriate for the Other Intermediate Care Within 2 Days Waiting Time Measurement.

Reablement Intermediate Care:

The waiting time is the duration between the REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME and REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME.

The Reablement Intermediate Care Waiting Time Measurement:

- REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME:
  - The PATIENT is identified by a CARE PROFESSIONAL or Social Care Worker as needing reablement to enable care to be delivered in their own home as a safe alternative to hospital or Community Bed-based Intermediate Care.
    - For step up care, the need for the Reablement Intermediate Care Service is identified for a community-located PATIENT by a community-based CARE PROFESSIONAL or Social Care Worker
    - For step down care, the need for the Reablement Intermediate Care Service is identified for an acute hospital-located PATIENT based on a "medically optimised for

discharge" decision making process that determines care in hospital is no longer needed.

- REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME:
  - The CARE CONTACT DATE and CARE CONTACT TIME of the first face-to-face contact from a reablement worker in their own home.

Home-based Intermediate Care:

The waiting time is the duration between the REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME and REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME.

The Home-based Intermediate Care Waiting Time Measurement:

- REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME:
  - The PATIENT is identified by a CARE PROFESSIONAL or Social Care Worker as needing Home-based Intermediate Care as a safe alternative to hospital or Community Bed-based Intermediate Care.
    - For step up care, the need for the Home-based Intermediate Care Service is identified for a community-located PATIENT by a community-based CARE PROFESSIONAL or Social Care Worker.
    - For step down care, the need for the Home-based Intermediate Care Service is identified for an acute hospital-located PATIENT based on a "medically optimised for discharge" decision making process that determines care in hospital is no longer needed.
- REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME:
  - The CARE CONTACT DATE and CARE CONTACT TIME of the first face-to-face contact the PATIENT receives from an Intermediate Care Service CARE PROFESSIONAL in their own home.

Community Bed-based Intermediate Care:

The waiting time is measured to ensure there are 2 midnights or fewer between the REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME and REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME.

The Community Bed-based Intermediate Care Waiting Time Measurement:

- REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME:

- The PATIENT is identified by a CARE PROFESSIONAL or Social Care Worker as needing Community Bed-based Intermediate Care as a safe alternative to acute hospital care.
    - For step up care, the need for the Community Bed-based Intermediate Care is identified for a community-located PATIENT by a community-based CARE PROFESSIONAL or Social Care Worker.
    - For step down care, the need for the Community Bed-based Intermediate Care is identified for an acute hospital-located PATIENT based on a "medically optimised for discharge" decision making process that determines care in hospital is no longer needed.

- REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME:
    - The PATIENT is admitted to community-commissioned Hospital Bed.

This supporting information is also known by these names:

Context	Alias
plural	Other Intermediate Care Waiting Time Measurements

OTHER INTERMEDIATE CARE WITHIN 2 DAYS WAITING TIME MEASUREMENT

Change to Supporting Information: New Supporting Information

An Other Intermediate Care Within 2 Days Waiting Time Measurement is a REFERRAL TO TREATMENT PERIOD.

An Other Intermediate Care Within 2 Days Waiting Time Measurement is for Intermediate Care other than Crisis Response Intermediate Care, i.e. Reablement Intermediate Care, Home-based Intermediate Care and Community Bed-based Intermediate Care.

Reablement Intermediate Care:

The waiting time is measured to ensure there are 2 midnights or fewer between the REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME and REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME.

The Reablement Intermediate Care Within 2 Days Waiting Time Measurement:

- REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME:
    - The PATIENT is identified by a CARE PROFESSIONAL or Social Care Worker as needing reablement to enable care to be delivered in their own home as a safe alternative to hospital or Community Bed-based Intermediate Care.

        - For step up care, the need for the Reablement Intermediate Care Service is identified for a community-located PATIENT by a community-based CARE PROFESSIONAL or Social Care Worker.

        - For step down care, the need for the Reablement Intermediate Care Service is identified for an acute hospital-located PATIENT based on a "medically optimised for discharge" decision making process that determines care in hospital is no longer needed.

- REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME:
    - The CARE CONTACT DATE and CARE CONTACT TIME of the first face-to-face contact from a reablement worker in their own home.

Home-based Intermediate Care:

The waiting time is measured to ensure there are 2 midnights or fewer between the REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME and REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME.

The Home-based Intermediate Care Within 2 Days Waiting Time Measurement:

- REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME:
    - The PATIENT is identified by a CARE PROFESSIONAL or Social Care Worker as needing Home-based Intermediate Care as a safe alternative to hospital or Community Bed-based Intermediate Care.

        - For step up care, the need for the Home-based Intermediate Care Service is identified for a community-located PATIENT by a community-based CARE PROFESSIONAL or Social Care Worker

        - For step down care, the need for the Home-based Intermediate Care Service is identified for an acute hospital-located PATIENT based on a "medically optimised for discharge" decision making process that determines care in hospital is no longer needed.

- REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME:
    - The CARE CONTACT DATE and CARE CONTACT TIME of the first face-to-face contact the PATIENT receives from an Intermediate Care Service CARE PROFESSIONAL in their own home.

Community Bed-based Intermediate Care:

The waiting time is measured to ensure there are 2 midnights or fewer between the REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME and

REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME.

The Community Bed-based Intermediate Care Within 2 Days Waiting Time Measurement:

- REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME:
  - The PATIENT is identified by a CARE PROFESSIONAL or Social Care Worker as needing Community Bed-based Intermediate Care as a safe alternative to acute hospital care.
    - For step up care, the need for the Community Bed-based Intermediate Care is identified for a community-located PATIENT by a community-based CARE PROFESSIONAL or Social Care Worker.
    - For step down care, the need for the Community Bed-based Intermediate Care is identified for an acute hospital-located PATIENT based on a "medically optimised for discharge" decision making process that determines care in hospital is no longer needed.
- REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME:
  - The PATIENT is admitted to community-commissioned Hospital Bed.

This supporting information is also known by these names:

Context	Alias
plural	Other Intermediate Care Within 2 Days Waiting Time Measurements

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PERSONALISED CARE AND SUPPORT PLAN

Change to Supporting Information: New Supporting Information

A Personalised Care and Support Plan is a CARE PLAN.

A Personalised Care and Support Plan is a plan that sets out all the health and wellbeing needs of a PATIENT following a comprehensive holistic assessment of those needs.

A Personalised Care and Support Plan:

- is a way of capturing and recording conversations, decisions and agreed outcomes in a way that makes sense to the PATIENT
- should be proportionate, flexible and coordinated and adaptable to a PATIENT's health condition, situation and care and support needs
- should include a description of the PATIENT, what matters to them and all the necessary elements that would make the plan achievable and effective.

For further information on Personalised Care and Support Plans, see the NHS England website at: Personalised care and support planning handbook: The journey to person-centred care.

This supporting information is also known by these names:

Context	Alias
plural	Personalised Care and Support Plans

REABLEMENT INTERMEDIATE CARE

Change to Supporting Information: New Supporting Information

Reablement Intermediate Care is an ACTIVITY GROUP.

Reablement Intermediate Care provides clinical assessments and CLINICAL INTERVENTIONS to PATIENTS in their own home to enable the PERSON to recover skills, and regain confidence, and to maximise their independence.

- Step up Reablement Intermediate Care:
  - provides care to PATIENTS (at home and/or in the community) to help avoid unnecessary hospital admission for PATIENTS who following assessment are at risk of being sent to and/or admitted to hospital
  - includes PATIENTS who may be in their last years or months of life but are not in their last days of life

- Step down Reablement Intermediate Care:
  - provides care to PATIENTS (at home or in their community) following an admission to hospital and who are determined by a "medically optimised for discharge" decision making process to be no longer in need of hospital care
  - includes PATIENTS who may be in their last years or months of life but are not in their last days of life.

For further information on Reablement Intermediate Care, see the:

- age.uk website at: Reablement
- National Institute for Health and Care Excellence (NICE) website at: Intermediate care including reablement: NICE guideline [NG74].

REABLEMENT INTERMEDIATE CARE SERVICE

Change to Supporting Information: New Supporting Information

A Reablement Intermediate Care Service is a SERVICE.

A Reablement Intermediate Care Service comprises assessments and CLINICAL INTERVENTIONS provided to PATIENTS in their home (or Care Home) within 2 days of need for Reablement Intermediate Care being identified, which aims to help them recover, and relearn skills, and regain confidence and to maximise their independence. For most PATIENTS CLINICAL INTERVENTIONS last up to 6 weeks.

A Reablement Intermediate Care Service can be delivered by a Multidisciplinary Team, but is most commonly delivered by Social Care Workers.

This supporting information is also known by these names:

Context	Alias
plural	Reablement Intermediate Care Services

STRATEGIC DATA COLLECTION SERVICE IN THE CLOUD

Change to Supporting Information: New Supporting Information

The Strategic Data Collection Service in the Cloud (SDCS Cloud) is a secure solution using the cloud technology.

The Strategic Data Collection Service in the Cloud is different from other existing Strategic Data Collection Service collection tools.

The Strategic Data Collection Service in the Cloud provides:

- improved user experience and faster data quality feedback
- a secure solution using the cloud technology which will integrate with improved Data Processing Services.

For further information on the Strategic Data Collection Service in the Cloud, see the NHS Digital website at: Strategic Data Collection Service in the cloud (SDCS Cloud).

This supporting information is also known by these names:

Context	Alias
shortname	SDCS Cloud

XML SCHEMA TRUD DOWNLOAD

Change to Supporting Information: Changed Dataset

Background:

XML Schemas and Release Notes can be downloaded from Technology Reference Data Update Distribution (TRUD).

In order to access the XML Schemas and Release Notes on Technology Reference Data Update Distribution (TRUD), users will be required to:

- Create a TRUD account at: TRUD: Account Creation (if an account does not currently exist. This only has to be done once to access any XML Schema)
- Log into TRUD at: TRUD: Log in
- Access NHS Data Model and Dictionary: DD XML Schemas and subscribe to the XML Schema to be downloaded
- Accept the licence and request the subscription (an email will be sent immediately to confirm that the request has been accepted and the files can be downloaded, which avoids any delays)
- Once the "Subscription accepted" email has been received, download the zip file from NHS Data Model and Dictionary: DD XML Schemas.

Once an XML Schema has been added to TRUD, users who have subscribed to that item will be automatically notified by email of any updates to that area, for example, new versions, retirements etc.

XML Schema Download:

XML Schemas and Release Notes for the following Data Sets in the NHS Data Model and Dictionary can be downloaded from Technology Reference Data Update Distribution (TRUD) at: NHS Data Model and Dictionary: DD XML Schemas.

- Cancer Outcomes and Services Data Set (COSDS)
- Community Services Data Set (CSDS)
- Commissioning Data Set (CDS) V6-2
- Commissioning Data Set (CDS) V6-2-1
- Commissioning Data Set (CDS) V6-2-2
- CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set
- Diagnostic Imaging Data Set (DIDS)
- HIV and AIDS Reporting Data Set (HARS)
- Information Sharing to Tackle Violence Minimum Data Set (ISTVDS)
- Maternity Services Data Set (MSDS)
- National Cancer Waiting Times Monitoring Data Set (NCWTMDS)

For supplementary information on the XML Schema Publication and Download, see the NHS Data Model and Dictionary Service part of the NHS Digital website at: Policies: XML Schema Publication and Download guidance.

YOUNG PERSONS TRANSITION PLAN

Change to Supporting Information: New Supporting Information

A Young Persons Transition Plan is a CARE PLAN.

A Young Persons Transition Plan is owned by NHS England and NHS Improvement.

A Young Persons Transition Plan is a PERSON-centred plan that sets out a process for transitioning from Children's Services to Adult Services that reflects their individual characteristics, aspirations, and families and the different SERVICES they use, rather than apply a pre-determined set of transition options.

A Young Persons Transition Plan is strengths-based, and focuses on what is positive and possible for the Child or Young Person responding fully to their preferences. It sees the PERSON using care and support as an individual and equal partner with health and CARE PROFESSIONALS to make choices about their own care and support.

For further information on Young Persons Transition Plans, see the NHS England website at: Commissioning for transition to adult services for young people with Special Educational Needs and Disability (SEND).

This supporting information is also known by these names:

Context	Alias
plural	Young Persons Transition Plans

CARE ACTIVITY

Change to Class: Changed Attributes

Attributes of this Class are:

CARE ACTIVITY TYPE FOR PATIENT LEVEL INFORMATION COSTING

~~COMMUNITY CARE ACTIVITY TYPE CODE~~

COMMUNITY CARE ACTIVITY TYPE

CONSULTATION MEDIUM USED

FEMALE GENITAL MUTILATION IDENTIFICATION METHOD CODE

METHOD OF COMMUNICATION FOR END OF CANCER FASTER DIAGNOSIS PATHWAY

MOTHER ANTENATALLY BOOKED INDICATOR

RESTRICTIVE INTERVENTION POST INCIDENT REVIEW HELD INDICATOR

RESTRICTIVE INTERVENTION POST INCIDENT REVIEW NOT HELD REASON FOR PATIENT

RESTRICTIVE INTERVENTION RESTRAINT INJURY INDICATOR

RESTRICTIVE INTERVENTION TYPE

SEXUAL AND REPRODUCTIVE HEALTH CARE ACTIVITY

CARE PLAN

Change to Class: Changed Attributes

Attributes of this Class are:

K	CARE PLAN IDENTIFIER
	CANCER CARE PLAN INTENT
	CANCER RECURRENCE CARE PLAN INDICATOR
	CARE PLAN AGREED BY
	CARE PLAN TYPE
	CARE PLAN TYPE FOR COMMUNITY CARE
	CARE PLAN TYPE FOR MENTAL HEALTH
	CHILD PROTECTION PLAN INDICATION CODE
	CHILD PROTECTION PLAN REASON CODE
	DISCHARGE PLAN AGREED BY
	INTENDED DELIVERY PLACE
	MATERNITY PERSONALISED CARE PLAN INDICATOR
	MULTIDISCIPLINARY TEAM CANCER CARE PLAN DISCUSSED INDICATOR
	MULTIDISCIPLINARY TEAM MEETING TYPE FOR CANCER
	NO CANCER TREATMENT REASON

PERSON RELATIONSHIP

Change to Class: Changed Attributes

Attributes of this Class are:

	LEAD CONTACT INDICATOR
	PERSON RELATIONSHIP TYPE DONOR TO RECIPIENT
	RELATIONSHIP TO PERSON FOR CHILDREN AND YOUNG PEOPLE
	RELATIONSHIP TO PERSON FOR COMMUNITY

REFERRAL TO TREATMENT PERIOD

Change to Class: Changed Attributes

Attributes of this Class are:

K	REFERRAL TO TREATMENT PERIOD START DATE
	REFERRAL TO TREATMENT PERIOD END DATE
	REFERRAL TO TREATMENT PERIOD END TIME
	REFERRAL TO TREATMENT PERIOD START TIME
	REFERRAL TO TREATMENT PERIOD STATUS

REPORTING PERIOD

Change to Class: Changed Attributes

Attributes of this Class are:

K	REPORTING PERIOD END DATE
K	REPORTING PERIOD START DATE
	REPORTING PERIOD END TIME
	REPORTING PERIOD QUARTER END DATE
	REPORTING PERIOD QUARTER START DATE
	REPORTING PERIOD START TIME

SESSION

Change to Class: Changed Attributes

Attributes of this Class are:

K	SESSION DATE
K	SESSION IDENTIFIER
K	SESSION TIME
	~~GROUP SESSION TYPE CODE FOR COMMUNITY CARE~~
	GROUP SESSION TYPE FOR COMMUNITY CARE
	GROUP SESSION TYPE FOR MENTAL HEALTH

ACCOMMODATION STATUS CODE

Change to Attribute: Changed Dataset, Description

An indication of the type of accommodation that a PATIENT currently has. This should be based on the PATIENT's main or permanent residence.

National Codes:

MA00	**Mainstream Housing**
MA01	Owner occupier
MA02	Settled mainstream housing with family/friends
MA03	Shared ownership scheme e.g. Social Homebuy Scheme (tenant purchase percentage of home value from landlord)
MA04	Tenant - Local Authority/Arms Length Management Organisation/Registered Landlord
MA05	Tenant - Housing Association
MA06	Tenant - private landlord
~~MA09~~	~~Other mainstream housing~~
MA09	Other mainstream housing (not listed)
HM00	**Homeless**
HM01	Rough sleeper

HM02 Squatting

HM03 Night shelter/emergency hostel/Direct access hostel (temporary accommodation accepting self referrals, no waiting list and relatively frequent vacancies)

HM04 Sofa surfing (sleeps on different friends floor each night)

HM05 Placed in temporary accommodation by Local Authority (including Homelessness resettlement service) e.g. Bed and Breakfast accommodation

HM06 Staying with friends/family as a short term guest

~~HM07 Other homeless~~

HM07 Other homeless (not listed)

MH00 **Accommodation with mental health care support**

MH01 Supported accommodation (accommodation supported by staff or resident caretaker)

MH02 Supported lodgings (lodgings supported by staff or resident caretaker)

MH03 Supported group home (supported by staff or resident caretaker)

MH04 Mental Health Registered Care Home

~~MH09 Other accommodation with mental health care and support~~

MH09 Other accommodation with mental health care and support (not listed)

HS00 **Acute/long stay healthcare residential facility/hospital**

~~HS01 NHS acute psychiatric ward~~

HS01 NHS acute psychiatric WARD

HS02 Independent hospital/clinic

HS03 Specialist rehabilitation/recovery

HS04 Secure psychiatric unit

HS05 Other NHS facilities/hospital

~~HS09 Other acute/long stay healthcare residential facility/hospital~~

HS09 Other acute/long stay healthcare residential facility/hospital (not listed)

CH00 **Accommodation with other (not specialist mental health) care support**

CH01 Foyer - accommodation for young people aged 16-25 who are homeless or in housing need

CH02 Refuge

CH03 Non-Mental Health Registered Care Home

~~CH09 Other accommodation with care and support (not specialist mental health)~~

CH09 Other accommodation with care and support (not specialist mental health) (not listed)

CJ00 **Accommodation with criminal justice support**

CJ01 Bail/Probation hostel

CJ02 Prison

CJ03 Young Offender Institution

CJ04 Detention Centre

~~CJ05 Young Offender Institution (15-17) **~~

~~CJ06 Young Offender Institution (18-21) **~~

~~CJ07 Secure Children's Home (Secure Welfare Accommodation only) *~~

~~CJ08 Secure Children's Home (Youth Detention Accommodation only) *~~

~~CJ09 Other accommodation with criminal justice support such as ex-offender support ***~~

~~CJ10 Secure Children's Home (Secure Welfare Accommodation and Youth Detention Accommodation) *~~

~~CJ11 Secure Training Centre *~~

~~CJ12~~	~~Other accommodation with criminal justice support *~~
CJ05	Young Offender Institution (15-17)
CJ06	Young Offender Institution (18-21)
CJ07	Secure Children's Home (Secure Welfare Accommodation only)
CJ08	Secure Children's Home (Youth Detention Accommodation only)
CJ09	Other accommodation with criminal justice support such as ex-offender support (Retired 1 April 2020)
CJ10	Secure Children's Home (Secure Welfare Accommodation and Youth Detention Accommodation)
CJ11	Secure Training Centre
CJ12	Other accommodation with criminal justice support (not listed)
SH00	**Sheltered Housing (accommodation with a scheme manager or warden living on the premises or nearby, contactable by an alarm system if necessary)**
SH01	Sheltered housing for older persons
SH02	Extra care sheltered housing (also known as 'very sheltered housing'. For people who are less able to manage on their own, but who do need an extra level of care. Services offered vary between schemes, but meals and some personal care are often provided.)
SH03	Nursing Home for older persons
~~SH09~~	~~Other sheltered housing~~
SH09	Other sheltered housing (not listed)
ML00	**Mobile accommodation**
	Other
OC96	Not elsewhere classified

~~Notes:~~

- ~~* National Codes CJ07, CJ08, CJ10, CJ11 and CJ12 are **only** valid for the Mental Health Services Data Set. They are **NOT** valid in any other data set.~~
- ~~** National Codes CJ05 and CJ06 have been introduced for the Mental Health Services Data Set **only** to add further granularity to National Code CJ03. However, National Code CJ03 is still valid for the Mental Health Services Data Set where extra detail cannot be collected.~~
- ~~*** National Code CJ09 is **only** valid for the Community Services Data Set. It is **NOT** valid in any other data set.~~

ACTIVITY DATE

Change to Attribute: Changed Dataset

The date, month, year and century, or any combination of these elements, that is of relevance to an ACTIVITY.

The specific nature of the ACTIVITY DATE will be identified by the ACTIVITY DATE TYPE.

ACTIVITY DURATION

Change to Attribute: Changed Dataset

The duration of an ACTIVITY.

ACTIVITY GROUP TYPE

Change to Attribute: Changed Description

The type of ACTIVITY GROUP.

National Codes:

01	Accident and Emergency Episode
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
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
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
Community Bed-based Intermediate Care
Crisis Response Intermediate Care
Home-based Intermediate Care
Reablement Intermediate Care

Note:
The list is not in alphabetical order.

ACTIVITY IDENTIFIER

Change to Attribute: Changed Dataset

A unique number or set of characters that is applicable to only one ACTIVITY for a PATIENT within an Organisation.

ACTIVITY LOCATION TYPE CODE

Change to Attribute: Changed Dataset

The type of LOCATION for an ACTIVITY:

- where PATIENTS are seen
- where SERVICES are provided or
- from which requests for SERVICES are sent.

National Codes:

CODE	VALUE	NOTES
	PATIENT Main Residence or Related Location	
A01	PATIENT's Home	
A02	Carer's Home	
A03	PATIENT's Workplace	

A04	Other PATIENT Related Location	E.g. temporary address
	Health Centre Premises	
B01	Primary Care Health Centre	Primary Care Health Centre with or without GP Practice(s) based in it, providing community-based healthcare services such as podiatry, community dentistry, ophthalmology, minor injuries nursing etc, Sexual and Reproductive Health Service, health promotion etc, and sometimes hosting outreach services from NHS Trusts and NHS Foundation Trusts
B02	Polyclinic	Provide similar services to Primary Care Health Centre but also additional services such as diagnostics, minor procedures, Out-Patient Appointments, urgent care etc. and also co-located services with Local Authority Social Care. May also provide extended/out of hours services.
	GENERAL PRACTITIONER and OPHTHALMIC MEDICAL PRACTITIONER	
C01	General Medical Practitioner Practice	Stand-alone GP Practice premises, not part of a Primary Care Health Centre
C02	Dental Practice	Stand-alone GP Practice premises, not part of a Primary Care Health Centre
C03	OPHTHALMIC MEDICAL PRACTITIONER Premises	
	Walk In Centres, Out of Hours Premises and Emergency Community Dental Services	
D01	Walk In Centre	May be NHS GENERAL PRACTITIONER Led, NURSE-led, or provided by private company. May be sited in different areas - health care premises, in retail premises etc
D02	Out of Hours Centre	May be NHS GENERAL PRACTITIONER-Led, NURSE-led, or provided by private company. May be sited in different areas - health care premises, in retail premises etc
D03	Emergency Community Dental Service	Run by Community Dental Services not GENERAL DENTAL PRACTITIONERS
	Locations on Hospital Premises	
E01	Out-Patient Clinic	
E02	WARD	
E03	Day Hospital	
E04	Accident and Emergency or Minor Injuries Department	
E99	Other Departments	E.g. Pathology Laboratories, physiotherapy, diagnostic imaging, Occupational Therapy, Pharmacy Premises etc
	Hospice Premises	

F01	Hospice	
	Nursing and Residential Homes	
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 *	
	Day Centre Premises	
H01	Day Centre	Facilities operated by the NHS, Social Services or private or voluntary bodies, providing day care and respite care for elderly or disabled people
	Resource Centre Premises	
J01	Resource Centre	Premises where information and support for PATIENTS and their families/Carers is provided.
	Dedicated Facilities for Children and Families	
K01	Sure Start Children's Centre	Children's centres are service hubs where children under five years old and their families can receive seamless integrated services and information. Services vary according to centre but may include: • Integrated early education and childcare • Support for parents including advice on parenting, local childcare options and access to specialist services for families • Child and family health services • Helping parents into work
K02	Child Development Centre	
	Educational, Childcare and Training Establishments	
L01	School	Including Extended Services, where provided on School premises (where provided off School premises, use other appropriate location)
L02	Further Education College	
L03	University	
L04	Nursery Premises	Pre-school Nurseries attached to Schools would be classed as Schools in their own right
L05	Other Childcare Premises	E.g. Childminder
L06	Training Establishments	
L99	Other Educational Premises	Such as Teenage Pregnancy Units, School Preparation Units (for toddlers), Pupil Referral Units (excluded older children and young people), units providing specialist education e.g. deaf children, autistic children etc
	Justice and Home Office 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) **	
	Public Locations	
N01	Street or other public open space	Public areas such as streets, parks, outdoor sports facilities etc
N02	Other publicly accessible area or building	Publicly accessible premises such as Youth Centres, supermarkets, shops and other retail locations such as shopping centres, community facilities such as libraries, church halls, community centres etc
N03	Voluntary or charitable agency premises	
N04	Dispensing Optician Premises	
N05	Dispensing Pharmacy Premises	Where it is not on a Hospital Site
	Other Locations	
X01	Other locations not elsewhere classified	

Notes:

- Note: * National Code G04 is for use in the Community Services Data Set, Maternity Services Data Set and Mental Health Services Data Set. The values are not currently permitted to flow in other data sets. Users of these other data sets must map National Code G04 locally to other appropriate ACTIVITY LOCATION TYPE CODES for the purposes of flowing data.
- ** National Codes M06 and M07 have been introduced for the Mental Health Services Data Set only to add further granularity to National Code M04. However, National Code M04 is still valid for the Mental Health Services Data Set where extra detail cannot be collected. National Codes M06 and M07 are **NOT** valid in any other data set.

ACTIVITY SERVICE REQUEST DATE

Change to Attribute: Changed Dataset

The date that a SERVICE REQUEST for an ACTIVITY was made.

ACTIVITY TIME

Change to Attribute: Changed Dataset

The time (using a 24 hour clock) that is of relevance to an ACTIVITY.

The specific nature of the time will be identified by the ACTIVITY TIME TYPE.

ADMINISTRATIVE CATEGORY CODE

Change to Attribute: Changed Dataset

This is recorded for PATIENT ACTIVITY.

A PATIENT who is an Overseas Visitor does not qualify for free NHS healthcare and can choose to pay for NHS treatment or for private treatment. If they pay for NHS treatment then they should be recorded as NHS PATIENTS.

The PATIENT's ADMINISTRATIVE CATEGORY CODE may change during an episode or spell. For example, the PATIENT may opt to change from NHS to private health care. In this case, the start and end dates for each new ADMINISTRATIVE CATEGORY PERIOD (episode or spell) should be recorded.

If the ADMINISTRATIVE CATEGORY CODE changes during a Hospital Provider Spell the ADMINISTRATIVE CATEGORY CODE (ON ADMISSION) is used to derive the 'Category of PATIENT' for Hospital Episode Statistics (HES).

The category 'amenity PATIENT' is only applicable to PATIENTS using a Hospital Bed.

National Codes:

01	NHS PATIENT, including Overseas Visitors charged under the National Health Service (Overseas Visitors Hospital Charging Regulations)
02	Private PATIENT, one who uses accommodation or SERVICES authorised under the National Health Service Act 2006
03	Amenity PATIENT, one who pays for the use of a single room or small ward in accordance with the National Health Service Act 2006
04	Category II PATIENT, one for whom work is undertaken by hospital medical or dental staff within category II as defined in paragraph 37 of the Terms and Conditions of Service of Hospital Medical and Dental Staff.

APPOINTMENT DATE OFFERED

Change to Attribute: Changed Dataset

The actual date offered for an APPOINTMENT in response to a SERVICE REQUEST or an invitation as part of a HEALTH PROGRAMME.

ATTENDED OR DID NOT ATTEND

Change to Attribute: Changed Dataset

An indication of whether an APPOINTMENT for a CARE CONTACT took place.

If the APPOINTMENT did not take place it also indicates if advance warning was given.

When an APPOINTMENT is cancelled the APPOINTMENT CANCELLED DATE should also be recorded.

National Codes:

5	Attended on time or, if late, before the relevant CARE PROFESSIONAL was ready to see the PATIENT
6	Arrived late, after the relevant CARE PROFESSIONAL was ready to see the PATIENT, but was seen
7	PATIENT arrived late and could not be seen
2	APPOINTMENT cancelled by, or on behalf of, the PATIENT
3	Did not attend - no advance warning given
4	APPOINTMENT cancelled or postponed by the Health Care Provider
0	Not applicable - APPOINTMENT occurs in the future *

Note: The National Codes have been listed in logical sequence rather than alphanumeric order.

* Note that code 0 - '*Not applicable - APPOINTMENT occurs in the future*' is NOT valid for use in the following data sets:

- Community Services Data Set
- Improving Access to Psychological Therapies Data Set
- Maternity Services Data Set
- Mental Health Services Data Set

Use in the Future Outpatient Commissioning Data Set:

- For referral records with **no** APPOINTMENT yet made, or for **future** APPOINTMENTS, code 0 - *Not applicable - APPOINTMENT occurs in the future* should be used.
- Where the future attendance has been ***cancelled***, use the appropriate value from the National Codes.

BREASTFEEDING STATUS

Change to Attribute: Changed Dataset

The breastfeeding status of a baby.

National Codes:

01 Exclusively breast milk feeding
02 Partially breast milk feeding
03 No breast milk feeding at all

CARE CONTACT CANCELLATION REASON

Change to Attribute: Changed Dataset

The reason a CARE CONTACT was cancelled.

National Codes:

01 Cancelled for Clinical Reasons
02 Cancelled for Non-clinical Reasons

CARE CONTACT SUBJECT

Change to Attribute: Changed Dataset

The PERSON who was the subject of the CARE CONTACT.

National Codes:

01 PATIENT
02 Patient Proxy

CARE PLAN AGREED BY

Change to Attribute: Changed Dataset

The type of PERSON, SERVICE or Organisation that agreed the CARE PLAN for the PATIENT.

National Codes:

10 PATIENT or Patient Proxy
11 Family member or Carer
12 Advocate
13 Clinical Service or Team
14 Local Community Support Team
15 Commissioner

CARE PLAN IDENTIFIER

Change to Attribute: Changed Dataset

A unique identifier for a CARE PLAN.

CARE PLAN TYPE FOR COMMUNITY CARE

Change to Attribute: New Attribute

The type of CARE PLAN for the PATIENT recorded by the SERVICE for the Community Services Data Set.

National Codes:

01 Young Persons Transition Plan
02 Discharge Plan
03 Personalised Care and Support Plan

This attribute is also known by these names:

Context	Alias
plural	CARE PLAN TYPES FOR COMMUNITY CARE

CARE PLAN TYPE FOR COMMUNITY CARE

Change to Attribute: New Attribute

CARE PLAN TYPE FOR COMMUNITY CARE

Data Elements:

CARE PLAN TYPE (COMMUNITY CARE)

CARE PROFESSIONAL IDENTIFIER

Change to Attribute: Changed Dataset

A number or set of characters which uniquely identifies a CARE PROFESSIONAL.

CARE PROFESSIONAL STAFF GROUP FOR COMMUNITY CARE

Change to Attribute: Changed Dataset, Description

The staff group of a CARE PROFESSIONAL working in a Community Health Service.

National Codes:

	Allied Health Professionals
A01	Art Therapist
A02	Clinical Psychologist
A03	Dietitian
A04	Drama Therapist
A05	Music Therapist
A06	Occupational Therapist
A07	Orthotist
A08	Physiotherapist
A09	Podiatrist
A10	Prosthetist
A11	Psychotherapist
A12	Radiographer
A13	Speech and Language Therapist
A14	Orthoptist
	Medical/Dental
M01	Community Dentist
M02	CONSULTANT
M03	GENERAL MEDICAL PRACTITIONER
M04	GENERAL MEDICAL PRACTITIONER with Special Interest
	Nursing, Health Visiting and Midwifery
N01	MIDWIFE
N02	District NURSE
N03	Health Visitor
N04	Macmillan NURSE
N05	School Nurse
N06	Specialist Nursing - Active Case Management (Community Matrons)
N07	Specialist Nursing - Arthritis Nursing/Liaison
N08	Specialist Nursing - Asthma and Respiratory Nursing/Liaison
N09	Specialist Nursing - Breast Care Nursing/Liaison
N10	Specialist Nursing - Cancer Related
N11	Specialist Nursing - Cardiac Nursing/Liaison
N12	Specialist Nursing - Children's Services
N13	Specialist Nursing - Community Cystic Fibrosis
N14	Specialist Nursing - Continence Services
N15	Specialist Nursing - Diabetic Nursing/Liaison
N16	Specialist Nursing - Enteral Feeding Nursing Services
N17	Specialist Nursing - Haemophilia Nursing Services
N18	Specialist Nursing - HIV/AIDS Nursing Services (Retired 01 September 2015)
N19	Specialist Nursing - Infectious Diseases

N20	Specialist Nursing - Intensive Care Nursing
N21	Specialist Nursing - Palliative/Respite Care
N22	Specialist Nursing - Parkinson's and Alzheimers Nursing/Liaison
N23	Specialist Nursing - Rehabilitation Nursing
N24	Specialist Nursing - Stoma Care Services
N25	Specialist Nursing - Tissue Viability Nursing/Liaison
N26	Specialist Nursing - Transplantation Patients Nursing Service
N27	Specialist Nursing - Treatment Room Nursing Services
N28	Specialist Nursing - Tuberculosis Specialist Nursing
N29	Specialist Nursing - Other Specialist Nursing
N30	Specialist Nursing - Safeguarding
N31	Practice Nursing (Retired 01 September 2015)
N32	Staff NURSE
N33	Other Registered NURSE
N34	Public Health NURSE
	Other Care Professionals
C01	Appliances Technician
C02	Audiologist
C03	Counsellor
C04	Nursery Nurse
C06	Play Therapist
C07	Social Worker
C08	Voluntary Care Worker
C09	Screener (in a National Screening Programme)
C10	Health Trainer (Non Clinical)
C11	Health Trainer (Clinical)
C12	Health Care Assistant
C13	Health Care Support Worker
~~C99~~	~~Other CARE PROFESSIONAL~~
C99	Other CARE PROFESSIONAL (not listed)

CARE PROFESSIONAL TEAM IDENTIFIER

Change to Attribute: Changed Dataset

A unique identifier for a CARE PROFESSIONAL TEAM.

CHILDHOOD IMMUNISATION TYPE

Change to Attribute: Changed Dataset, Description

The type of childhood immunisation given to a child on the IMMUNISATION DATE.

Note: National Codes in bold are at a high level. Either the higher level national code or the lower level code national code should be reported as required by the Data Set.

National Codes:

010 Diphtheria
011 D3 - Diphtheria
012 D4 - Diphtheria booster
020 Pertussis
021 aP3 - Pertussis
022 aP4 - Pertussis booster
030 Tetanus
031 T3 - Tetanus
032 T4 - Tetanus booster
040 Polio
041 Po3 - Polio
042 Po4 - Polio booster
050 Haemophilus influenzae type b
051 Hib3 - Haemophilus influenzae type b
060 Measles, Mumps, Rubella (MMR)
061 MMR1 - Measles, Mumps, Rubella
062 MMR2 - Measles, Mumps, Rubella
070 Meningococcal serogroup C (MenC) **
080 Haemophilus influenzae type b and Meningococcal C (booster) (Hib/MenC (booster))
090 Pneumococcal (PCV)
091 PCV2 - Pneumococcal
092 PCV (booster) - Pneumococcal (booster)
100 Low dose Diphtheria
110 Human papillomavirus (HPV)
120 Rotavirus
130 Hepatitis B (Hep B)
131 Hepatitis B (Hep B3) - Routine *
132 Hepatitis B (Hep B) - Selective *
140 Tuberculosis (BCG)
150 Meningococcal serogroup B (MenB)
151 MenB2 - Meningococcal serogroup B
152 MenB (booster) - Meningococcal serogroup B (booster)
160 Meningococcal ACWY **
170 Nasal Flu Vaccination **

Notes:

- * National Codes 131 and 132 are not valid for use in the Community Services Data Set.

- ~~** National Code 70 is not valid for use in the Cover of Vaccination Evaluated Rapidly (COVER) Data Set.~~
- ** National Code 70, 160 and 170 are not valid for use in the Cover of Vaccination Evaluated Rapidly (COVER) Data Set.

CHILD PROTECTION PLAN REASON CODE

Change to Attribute: Changed Dataset

The reason the Child or Young Person is subject to an active Child Protection Plan.

National Codes:

01	Neglect
02	Physical Abuse
03	Emotional Abuse
04	Sexual Abuse

CLINICAL CLASSIFICATION CODE

Change to Attribute: Changed Dataset

A unique clinical classification identifier for a CODED CLINICAL ENTRY.

This could be OPCS Classification of Interventions and Procedures (OPCS-4) codes or International Classification of Diseases (ICD) codes.

See Clinical Coding for further information about the types of CODED CLINICAL ENTRIES.

CLINICAL INVESTIGATION RESULT RECEIVED DATE

Change to Attribute: Changed Dataset

The date the CLINICAL INVESTIGATION RESULT ITEM is received from the Laboratory by the Health Care Provider.

CLINICAL INVESTIGATION RESULT VALUE

Change to Attribute: Changed Dataset

The recorded value for a CLINICAL INVESTIGATION RESULT ITEM.

A UNIT OF MEASUREMENT may be recorded for a CLINICAL INVESTIGATION RESULT VALUE.

CLINICAL TERMINOLOGY CODE

Change to Attribute: Changed Dataset

A unique clinical terminology identifier for a CODED CLINICAL ENTRY.

This could be Read Coded Clinical Terms, SNOMED CT concepts or defined in the National Interim Clinical Imaging Procedure Code Set.

See Clinical Coding for further information about the types of CODED CLINICAL ENTRIES.

Note: SNOMED CT is the Information Standard for clinical terminology for use within the NHS; it is planned that in time this will be the only terminology used by the NHS.

COMMUNITY CARE ACTIVITY TYPE renamed from COMMUNITY CARE ACTIVITY TYPE CODE

Change to Attribute: Changed Dataset, Name

The type of CARE ACTIVITY performed during a CARE CONTACT by a Community Health Service CARE PROFESSIONAL.

National Codes:

01	Administering Tests
02	Assessment
03	CLINICAL INTERVENTION
04	Counselling, Advice, Support
05	PATIENT Specific Health Promotion
06	Multidisciplinary Team Review
07	Supporting Another Clinician
08	Health Visitor New Birth Visit
09	Health Visitor Health Review (6-8 weeks)
10	Health Visitor Health Review (1 year)
11	Health Visitor Health Review (2-2.5 years)
12	Health Visitor Formal handover to School Nursing Service (4-5 years)
97	Other (not listed)
98	Other (Retired 01 September 2015)

COMMUNITY CARE ACTIVITY TYPE renamed from COMMUNITY CARE ACTIVITY TYPE CODE

Change to Attribute: Changed Dataset, Name

- null
- Changed Name from Data_Dictionary.Attributes.C.Com.COMMUNITY_CARE_ACTIVITY_TYPE_CODE to Data_Dictionary.Attributes.C.Com.COMMUNITY_CARE_ACTIVITY_TYPE

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR

Change to Attribute: Changed Dataset, Description

~~An indication of whether a disabled PERSON requires constant (round the clock) care and/or supervision for maintenance of their safety and/or wellbeing.~~An indication of whether a disabled PATIENT requires constant (round the clock) care and/or supervision for maintenance of their safety and/or wellbeing.

National Codes:

~~Y~~	~~Yes - PERSON requires constant care and/or supervision~~
~~N~~	~~No - PERSON does not require constant care and/or supervision~~
Y	Yes - PATIENT requires constant care and/or supervision
N	No - PATIENT does not require constant care and/or supervision

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CONSULTATION MEDIUM USED

Change to Attribute: Changed Dataset

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.

The consultation should directly support diagnosis and care planning and must replace a face to face Out-Patient Attendance Consultant, Clinic Attendance Nurse or Clinic Attendance Midwife, types of CARE ACTIVITY.

A record of the consultation must be retained in the PATIENT's records.

Telephone contacts solely for informing PATIENTS of results are excluded.

National Codes:

01	Face to face communication
02	Telephone
03	Telemedicine
04	Talk type for a PERSON unable to speak
05	Email **

06 Short Message Service (SMS) - Text Messaging ***
07 On-line Triage****
98 Other (not listed) *

Notes:

- National Code 03 has been updated in Data Dictionary Change Notice 1734 "Consultation Medium Used Update". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.
- * National Code 98 *'Other'* is **only** used for the Community Services Data Set, Maternity Services Data Set, Mental Health Services Data Set and Sexual and Reproductive Health Activity Data Set. It is **NOT** valid in any other data set including Commissioning Data Set version 6-2.
- ** National Codes 05 '*Email*' is **NOT** valid for Commissioning Data Set version 6-2.
- *** National Code 06 '*Short Message Service (SMS) - Text Messaging*' is **NOT** valid for Commissioning Data Set version 6-2 and the HIV and AIDS Reporting Data Set.
- **** National Code 07 *'On-line Triage'* is **only** used for the GUMCAD Sexually Transmitted Infection Surveillance System Data Set. It is **NOT** valid in any other data set including Commissioning Data Set version 6-2.

CONSULTATION TYPE

Change to Attribute: Changed Dataset

The type of consultation between the CARE PROFESSIONAL and the PATIENT.

National Codes:

01 Initial Consultation
02 Follow-up Consultation

DATA SET VERSION NUMBER

Change to Attribute: Changed Dataset

The version number of a Data Set.

DEATH LOCATION TYPE CODE

Change to Attribute: Changed Dataset

The type of LOCATION:

- At which a PERSON died or

- The preferred LOCATION of death of the PATIENT, as stated by the PATIENT, Patient Proxy or Carer.

Note that Organisations may choose to collect the DEATH LOCATION TYPE CODE codes at the high level (shown in **bold**) or at the more detailed level below each high-level code.

National Codes:

10 **Hospital**
20 **Private Residence**
21 PATIENT's own home
22 Other private residence (e.g. relative's home, Carer's home)
30 **Hospice**
40 **Care Home**
41 Care Home With Nursing
42 Care Home Without Nursing
50 **Other (not listed)**

DEATH NOT AT PREFERRED LOCATION REASON

Change to Attribute: Changed Dataset

The reason why the PATIENT did not die at their preferred LOCATION of death.

National Codes:

01 Family decided to move PATIENT to hospital
02 PATIENT was moved to hospital for clinical reasons
03 PATIENT changed their mind
04 Capacity not available at preferred LOCATION
05 Transfer delays
06 Social support issues
07 Need for access to adequate pain relief
98 Other (not listed)

DIAGNOSIS SCHEME IN USE

Change to Attribute: Changed Dataset

The type of CODED CLINICAL ENTRY used for the PATIENT DIAGNOSIS.

National Codes:

01 Accident & Emergency Diagnosis ***
02 ICD-10

03	Read Code 4Byte Version (retired 1 October 2009)
04	Read Coded Clinical Terms Version 2
05	Read Coded Clinical Terms Version 3 (CTV3) *
06	SNOMED CT® **

Notes:

- * Read Coded Clinical Terms Version 3 (CTV3) with qualifiers (previously known as 3.1) is not supported in the Commissioning Data Sets
- ** SNOMED CT® is not valid for Commissioning Data Set version 6-2
- *** Accident & Emergency Diagnosis is not valid for the Community Services Data Set, Maternity Services Data Set and Mental Health Services Data Set.

DISABILITY CODE

Change to Attribute: Changed Dataset

The DISABILITY of a PERSON.

This could be where:

- the PERSON has been diagnosed as disabled or
- the PERSON considers themself to be disabled.

A PERSON can have more than one DISABILITY CODE.

National Codes:

01	Behaviour and Emotional
02	Hearing
03	Manual Dexterity
04	Memory or ability to concentrate, learn or understand (Learning Disability)
05	Mobility and Gross Motor
06	Perception of Physical Danger
07	Personal, Self Care and Continence
08	Progressive Conditions and Physical Health (such as HIV, cancer, multiple sclerosis, fits etc)
09	Sight
10	Speech
XX	Other (not listed)
NN	No DISABILITY
ZZ	Not Stated (PERSON asked but declined to provide a response)

DISABILITY IMPACT PERCEPTION

Change to Attribute: Changed Dataset, Description

The PATIENT or Patient Proxy's perception of whether the PATIENT's day-to-day activities are limited because of a health problem or DISABILITY which has lasted, or is expected to last, at least 12 months.

National Codes:

01	Yes - limited a lot
02	Yes - limited a little
03	No - not limited
~~04~~	~~Prefer not to say (PERSON asked but declined to provide a response)~~
04	Prefer not to say (PATIENT asked but declined to provide a response)

EDUCATIONAL ASSESSMENT OUTCOME

Change to Attribute: Changed Dataset

The outcome of an EDUCATIONAL ASSESSMENT.

National Codes:

01	No Special Education Needs
02	School Action (Retired 01 September 2015)
03	School Action Plus and Statutory Assessment (Retired 01 September 2015)
04	Statemented (Retired 01 September 2015)
05	Subject to Education, Health and Care Plan (EHC)

EMPLOYMENT STATUS

Change to Attribute: Changed Dataset

The current EMPLOYMENT status of a PERSON.

National Codes:

01	Employed
02	Unemployed and actively seeking work
03	Undertaking full (at least 16 hours per week) or part-time (less than 16 hours per week) education or training as a student and not working or actively seeking work
04	Long-term sick or disabled, those receiving government sickness and disability benefits
05	Looking after the family or home as a homemaker and not working or actively seeking work
06	Not receiving government sickness and disability benefits and not working or actively seeking work
07	Unpaid voluntary work and not working or actively seeking work

08 Retired
ZZ Not Stated (PERSON asked but declined to provide a response)

ETHNIC CATEGORY CODE

Change to Attribute: Changed Dataset

The ethnicity of a PERSON, as specified by the PERSON.

Note: ETHNIC CATEGORY is the classification used for the 2001 census.

The Office for National Statistics has developed a further breakdown of the group from that given, which may be used locally.

National Codes:

White
- A British
- B Irish
- C Any other White background

Mixed
- D White and Black Caribbean
- E White and Black African
- F White and Asian
- G Any other mixed background

Asian or Asian British
- H Indian
- J Pakistani
- K Bangladeshi
- L Any other Asian background

Black or Black British
- M Caribbean
- N African
- P Any other Black background

Other Ethnic Groups
- R Chinese
- S Any other ethnic group

- Z Not stated

National code Z - Not Stated should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to.

EVENT DATE

Change to Attribute: Changed Dataset

The date, month, year and century, or any combination of these elements, of an EVENT.

EVENT TIME

Change to Attribute: Changed Dataset

The time (using a 24 hour clock) at which an EVENT, or the action in an EVENT, takes place.

FINDING SCHEME IN USE

Change to Attribute: Changed Dataset

The type of CODED CLINICAL ENTRY used for the finding.

National Codes:

01 ICD-10
02 Read Coded Clinical Terms Version 2
03 Read Coded Clinical Terms Version 3 (CTV3)
04 SNOMED CT®

GROUP SESSION TYPE FOR COMMUNITY CARE_ renamed from GROUP SESSION TYPE CODE FOR COMMUNITY CARE

Change to Attribute: Changed Dataset, Name

The type of Group Session provided by a Community Health Service.

National Codes:

01 Antenatal Session
02 Parent/Carer and Child Session
03 General Health Promotion Session
04 Screening Programme
05 Stop Smoking Education Programme

06 Substance Misuse
07 Weight Management
08 Contraception and Sexual Health
98 Other (not listed)

GROUP SESSION TYPE FOR COMMUNITY CARE_ renamed from GROUP SESSION TYPE CODE FOR COMMUNITY CARE

Change to Attribute: Changed Dataset, Name

- null
- Changed Name from Data_Dictionary.Attributes.G.Gr.GROUP_SESSION_TYPE_CODE_FOR_COMMUNITY_CARE to Data_Dictionary.Attributes.G.Gr.GROUP_SESSION_TYPE_FOR_COMMUNITY_CARE

GROUP THERAPY INDICATOR

Change to Attribute: Changed Dataset

An indication of whether a CARE ACTIVITY was delivered as Group Therapy.

National Codes:

Y Yes - CARE ACTIVITY was delivered as Group Therapy
N No - CARE ACTIVITY was delivered individually

INVESTIGATION EXAMINATION RESULT

Change to Attribute: Changed Dataset

An outcome of a physical examination as part of a Clinical Investigation.

National Codes:

01 Satisfactory
02 Problem Identified
03 Problem Suspected
NN Not Examined

JOB ROLE CODE

Change to Attribute: Changed Dataset

A National Code for a POSITION applicable to an EMPLOYEE.

National Codes:

01000	**Medical and Dental**
01001	Medical Director
01002	Clinical Director - Medical
01003	Professor
01004	Senior Lecturer
01005	CONSULTANT
01006	Dental surgeon acting as Hospital CONSULTANT
01007	Special salary scale in Public Health Medicine
01008	Associate Specialist (Closed to new entrants from 01 April 2008 or regrading from 01 April 2009)
01009	Staff Grade (Closed to new entrants 01 April 2008)
01010	Hospital Practitioner
01011	Clinical Assistant
01012	Specialist Registrar - Closed (Retired 01 April 2010)
01013	Senior House Officer - Closed (Retired 01 April 2010)
01014	House Officer - Pre-registration - Closed (Retired 01 April 2010)
01015	House Officer - Post-registration - Closed (Retired 01 April 2010)
01016	Trust Grade Doctor - House Officer level - Closed (Retired 01 April 2010)
01017	Trust Grade Doctor - SHO level - Closed (Retired 01 April 2010)
01018	Trust Grade Doctor - Specialist Registrar level - Closed (Retired 01 April 2010)
01019	Trust Grade Doctor - Career Grade level
01020	Director of Public Health
01021	Clinical Medical Officer
01022	Senior Clinical Medical Officer
01023	'Other' Community Health Service
01024	GENERAL PRACTITIONER
01025	GENERAL PRACTITIONER
01026	Salaried GENERAL PRACTITIONER
01027	Regional Dental Officer (Retired 01 October 2017)
01028	Clinical Director - Dental
01029	Dental Officer
01030	Senior Dental Officer
01031	Salaried Dental Practitioner
01032	Specialty Doctor
01033	Foundation Year 1
01034	Foundation Year 2
01035	Specialty Registrar

01036	Medical Student
01037	Trust Grade Doctor - Specialty Registrar
01038	Foundation Dentist
01039	Associate Postgraduate Dean
01040	Trust Grade Doctor - Foundation Level
01041	GP Senior Partner
01042	GP Partner/Provider
01043	GP Retainer
01044	GP Locum
01045	Dental Core Trainee
01046	Specialist Dentist
02000	**Students**
02001	Student NURSE - Adult Branch
02002	Student NURSE - Child Branch
02003	Student NURSE - Mental Health Branch
02004	Student NURSE - Learning Disabilities Branch
02005	Student MIDWIFE
02006	Student Health Visitor
02007	Student District Nurse
02008	Student School Nurse
02009	Student Practice Nurse
02010	Student Occupational Health Nurse
02011	Student Community Children's Nurse
02012	Student Mental Health Nurse
02013	Student Learning Disabilities Nurse
02014	Student Chiropodist
02015	Student Dietitian
02016	Student Occupational Therapist
02017	Student Orthoptist
02018	Student Physiotherapist
02019	Student Radiographer - Diagnostic
02020	Student Radiographer - Therapeutic
02021	Student Speech and Language Therapist
02022	Art, Music and Drama Student
02023	Student Psychotherapist
02024	Student Social Worker
02025	Student Paramedic
02026	Student Prosthetics and Orthotics

03000	**Nursing and Midwifery Registered**
03001	Director of Nursing
03002	Nurse Consultant
03003	Nurse Manager
03004	Modern Matron
03005	Specialist Nurse Practitioner
03006	Sister/Charge Nurse
03007	Staff Nurse
03008	Enrolled Nurse
03009	Midwife - Consultant
03010	Midwife - Specialist Practitioner
03011	Midwife - Manager
03012	MIDWIFE - Sister/Charge Nurse (Retired 01 December 2012)
03013	MIDWIFE
03014	Community Practitioner
03015	Community Nurse
03016	Advanced Practitioner
03017	Practice Nurse
03018	Extended Role Practice Nurse
03019	Practice Nurse Partner
03020	Practice Research Nurse
03021	Practice Nurse Dispenser
04000	**Allied Health Professionals**
04001	Art Therapist
04002	Art Therapist Consultant
04003	Art Therapist Manager
04004	Art Therapist Specialist Practitioner
04005	Chiropodist/Podiatrist
04006	Chiropodist/Podiatrist Consultant
04007	Chiropodist/Podiatrist Manager
04008	Chiropodist/Podiatrist Specialist Practitioner
04009	Dietitian
04010	Dietitian Consultant
04011	Dietitian Manager
04012	Dietitian Specialist Practitioner
04013	Drama Therapist
04014	Drama Therapist Consultant
04015	Drama Therapist Manager

04016	Drama Therapist Specialist Practitioner
04017	Multi Therapist
04018	Multi Therapist Consultant
04019	Multi Therapist Manager
04020	Multi Therapist Specialist Practitioner
04021	Music Therapist
04022	Music Therapist Consultant
04023	Music Therapist Manager
04024	Music Therapist Specialist Practitioner
04025	Occupational Therapist
04026	Occupational Therapist Consultant
04027	Occupational Therapist Manager
04028	Occupational Therapist Specialist Practitioner
04029	Orthoptist
04030	Orthoptist Consultant
04031	Orthoptist Manager
04032	Orthoptist Specialist Practitioner
04033	Orthotist
04034	Orthotist Consultant
04035	Orthotist Manager
04036	Orthotist Specialist Practitioner
04037	Paramedic
04038	Paramedic Consultant
04039	Paramedic Manager
04040	Paramedic Specialist Practitioner
04041	Physiotherapist
04042	Physiotherapist Consultant
04043	Physiotherapist Manager
04044	Physiotherapist Specialist Practitioner
04045	Prosthetist
04046	Prosthetist Consultant
04047	Prosthetist Manager
04048	Prosthetist Specialist Practitioner
04049	Radiographer - Diagnostic
04050	Radiographer - Diagnostic, Consultant
04051	Radiographer - Diagnostic, Manager
04052	Radiographer - Diagnostic, Specialist Practitioner
04053	Radiographer - Therapeutic

04054	Radiographer - Therapeutic, Consultant
04055	Radiographer - Therapeutic, Manager
04056	Radiographer - Therapeutic, Specialist Practitioner
04057	Speech and Language Therapist
04058	Speech and Language Therapist Consultant
04059	Speech and Language Therapist Manager
04060	Speech and Language Therapist Specialist Practitioner
04061	Advanced Practitioner
04062	Emergency Care Practitioner
05000	**Additional Professional, Scientific and Technical**
05001	Clinical Director
05002	OPTOMETRIST
05003	Pharmacist
05004	Psychotherapist
05005	Applied Psychologist - Clinical
05006	Chaplain
05007	Social Worker
05008	Approved Social Worker (Retired 01 October 2017)
05009	Youth Worker
05010	Specialist Practitioner
05011	Practitioner
05012	Technician
05013	Osteopath
05014	High Intensity Therapist
05015	Trainee High Intensity Therapist
05016	Physician Assistant (Retired 01 January 2016)
05017	Advanced Practitioner
05018	Physician Associate
05019	Operating Department Practitioner
05020	Social Care Manager
05021	Manager
05022	Approved Mental Health Professional
05023	Trainee Clinical Psychologist
05024	Trainee Counselling Psychologist
05025	Trainee Health Psychologist
05026	Trainee Other Applied Psychologist
05027	Applied Psychologist – Counselling
05028	Applied Psychologist – Educational

05029	Applied Psychologist – Forensic
05030	Applied Psychologist – Health
05031	Applied Psychologist – Occupational
05032	Applied Psychologist – Sport and Exercise
05033	Applied Psychologist – Neuropsychologist
05034	Counsellor
05035	Social Worker - Psychological Therapist
05036	Play Therapist
05037	Family Therapist
05038	Child and Adolescent Psychological Therapist or Psychotherapist
05039	Surgical Care Practitioner
06000	**Healthcare Scientists**
06001	Clinical Scientist (Retired 01 April 2013)
06002	Consultant Healthcare Scientist
06003	Biomedical Scientist (Retired 01 April 2013)
06004	Technician (Retired 01 April 2013)
06005	Therapist (Retired 01 April 2013)
06006	Manager
06007	Specialist Healthcare Scientist
06008	Healthcare Scientist
06009	Specialist Healthcare Science Practitioner
06010	Healthcare Science Practitioner
07000	**Additional Clinical Services**
07001	Health Care Support Worker
07002	Social Care Support Worker
07003	Home Help
07004	Healthcare Assistant
07005	Nursery Nurse
07006	Play Therapist
07007	Play Specialist
07008	Technician
07009	Technical Instructor
07010	Assistant/Associate Practitioner
07011	Counsellor
07012	Assistant
07013	Dental Surgery Assistant
07014	Medical Laboratory Assistant (Retired 01 January 2016)
07015	Phlebotomist

07016	Cytoscreener
07017	Student Technician
07018	Trainee Scientist
07019	Trainee Practitioner
07020	Nursing Cadet
07021	Healthcare Cadet
07022	Pre-reg Pharmacist
07023	Assistant Psychologist
07024	Assistant Psychotherapist
07025	Call Operator
07026	Gateway Worker
07027	Support, Time, Recovery Worker
07028	Psychological Wellbeing Practitioner
07029	Trainee Psychological Wellbeing Practitioner
07030	Apprentice (Retired 01 January 2019)
07031	Assistant Practitioner Nursing
07032	Ambulance Care Assistant/Patient Transport Service Driver
07033	Emergency Care Assistant
07034	Emergency Care Practitioner (Retired 01 January 2019)
07035	Emergency Medical Dispatcher
07036	Healthcare Science Associate
07037	Healthcare Science Assistant
07038	Trainee Healthcare Scientist
07039	Trainee Healthcare Science Practitioner
07040	Trainee Healthcare Science Associate
07041	Analyst
07042	Emergency Call Handler
07043	Urgent Care Assistant
07044	Urgent Care Practitioner
07045	Employment Support Worker or Advisor
07046	Family Therapist
07047	Nursing Associate
07048	Trainee Nursing Associate
08000	**Administrative and Clerical**
08001	Clerical Worker
08002	Receptionist
08003	Secretary
08004	Personal Assistant

08005	Medical Secretary
08006	Officer
08007	Manager
08009	Senior Manager
08010	Technician
08011	Accountant
08012	Librarian
08013	Interpreter
08014	Analyst
08015	Adviser
08016	Researcher
08017	Control Assistant
08018	Architect
08019	Lawyer
08020	Surveyor
08021	Chair
08022	Chief Executive
08023	Finance Director
08024	Other Executive Director
08025	Board Level director
08026	Non-executive Director
08027	Childcare Coordinator
08028	Apprentice (Retired 01 January 2019)
08029	Non-Emergency Call Handler
08030	Non-Emergency Medical Dispatcher
09000	**Estates and Ancillary**
09001	Support Worker
09002	Housekeeper
09003	Cook
09004	Porter
09005	Driver
09006	Telephonist
09007	Gardener/Groundsperson
09008	Technician
09009	Electrician
09010	Fitter
09011	Assistant
09012	Labourer

09013	Plumber
09014	Carpenter
09015	Bricklayer
09016	Painter/Decorator
09017	Work Analyst
09018	Chargehand
09019	Supervisor
09020	Engineer
09021	Building Officer
09022	Maintenance Craftsperson
09023	Building Craftsperson
09024	Mechanic
09025	Apprentice (Retired 01 January 2019)
09026	Cleaner
10000	**Supplementary Roles**
10001	Assessor
10002	Clinical Supervisor
10003	Educational Supervisor
10004	Tutor

LANGUAGE CODE

Change to Attribute: Changed Dataset

The language used by a PERSON.

LANGUAGE CODE is based on the ISO 639-1 two character language codes (see the ISO Registration Authority website) plus five communication method extensions:

- q1 Braille - for people who are unable to see
- q2 American Sign Language
- q3 Australian Sign Language
- q4 British Sign Language
- q5 Makaton - devised for children and adults with a variety of communication and Learning Disabilities

LOCAL PATIENT IDENTIFIER

Change to Attribute: Changed Dataset

A number used to identify a PATIENT uniquely within a Health Care Provider. It may be different from the PATIENT's casenote number and may be assigned automatically by the computer system.

Where care for NHS patients is sub-commissioned in the independent sector or overseas, the NHS commissioner PAS Number should be used. If no NHS PAS Number has been assigned the independent sector or overseas PAS Number should be used.

LOOKED AFTER CHILD INDICATOR

Change to Attribute: Changed Dataset

An indication of whether a PERSON is a Looked After Child.

National Codes:

Y	Yes - is a Looked After Child
N	No - is not a Looked After Child

NEWBORN BLOOD SPOT TEST OUTCOME STATUS

Change to Attribute: Changed Dataset

The outcome/status of a Newborn Blood Spot Test request.

NEWBORN BLOOD SPOT TEST OUTCOME STATUS is aligned with descriptors in SNOMED CT® as follows:

SNOMED CT Refset Metadata:

- Refset FSN: Newborn blood spot screening result status simple reference set (foundation metadata concept)
- Refset Id: 966281000000109

For further details relating to the SNOMED CT Refset Metadata, see the Data Dictionary for Care (DD4C) website at: Newborn blood spot screening result status.

National Codes:

01	Specimen received in Laboratory
02	Screening declined
03	Repeat/Further Sample Required
04	Condition not suspected
05	Carrier
06	Sickle Cell Disease not suspected, carrier of other haemoglobin
07	Condition not suspected, other disorders follow up

08 Condition suspected
09 Not screened/screening incomplete
10 Haemoglobin S not suspected (by DNA) No other haemoglobin /thalassemia excluded

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NEWBORN HEARING AUDIOLOGY OUTCOME

Change to Attribute: Changed Dataset

A coded CLINICAL INVESTIGATION RESULT ITEM for a Clinical Investigation of a Newborn Hearing Audiology Test.

Note: A referral for a Newborn Hearing Audiology Test is made if the child fails the Newborn Hearing Screening.

National Codes:

01 Hearing satisfactory
02 Confirmed bilateral hearing loss
03 Confirmed unilateral hearing loss
04 Diagnostic testing in progress
05 Diagnostic testing pending

NEWBORN HEARING SCREENING OUTCOME

Change to Attribute: Changed Dataset

A coded CLINICAL INVESTIGATION RESULT ITEM for a Clinical Investigation of a Newborn Hearing Screening.

National Codes:

01 Clear response, no follow up required
02 Clear response, targeted follow up required
03 No clear response, bilateral referral
04 No clear response, unilateral referral
98 Incomplete

NHS NUMBER

Change to Attribute: Changed Dataset

The NHS NUMBER, the primary identifier of a PERSON, is a unique identifier for a PATIENT within the NHS in England and Wales.

This will not vary by any Organisation of which a PERSON is a PATIENT.

It is mandatory to record the NHS NUMBER. There are exceptions, such as Accident and Emergency care, sexual health and major incidents, as defined in existing national policies.

The NHS NUMBER is 10 numeric digits in length. The tenth digit is a check digit used to confirm its validity. The check digit is validated using the Modulus 11 algorithm and the use of this algorithm is mandatory. There are 5 steps in the validation of the check digit:

Step 1 Multiply each of the first nine digits by a weighting factor as follows:

Digit Position
(starting from the left) Factor:

1	10
2	9
3	8
4	7
5	6
6	5
7	4
8	3
9	2

Step 2 Add the results of each multiplication together.

Step 3 Divide the total by 11 and establish the remainder.

Step 4 Subtract the remainder from 11 to give the check digit.

If the result is 11 then a check digit of 0 is used. If the result is 10 then the NHS NUMBER is invalid and not used.

Step 5 Check the remainder matches the check digit. If it does not, the NHS NUMBER is invalid.

Further guidance is available from the NHS Digital website at: NHS Number.

Note:
This was e-GIF approved for use in NHS England.
e-GIF and the Government Data Standards Catalogue **have been archived** and are available for reference only.

NHS NUMBER STATUS INDICATOR CODE

Change to Attribute: Changed Dataset
The trace status of the NHS NUMBER.

National Codes:

01	Number present and verified
02	Number present but not traced
03	Trace required
04	Trace attempted - No match or multiple match found
05	Trace needs to be resolved - (NHS NUMBER or PATIENT detail conflict)
06	Trace in progress
07	Number not present and trace not required
08	Trace postponed (baby under six weeks old) *

Note: * National Code 08 *'Trace postponed (baby under six weeks old)'* is **NOT** valid for the Maternity Services Data Set and Mental Health Services Data Set.

NHS OCCUPATION CODE

Change to Attribute: Changed Dataset

An NHS OCCUPATION CODE for an EMPLOYEE filling a POSITION.

The NHS OCCUPATION CODES are maintained by NHS Digital, on behalf of the Department of Health and Social Care and can be viewed in the NHS Occupation Code Manual.

NHS SERVICE AGREEMENT LINE NUMBER

Change to Attribute: Changed Dataset

A number (alphanumeric) to provide a unique identifier for a line within a NHS SERVICE AGREEMENT.

OBSERVATION SCHEME IN USE

Change to Attribute: Changed Dataset

The type of CLINICAL TERMINOLOGY CODE used for the observation.

National Codes:

01 Read Coded Clinical Terms Version 2
02 Read Coded Clinical Terms Version 3 (CTV3)
03 SNOMED CT®

OBSERVATION VALUE

Change to Attribute: Changed Dataset

The value of a CLINICAL INVESTIGATION RESULT ITEM.

OFFERED FOR ADMISSION DATE

Change to Attribute: Changed Dataset

The date offered for admission to hospital to start a Hospital Provider Spell.

ONWARD REFERRAL REASON

Change to Attribute: Changed Dataset

The reason why the PATIENT was referred from one SERVICE to another SERVICE, which may be in the same or a different Organisation.

National Codes:

01 Transfer of Clinical Responsibility
02 For Opinion Only
03 For Diagnostic Test Only
04 New Referral (Non Transfer)
96 Other (not listed)

ORGANISATION CODE

Change to Attribute: Changed Dataset

ORGANISATION CODE will be replaced with ORGANISATION IDENTIFIER, which is the most recent approved national information standard to describe the required definition.

An ORGANISATION CODE is a code which identifies an Organisation uniquely.

ORGANISATION CODES are managed by:

- Organisation Data Service (ODS)

- NHS Prescription Services
- NHS Dental Services.

Notes:

- Organisation Data Service codes can be downloaded from Technology Reference Data Update Distribution (TRUD)
- Organisation Data Service contact details can be found at Contact Details.

ORGANISATION CODING FRAMES

- All NHS Organisations are coded using coding frames, as shown in the tables below:

Character Position	1	2	3	4	5	6	7	8
Format	**a/n**	**a/n**	**a/n**	**a/n**	**a/n**	**a/n**	**a/n**	**a/n**
A Frame	Organisation Type Identifier	Organisation Identifier						
B Frame	Organisation Type Identifier			Organisation Identifier				
C Frame	Organisation Type Identifier		Organisation Identifier					
D Frame	Organisation Type Identifier	Organisation Identifier						
E Frame	Organisation Identifier							

F Frame	Organisation Type Identifier	Organisation Identifier					
G Frame	Organisation Type Identifier	Practice Identifier					
H Frame	Organisation Type Identifier	Organisation Identifier					
I Frame	Organisation Type Identifier	Organisation Identifier					
K Frame	Organisation Identifier						
L Frame	Organisation Type Identifier	Organisation Identifier	Organisation Type Identifier				
M Frame	Organisation and Organisation Type Identifier						
N Frame	Organisation Type Identifier	Organisation Identifier					

A Frame:

Example
Non NHS Organisation (Independent Provider) e.g. 8HA03

- 8 = Organisation Type Identifier
- Remainder = Organisation Identifier

B Frame:

Example
Local Service Provider e.g. LSP01

- LSP = Organisation Type Identifier
- 01 = Organisation Identifier

Also:

Application Service Provider	e.g. YGM01
Education Establishment	e.g. YDF01
NHS Support Agency	e.g. YDD01

C Frame:

Example
School e.g. EE134290

- EE = Organisation Type Identifier
- Remainder = Organisation Identifier

D Frame:

Example
Care Trust e.g. TAK

- T = Organisation Type Identifier
- AK = Organisation Identifier

Also:

Commissioning Support Unit (CSU) / Data Services for Commissioners Regional Office (DSCRO)	e.g. 0AA
High Level Health Geography, e.g. NHS England (Region Local Office)	e.g. Q72
Local Health Board (Wales)	e.g. 7A1
NHS Trust	e.g. RH8
Justice Organisation	e.g. VAA

E Frame:

Example
Government Office Region (GOR) e.g. K

- K = Organisation Identifier

Note: Government Office Region (GOR) is identified by a one character code; no other one character code exists.

F Frame:

Example
Pharmacy Headquarters e.g. P001

- P = Organisation Type Identifier
- 001 = Organisation Identifier

Also:

Care Home Headquarters	e.g.CA0A
Optical Headquarters	e.g.T1A1

G Frame:

Example
GP Practices in England and Wales e.g. Y00001

- Y = Organisation Type Identifier
- 00001 = Practice Identifier

Also:

Dental Practice	e.g.V20052

H Frame:

Example
Cancer Network e.g. N01

- N0 (where the 2nd character is numeric and not alpha) = Organisation Type Identifier
- 1 = Organisation Identifier

Also:

Booking Management System (BMS) Call Centre Establishment	e.g. YF1
Government Department	e.g. XDA
Independent Sector Healthcare Provider (ISHP) (where the 2nd character is alpha)	e.g. NV7
National Application Service Provider	e.g. YEA
Other Statutory Authority (OSA)	e.g. X16

I Frame:

Example
Special Health Authority (SpHA) e.g. T1150

- T1 = Organisation Type Identifier
- 150 = Organisation Identifier

K Frame:

Example
NHS Wales Informatics Service e.g. W00

- W00 = Organisation Identifier

L Frame:

Example
Northern Ireland Local Commissioning Group e.g. ZC010

- Characters 1-3 (ZC0) AND character 5 (0) = Organisation Type Identifier
- Character 4 = Organisation Identifier

Note: this is a 5 character method of displaying Northern Ireland Local Commissioning Group identifiers. Characters 3 and 5 are 'fillers'. If a 3 character code is required (as used by the Office for National Statistics in the NHS Postcode Directory) zeros can be omitted, e.g. ZC1.
The 3 character method of displaying the Northern Ireland Local Commissioning Group identifiers fit under the H Frame.
Guidance on the use of Northern Ireland codes can be found in Data Set Change Notice 19/2009.

M Frame:

Example
Clinical Commissioning Group (CCG) e.g. 12A

- 12A = Organisation and Organisation Type Identifier

Also:

Local Authority	e.g.000

N Frame:

Example
GP Abeyance and Dispersal GP Practice e.g. G7817414

- G78 = Organisation Type Identifier
- 17414 = Organisation Identifier

The structure and format of ORGANISATION CODES maintained by the Organisation Data Service, NHS Prescription Services, NHS Dental Services and other agencies are detailed in the tables below.

ORGANISATION CODES TABLES

Table 1: CODING FORMATS FOR ORGANISATIONS IN ENGLAND AND WALES

Organisation Type	Frame Type	Character Position								Code allocated by:	Notes/Comments
	See Coding Frames Table	1	2	3	4	5	6	7	8		
Application Service Provider	**B**	Y	G	M	A-9	A-9				ODS	E.g. YGM01
Booking Management System (BMS) Call Centre Establishment	**H**	Y	F	A-9						ODS	E.g. YF1
Cancer Network	**H**	N	0-9	A-9						ODS	E.g. N01
Cancer Registry	**A**	Y	0-9	0-9	0-9	0-9				ODS	E.g. Y0401 **All Cancer Registries in England are now part of the**

											National Cancer Registration and Analysis Service
Care Home Headquarters	**F**	A, C or D	A-9	A-9	A-9					ODS	E.g. CA0A
Care Trust (CT)	**D**	T	A-Y	A-Y						ODS	E.g. TAK
Clinical Commissioning Group (CCG)	**M**	0-9	0-9	A-Y						ODS	E.g. 12A
Clinical Network	**B**	Y	D	G	A-9	A-9				ODS	E.g. YDG01
Commissioning Support Unit (CSU) / Data Services for Commissioners Regional Office (DSCRO)	**D**	0	A-Y	A-Y						ODS	E.g. 0AA
Dental Practice - England and Wales	**G**	V	0-9	0-9	0-9	0-9	0-9			NHS Dental Services	E.g. V20052
Education Establishment	**B**	Y	D	F	A-9	A-9				ODS	E.g. YDF01
Executive Agency	**N/A**	X	0-9	0-9						ODS	E.g. X09

	See Note 1										
Executive Agency Programme	**N/A** See Note 1	X	0-9	0-9	0-9	0-9	0-9			ODS	First three characters denote Executive Agency E.g. X09001
Government Department	**H**	X	A-Y	A-Y						ODS	E.g. XDA
Government Office Region (GOR)	**E**	A-Y								ONS	E.g. K **Government Office Regions (GORs) closed 31 March 2011 - from 1 April 2011 referred to as Regions**
GP Abeyance and Dispersal GP Practice	**N**	G	7	8	0-9	0-9	0-9	0-9	0-9	ODS	E.g. G7817414
GP Practices in England and Wales	**G**	A-H, J-N, P, W & Y	0-9	0-9	0-9	0-9	0-9			NHS Prescription Services	Char 1 = W for Welsh GP Practice. All other values represent GP Practices in England. **Note: from 2003, ALL**

											newly allocated Practice Codes in England begin with a Y E.g. Y00001
Justice Organisation	**D**	V or W	A-Y	A-9						ODS	E.g. VAA
High Level Health Geography, e.g. NHS England (Region Local Office)	**D**	Q	A-9	A-9						ODS	E.g. Q72
Independent Sector Healthcare Provider (ISHP)	**H**	A, B, D, G, I, K, L, M , N, O, S, U, V, W	A-Y	A-Y, 0-9						ODS	E.g. NV7
Local Authority (LA)	**M**	0-9	0-9	0-9						ODS	E.g. 000
Local Health Board (Wales)	**B**	7	A-9	A-9						ODS	E.g. 7A1

Local Service Provider (LSP)	**B**	L	S	P	0-9	0-9				ODS	E.g. LSP01
Military Hospital	**B**	X	M	D	A-9	A-9				ODS	E.g.XMDA1
National Application Service Provider	**H**	Y	E	A-9						ODS	E.g. YEA
National Groupings (England)	**H**	Y	5	0-9						ODS	E.g. Y51
NHS Support Agency	**B**	Y	D	D	A-9	A-9				ODS	E.g. YDD01
NHS Trust	**D**	R	A-9	A-9						ODS	E.g. RH8
NHS Wales Informatics Service (NWIS)	**K**	W	0	0						ODS	**Only one organisation of this type exists for Wales** E.g. W00
Non NHS Organisation (Independent Provider)	**A**	8	A-Y	A-9	0-9	0-9				ODS	E.g. 8HA03
	N/A	Z	B	0	0	1				ODS	E.g. ZB001

Northern Ireland Health & Social Care Board											
Northern Ireland Health & Social Care Trust	**I**	Z	T	0-9	0-9	0-9				ODS	E.g. ZT001
Northern Ireland Local Commissioning Group	**L**	Z	C	0	0-9	0				Department for Health, Social Services and Public Safety (DHSSPS), Northern Ireland	E.g. ZC010 Note that characters 3 and 5 are 'fillers' to create a 5 character code. If a 3 character code is required (as used by the Office for National Statistics in the NHS Postcode Directory), zeros can be omitted and fits under the H frame: E.g. ZC1. *Guidance on the use of Northern Ireland codes can be found in Data Set Change Notice 19/2009.*
Optical Headquarters	**F**	T	0-9	A-9	A-9					ODS	E.g. T1A1
Other Statutory Authority (OSA)	**H**	X	0-9	0-9						ODS	E.g. X16

Pharmacy	**A**	F	A-Y	A-9	A-9	A-9				ODS	E.g. FA002
Pharmacy Headquarters	**F**	P	A-9	A-9	A-9					ODS	E.g. P001
Primary Care Trust (PCT)	**D**	5	A-9	A-9						ODS	E.g. 5CT **All Primary Care Trusts closed 31 March 2013**
Prison Health Service	**B**	Y	D	E	A-9	A-9				ODS	E.g. YDE01
School	**C**	E	E	A-9	A-9	A-9	A-9	A-9	A-9	Department for Education and ODS	E.g. EE134290
Special Health Authority (SpHA)	**I**	T	1	0-9	0-9	0				ODS	E.g. T1150
Strategic Health Authority (SHA)	**D**	Q	A-9	A-9						ODS	E.g. Q30 **All Strategic Health Authorities in England closed 31 March 2013**
Welsh Assembly	**D**	W	0-9	0-9						ODS	E.g. W01

Welsh Health Commission	**A**	W	0-9	0-9	A-Y	A-Y				ODS	E.g. W01HC

Notes:

- Codes for Executive Agency, Executive Agency Programme, Executive Agency Site and Executive Agency Programme Department do not easily fit into the coding frames as shown above and are therefore not included. This is due to their unusual structure in that there are more hierarchical 'tiers' than with other organisations.

  Executive Agency and Executive Agency Programme are both considered Organisation level entities, although each Programme does have a relationship to an Executive Agency. Executive Agency codes are three characters long. Executive Agency Programme codes are six, and their first three characters are the same as the Executive Agency they are associated to.

  Department codes of eight characters long can then be allocated underneath a Programme code (sharing the first six characters). Executive Agency Site codes of five characters long can be allocated under an Executive Agency code (and share the first three characters).

- *A-9 indicates that characters A-Z and 0-9 are valid: except B, I, O, S, U and Z (to avoid ambiguity). This applies to all ORGANISATION CODES in the Coding Format Table above except Independent Sector Healthcare Providers (ISHP).*

Table 2: CODING FORMATS FOR ORGANISATIONS IN SCOTLAND

Scottish ORGANISATION CODES are supplied by the Information Standards Directorate (ISD) from NHS Scotland and published by the Organisation Data Service.

Organisation Type	Character Position						Code allocated by:	Notes/Comments
	1	2	3	4	5	6		
GP Practice - Scotland	S	0-9	0-9	0-9	0-9	0-9	NHS	
Scottish GP Fundholder	S	A-Z	B	0-9	0-9		ISD, Scotland	2nd character identifies the Health Board the GPFH reports to. 3rd character

								(always B) shows GPFH status.
Scottish Health Agency	S	D	0-9	0-9	0-9		ISD, Scotland	2nd character (D) identifies Scottish Office agencies
Scottish Health Board	S	A-Z	9	9	9		ISD, Scotland	
Scottish Provider	S	A-Z	A,C,D	0-9	0-9		ISD, Scotland	2nd character identifies the Health Board the organisation reports to. 3rd character identifies the organisation type: A= Health Unit C = Hospital Trust D = Nursing Home

Table 3: CODING FORMATS for ORGANISATIONS in OTHER HOME COUNTRIES

Organisation Type	Character Position						Code allocated by:	Notes/Comments
	1	2	3	4	5	6		
GP Practice - Alderney	A	L	D	0-9	0-9	0-9	NHS Prescription Services	
GP Practice - Guernsey	G	U	E	0-9	0-9	0-9	NHS Prescription Services	

GP Practice - Isle of Man (IOM)	Y	0-9	0-9	0-9	0-9	0-9	NHS Prescription Services	
GP Practice - Jersey	J	E	R	0-9	0-9	0-9	NHS Prescription Services	
Primary Healthcare Directorate (Isle of Man)	Y	K	A-9				ODS	E.g. YK1

Note: A-9 indicates that characters A-Z and 0-9 are valid: except B, I, O, S, U and Z (to avoid ambiguity).

ORGANISATION IDENTIFIER

Change to Attribute: Changed Dataset

A unique identifier for an ORGANISATION.

Note:

- ORGANISATION IDENTIFIERS are governed by the fundamental standard for "Health and Social Care Organisation Reference Data" (HSC Org Ref Data).
- The standard only relates to ORGANISATION IDENTIFIERS which are maintained and published by the Organisation Data Service (ODS). See Health and Social Care Organisation Reference Data.

The Format/Length of a published code for an:

- Organisation is min an3 max an8
- Organisation Site is min an5 max an9.

ORGANISATION CODE will be replaced with ORGANISATION IDENTIFIER, which is the most recent approved national information standard to describe the required definition.

ORGANISATION SITE CODE

Change to Attribute: Changed Dataset

ORGANISATION SITE CODE will be replaced with ORGANISATION IDENTIFIER, which is the most recent approved national information standard to describe the required definition.

An ORGANISATION SITE CODE is a code which identifies an Organisation Site uniquely.

Note: Only ORGANISATION SITE CODES which have been notified to and issued by the Organisation Data Service may be used.

Notes:

- Organisation Data Service codes can be downloaded from Technology Reference Data Update Distribution (TRUD)
- Organisation Data Service contact details can be found at Contact Details.

ORGANISATION SITE CODING FRAMES

- All NHS Organisation Sites are coded using coding frames, as shown in the tables below:

Character Position	1	2	3	4	5	6	7	8	9
Format	**a/n**	**a/n**	**a/n**	**a/n**	**a/n**	**a/n**	**a/n**	**a/n**	**a/n**
A Frame	Organisation Type Identifier			Organisation Identifier		Site or Sub-Division Identifier			
B Frame	Organisation Type Identifier	Organisation Identifier		Site or Sub-Division Identifier					
C Frame	Organisation Type Identifier		Organisation Identifier	Site or Sub-Division Identifier					
D Frame		Practice Identifier					Branch Surgery Identifier		

	Organisation Type Identifier					
F Frame	Organisation Type Identifier	Organisation Identifier				
H Frame	Organisation Type Identifier	Organisation Identifier				
I Frame	Organisation Type Identifier	Organisation Identifier				
J Frame	Organisation Type Identifier	Organisation Identifier				
K Frame	Organisation and Organisation Type Identifier	Organisation Site Identifier				
L Frame	Organisation Type Identifier *and* Site or Sub-Division Identifier					

A Frame:

Example
Local Service Provider Site e.g. LSP0101

- LSP = Org Type Identifier
- 01 = Organisation Identifier
- 01 = Site or Sub-Division Identifier

B Frame:

Example
Care Trust Site e.g. TAK01

- T = Organisation Type Identifier
- AK = Organisation Identifier
- 01 = Site or Sub-Division Identifier

Also:

Government Department Site	e.g. XDA01
High Level Health Geography Site, e.g. NHS England (Region Local Office) site	e.g. Q7201
Local Authority Site	e.g. 000AA
Local Health Board (Wales) Site	e.g. 7A101
NHS Trust Site	e.g. RH802
Other Statutory Authority (OSA) Site	e.g. X1601
	e.g. Q3001

C Frame:

Example
Independent Sector Healthcare Provider (ISHP) Site e.g. NV701

- NV = Organisation Site Type Identifier
- 7 = Organisation Identifier
- 01 = Site or Sub-Division Identifier

D Frame

Example
GP Practice Branch Surgery: e.g. H81010002

- H (and length of code) = Organisation Identifier
- 81010 = Organisation Identifier (parent GP Practice)
- 002 = Branch Surgery Identifier

F Frame

Example
Commissioning Support Unit Site: e.g. 0AA01

- 0 = Organisation Type Identifier
- AA01 = Organisation Identifier

H Frame

Example
Prison: e.g. YDE01

- YDE = Organisation Type Identifier
- 01 = Site or Sub-Division Identifier

I Frame

Example
Optical Site: e.g. TP01A

- TP = Organisation Type Identifier
- 01A = Site or Sub-Division Identifier

J Frame

Example
Care Home Site: e.g. VN01A

- VN = Organisation Type Identifier
- 01A = Site or Sub-Division Identifier

Also:

Health Observatory	e.g. XP001
Primary Healthcare Directorate (Isle of Man) Site	e.g. YK101

K Frame

Example
Clinical Commissioning Group (CCG) Site e.g. 11AAA - 99YZZ

- 11A = Organisation and Organisation Type Identifier
- AA = Organisation Site Identifier

L Frame

Example
Special Health Authority (SpHA) Site: e.g. T115A

- T115A – Organisation Type Identifier *and* Site or Sub-Division Identifier

The structure and format of ORGANISATION SITE CODES maintained by the Organisation Data Service, NHS Prescription Services and other agencies are detailed in the tables below.

NHS ORGANISATION SITE CODES TABLES

Coding Formats

Table 1: CODING FORMATS FOR ORGANISATION SITES IN ENGLAND AND WALES

Organisation Site Type	Frame Type	Character Position									Code allocated by:	Notes/Comments
	See Coding Frames Table	1	2	3	4	5	6	7	8	9		
Care Home Site	**J**	V	L, M or N	A-9	A-9	A-9					ODS	E.g. VN01A, VM01A, VL01A
Care Trust Site	**B**	T	A-Y	A-Y	A-9	A-9					ODS	First three characters denote owning Care Trust E.g. TAK01
Clinical Commissioning Group (CCG) Site	**K**	0-9	0-9	A-Y	A-Y	A-Y					ODS	First three characters denote owning Clinical Commissioning Group E.g. 11AAA - 99YZZ
	F	0	A-Y	A-Y	A-9	A-9					ODS	E.g. 0AA01

Commissioning Support Unit (CSU) Site												
Executive Agency Site	**N/A** **See Note**	X	0-9	0-9	0-9	0-9					ODS	First three characters denote Executive Agency E.g. X0901
Government Department Site	**B**	X	A-Y	A-Y	0-9	0-9					ODS	First three characters denote Government Department E.g. XDA01
GP Practice Branch Surgery - England and Wales	**D**	A-H, J-N, P, W & Y	0-9	0-9	0-9	0-9	0-9	0-9	0-9	0-9	ODS	First 6 characters denote parent practice. Char 1 = W for Welsh GP Practice. All other values represent English GP Practices E.g. H81010002
Health Observatory	**J**	X	P	0-9	0-9	0-9					ODS	E.g. XP001
High Level Health Geography Site, e.g.NHS England (Region Local Office) site	**B**	Q	A-9	A-9	A-9	A-9					ODS	E.g. Q7201

Independent Sector Healthcare Provider (ISHP) Site	**C**	A, B, D, G, I, K, L, M , N, O, S, U, V, W	A-Y	A-Y, 0-9	A-Y, 0-9	A-Y, 0-9					ODS	First three characters denote owning Independent Sector Healthcare Provider (ISHP) E.g. NV701 Note: The A-Y range includes all letters except Z
Local Authority (LA) Site	**B**	0-9	0-9	0-9	A-Z	A-Z					ODS	First three characters denote parent Local Authority E.g. 000AA
Local Health Board (Wales) Site	**B**	7	A-9	A-9	A-9	A-9					ODS	First three characters denote owning NHS Trust E.g. 7A101
Local Service Provider Site	**A**	L	S	P	0-9	0-9	0-9	0-9			ODS	First five characters denote owning Local Service Provider E.g. LSP0101
NHS Trust Site	**B**	R	A-9	A-9	A-9	A-9					ODS	First three characters denote owning NHS Trust E.g. RH802

Optical Site	**I**	T	P or Q	0-9	A-9	A-9					ODS	E.g. TP01A, TQ01A
Other Statutory Authority (OSA) Site	**B**	X	0-9	0-9	0-9	0-9					ODS	First three characters denote owning Other Statutory Authority E.g. X1601
Primary Care Trust (PCT) Site	**B**	5	A-9	A-9	A-9	A-9					ODS	First three characters denote owning Primary Care Trust E.g. 5CT49 **All Primary Care Trusts closed 31 March 2013**
Special Health Authority (SpHA) Site	**L**	T	1	0-9	0-9	A-Y, 1-9					ODS	The characters do **NOT** denote any ownership. E.g. T115A
Strategic Health Authority (SHA) Site	**B**	Q	A-9	A-9	A-9	A-9					ODS	First three characters denote owning SHA Trust E.g. Q3001 **All Strategic Health Authorities closed 31 March 2013 - from 1 April 2013 referred to as High Level Health Geography Site**

Note: Codes for Executive Agency, Executive Agency Programme, Executive Agency Site and Executive Agency Programme Department do not easily fit into the coding frames as shown above and are therefore not included. This is due to their unusual structure in that there are more hierarchical 'tiers' than with other organisations.

Executive Agency and Executive Agency Programme are both considered Organisation level entities, although each Programme does have a relationship to an Executive Agency. Executive Agency codes are three characters long. Executive Agency Programme codes are six, and their first three characters are the same as the Executive Agency they are associated to.

Department codes of eight characters long can then be allocated underneath a Programme code (sharing the first six characters). Executive Agency Site codes of five characters long can be allocated under an Executive Agency code (and share the first three characters).

Note: A-9 indicates that characters A-Z and 0-9 are valid: except B, I, O, S, U and Z (to avoid ambiguity). This applies to all ORGANISATION SITE CODES in the Coding Format Table above except Independent Sector Healthcare Provider (ISHP) sites.

Table 2: CODING FORMATS FOR ORGANISATION SITES IN OTHER HOME COUNTRIES

Organisation Site Type	Frame Type	Character Position									Code allocated by:	Notes/Comments
	See Coding Frames Table	1	2	3	4	5	6	7	8	9		
Primary Healthcare Directorate (Isle of Man) Site	**J**	Y	K	A-9	A-9	A-9					ODS	E.g. YK101

Note: A-9 indicates that characters A-Z and 0-9 are valid: except B, I, O, S, U and Z (to avoid ambiguity).

PARENTAL RESPONSIBILITIES INDICATOR

Change to Attribute: Changed Description

~~An indication of whether a PERSON has parental responsibilities for a child or young PERSON, as stated by the PERSON.~~An indication of whether a PATIENT has parental responsibilities for a child or young person, as stated by the PATIENT.

For further information on parental responsibilities, see the gov.uk website at: Parental rights and responsibilities.

National Codes:

~~Y~~	~~Yes - PERSON has parental responsibilities for a child or young PERSON~~
~~N~~	~~No - PERSON does not have parental responsibilities for a child or young PERSON~~
~~Z~~	~~Not Stated (PERSON asked but declined to provide a response)~~
Y	Yes - PATIENT has parental responsibilities for a child or young person
N	No - PATIENT does not have parental responsibilities for a child or young person
Z	Not Stated (PATIENT asked but declined to provide a response)

PATIENT PATHWAY IDENTIFIER

Change to Attribute: Changed Dataset
An identifier, which together with the ORGANISATION CODE / ORGANISATION IDENTIFIER of the issuer, uniquely identifies a PATIENT PATHWAY.

This is a specific type of the attribute ACTIVITY IDENTIFIER.

Where a pathway is initiated by a SERVICE REQUEST using the Choose and Book system, the PATIENT PATHWAY will be uniquely identified by the Unique Booking Reference Number (UBRN) of the first referral and the ORGANISATION CODE of Choose and Book which is X09.

Where the pathway is initiated by some other method, the PATIENT PATHWAY IDENTIFIER will be allocated by the Organisation receiving the SERVICE REQUEST which together with that Organisation's ORGANISATION CODE / ORGANISATION IDENTIFIER will uniquely identify the PATIENT PATHWAY.

PERSON AT RISK OF UNEXPECTED DEATH INDICATOR

Change to Attribute: Changed Dataset, Description

An indication of whether a PATIENT is at risk of sudden, unexpected death, as assessed by a CARE PROFESSIONAL.

~~For the Community Services Data Set, this is whether a Child or Young Person is at risk of sudden, unexpected death before the age of 18.~~

National Codes:

Y Yes - PATIENT at risk of unexpected death
N No - PATIENT not at risk of unexpected death

PERSON BIRTH DATE

Change to Attribute: Changed Dataset

The date on which a PERSON was born or is officially deemed to have been born.

Note:
This was e-GIF approved for use in NHS England.
e-GIF and the Government Data Standards Catalogue **have been archived** and are available for reference only.

PERSON COUNT

Change to Attribute: Changed Dataset

The number or count relating to a PERSON.

PERSON DEATH DATE

Change to Attribute: Changed Dataset

The date on which a PERSON died or is officially deemed to have died.

This is as recorded on the Death Certificate.

Note:
This was e-GIF approved for use in NHS England.
e-GIF and the Government Data Standards Catalogue **have been archived** and are available for reference only.

PERSON PROPERTY EFFECTIVE END DATE

Change to Attribute: Changed Dataset

The date when a PERSON PROPERTY is no longer applicable to the PATIENT.

PERSON PROPERTY EFFECTIVE START DATE

Change to Attribute: Changed Dataset

The date when a PERSON PROPERTY became effective for a PATIENT.

Examples may be the date when the PATIENT experienced a symptom or gave up smoking.

PERSON PROPERTY OBSERVED DATE

Change to Attribute: Changed Dataset

The date when the PERSON PROPERTY was observed by a PERSON.

PERSON PROPERTY RECORDED DATE

Change to Attribute: Changed Dataset

The date when the PERSON PROPERTY was recorded by a PERSON.

For the National Renal Data Set, in a computerised system this data would be derived from the date the information was entered.

PERSON SCORE

Change to Attribute: Changed Dataset

The score taken from an ASSESSMENT TOOL.

This could be for an individual element of, or question within, an ASSESSMENT TOOL, a subtotal or total score.

The purpose of the PERSON SCORE is to measure changes in health and wellbeing.

PERSON STATED GENDER CODE

Change to Attribute: Changed Dataset

The gender of a PERSON.

PERSON STATED GENDER CODE is self declared or inferred by observation for those unable to declare their PERSON STATED GENDER.

National Codes:

1 Male
2 Female
9 Indeterminate (unable to be classified as either male or female)

PERSON GENDER CODE will be replaced with PERSON STATED GENDER CODE or PERSON PHENOTYPIC SEX CLASSIFICATION, which is the most recent approved national information standard to describe the required definition.

POSTCODE

Change to Attribute: Changed Dataset

The code assigned by Royal Mail to identify postal delivery areas across the United Kingdom.

POSTCODES may also be used to identify a GEOGRAPHIC AREA.

Note:
This was e-GIF approved for use in NHS England.
e-GIF and the Government Data Standards Catalogue **have been archived** and are available for reference only.

PREFERRED DEATH LOCATION DISCUSSED INDICATOR

Change to Attribute: Changed Dataset, Description

~~An indication of whether the preferred LOCATION of death was discussed with the PATIENT or Patient Proxy by a CARE PROFESSIONAL.~~An indication of whether the preferred LOCATION of death was discussed with the PATIENT or Patient Proxy by a CARE PROFESSIONAL, in the event that there is an expected risk of death of the PATIENT.

~~For the Community Services Data Set, this is whether the preferred LOCATION of death was discussed with the Child or Young Person or their family, in the event that there is an expected risk of death before the age of 18 for the Child or Young Person.~~

National Codes:

Y Yes - the preferred LOCATION of death was discussed with the PATIENT or Patient Proxy
N No - the preferred LOCATION of death was not discussed with the PATIENT or Patient Proxy

PRESCRIPTION DATE

Change to Attribute: Changed Dataset

The date on which the PRESCRIPTION was signed by the CARE PROFESSIONAL.

PRIMARY DATA COLLECTION SYSTEM IN USE

Change to Attribute: Changed Dataset
The name of the Primary Data Collection System in use by the Health Care Provider.

PRIORITY TYPE

Change to Attribute: Changed Dataset

The priority of a SERVICE REQUEST.

In the case of SERVICES to be provided by a CONSULTANT, it is as assessed by or on behalf of the CONSULTANT.

- PRIORITY TYPE National Code *'Urgent'* should be used where the SERVICE REQUEST is defined as clinically urgent, but it does not fall under the criteria for *'Two Week Wait'* (see below).

- PRIORITY TYPE National Code *'Two Week Wait'* should be used where either:
  - the SERVICE REQUEST meets the criteria for an urgent GENERAL PRACTITIONER referral for suspected cancer.
    These referrals should be made in accordance with the National Institute for Health and Care Excellence (NICE) clinical guidelines on referral for suspected cancer.
    For further information, see the National Institute for Health and Care Excellence website at: NICE guidance.
    or
  - the PATIENT has been referred urgently for breast symptoms, but the referral does not meet the criteria for urgent GENERAL PRACTITIONER referrals for suspected cancer.

National Codes:

1 Routine
2 Urgent
3 Two Week Wait

PROCEDURE SCHEME IN USE

Change to Attribute: Changed Dataset

The type of CODED CLINICAL ENTRY used for the CLINICAL INTERVENTION.

National Codes:

01	Accident & Emergency Treatment ***
02	OPCS-4 ***
03	Read Code 4Byte Version (retired 1 October 2009)
04	Read Coded Clinical Terms Version 2
05	Read Coded Clinical Terms Version 3 (CTV3) *
06	SNOMED CT® **

Notes:

- * Read Coded Clinical Terms Version 3 (CTV3) with qualifiers (previously known as 3.1) is not supported in the Commissioning Data Sets
- ** SNOMED CT® is not valid for Commissioning Data Set version 6-2
- *** Accident & Emergency Treatment and OPCS-4 are not valid for the Community Services Data Set, Maternity Services Data Set and Mental Health Services Data Set.

PROFESSIONAL REGISTRATION BODY CODE

Change to Attribute: Changed Dataset, Description

A code which identifies the PROFESSIONAL REGISTRATION BODY.

National Codes:

01	General Chiropractic Council
02	General Dental Council
03	General Medical Council
04	General Optical Council
05	Social Care Wales **
06	Scottish Social Services Council (Retired 01 April 2013)
07	General Social Care Council (for England) (Retired 01 August 2012)
08	Health and Care Professions Council
09	Nursing and Midwifery Council
10	Royal Pharmaceutical Society (Retired 27 September 2010)
11	British Psychological Society (Retired 01 October 2017)
12	Association for Operating Department Practitioners (Retired January 2015)
13	Association of Chartered Certified Accountants (Retired 01 October 2017)
14	Chartered Institute of Personnel and Development (Retired 01 October 2017)
15	Chartered Institute of Management Accountants (Retired 01 October 2017)
16	General Pharmaceutical Council
~~17~~	~~General Osteopathic Council~~ ~~*~~

17 General Osteopathic Council

Notes:

- ~~* National Code 17 is not valid for use in the Community Services Data Set.~~
- ** The National Code description has been updated as a result of the work undertaken for the development of the National Workforce Data Set.
  ~~The Community Services Data Set and Maternity Services Data Set specifications will be updated in the next versions of the Information Standards where they are not already correct.~~
  The Maternity Services Data Set specification will be updated in the next version of the Information Standards where it is not already correct.

PROFESSIONAL REGISTRATION ENTRY IDENTIFIER

Change to Attribute: Changed Dataset

The registration identifier allocated by an Organisation.

Examples include:

- GENERAL DENTAL COUNCIL REGISTRATION NUMBER
- GENERAL MEDICAL COUNCIL REFERENCE NUMBER.

REASON FOR REFERRAL TO COMMUNITY CARE

Change to Attribute: Changed Dataset, Description

The reason that a PATIENT was referred to a Community Health Service.

National Codes:

001 Accident/Trauma
002 Alopecia
003 Antenatal Care
004 Bereavement
005 Bladder Care
006 Blood Pressure
007 Bowel Problems
008 Cancer
009 Cardiac Conditions
010 Catheter Problems
011 Cerebral Palsy
012 Cleft Palate

013 Cognitive Problems
014 Colostomy Care
015 Continence Problems
016 Contraception and Sexual Health (Retired 01 September 2015)
017 Developmental Problems
018 Diabetes
019 Diarrhoea and Vomiting
020 Dizziness/Balance Problems
021 Downs Syndrome
022 Deep Vein Thrombosis
023 Ear Infections/Problems
024 Eating Disorder
025 Emotional/Behavioural Problems
026 End of Life Support
027 Epilepsy
028 Equipment Provision
029 Eustachian Tube Dysfunction
030 Falls Risk
031 Family Support
032 Feeding/Swallowing Problems
033 Foot Care/Problems
034 Head Injury
035 Hearing Problems/Loss
036 Immunisation
037 Laryngectomy
038 Leg Ulcer
039 Looked After Children
040 Low Muscle Tone
041 Lymphoedema Management
042 Mobility Problems
043 Musculoskeletal Problems
044 Neurological Problems
045 Healthy Child Pathway
046 Nutrition and Dietetics
047 Ophthalmic Problems
048 Over 75 Assessment
049 Pain/Symptom Control
~~050 Parkinsons Disease~~
050 Parkinson's Disease
051 Personal Hygiene
052 Post Operative Care
053 Pressure Ulcer
054 Problems with Activities of Daily Living

055 Psychological Conditions
056 Rehabilitation
057 Respiratory Conditions
058 Safeguarding
059 Skin Problems
060 Sleep Problems
061 Smoking Cessation
062 Speech and Language Problems
063 Stoma Care
064 Structural/Functional Impairment
065 Substance Misuse
066 Trismus/Restricted Mouth Opening
067 Tuberculosis
068 Vascular Problems
069 Vomiting/Nausea
070 Wound Care
071 Multiple Complex Communication Difficulties
072 Dental Care/Problems
073 Haematology/Phlebotomy
074 Chronic Fatigue Syndrome/Myalgic Encephalopathy
075 Chronic Allergy/Immunological Problem
076 Metabolic/Endocrine Disorders
077 Renal Problems
078 Minor Surgery
079 Gastrostomy Management/Care
080 Care of the Next Infant (CONI) Pathway
081 Failure to Thrive
082 Maternal Mood Problems
083 Complex Social Factors (as defined by the National Institute for Health and Care Excellence guidance)
084 Condition(s) Requiring Respite Care
085 Other Congenital Conditions
086 Blood Disorders
087 Genetic Disorders
088 Neonatal Abstinence Syndrome

Note: This list is not in alphabetical order.

REFERRAL CLOSURE REASON

Change to Attribute: Changed Dataset

The reason that a REFERRAL REQUEST was closed by a Health Care Provider.

National Codes:

01	Admitted elsewhere (at the same or other Health Care Provider)
02	Treatment completed
03	Moved out of the area
04	No further treatment appropriate
05	PATIENT did not attend
06	PATIENT died
07	PATIENT requested discharge
08	Referred to other speciality/SERVICE (at the same or other Health Care Provider)
09	PATIENT refused to be seen

REFERRAL REJECTION REASON

Change to Attribute: Changed Dataset

The reason that a REFERRAL REQUEST was rejected by a Health Care Provider.

National Codes:

01	Duplicate REFERRAL REQUEST (PATIENT already undergoing treatment for the same condition at the same or other Health Care Provider)
02	Inappropriate REFERRAL REQUEST (REFERRAL REQUEST is inappropriate for the SERVICES offered by the Health Care Provider)
03	Incomplete REFERRAL REQUEST (incomplete information on REFERRAL REQUEST)

REFERRAL REQUEST RECEIVED DATE

Change to Attribute: Changed Dataset

The date the REFERRAL REQUEST was received by the Health Care Provider.

The waiting time for a first Out-Patient Appointment should be calculated from the date when the REFERRAL REQUEST is received.

- For electronic REFERRAL REQUESTS the REFERRAL REQUEST RECEIVED DATE is the date the REFERRAL REQUEST is received electronically by the Health Care Provider
- For Choose and Book, the referral is received when the PATIENT's Unique Booking Reference Number (UBRN) is used to book the first Out-Patient Appointment slot (i.e. converted).

Where an electronic REFERRAL REQUEST made through Choose and Book is rejected by the chosen provider, the ORIGINAL REFERRAL REQUEST RECEIVED DATE should be used when the PATIENT is subsequently re-referred to another service, so that PATIENTS are not unfairly disadvantaged when their waiting time calculations are made.

In the circumstance that a PATIENT calls the national Choose and Book Appointments Line and an APPOINTMENT SLOT is not available with the chosen Health Care Provider, the national Choose and Book Appointments Line will electronically forward the REFERRAL REQUEST details to the chosen Health Care Provider so the Health Care Provider can liaise directly with the PATIENT to arrange their Out-Patient Appointment. The REFERRAL REQUEST RECEIVED DATE will be the date that the Health Care Provider receives electronic notification from the national Choose and Book Appointments Line that the PATIENT has experienced slot unavailability. (Note that this is NOT the date that the Health Care Provider opens or actions the electronic notification).

For written REFERRAL REQUESTS letters must be opened and date stamped on the day of receipt. It is this date that must be entered on any Patient Administration System (PAS) or similar system, not the date on which the information is fed into the system if this is later than the date of receipt.

If the REFERRAL REQUEST takes the form of a phone call followed by a letter, record the date when the letter arrives. If there is no following letter, the date of the verbal request should be recorded.

REFERRAL REQUEST RECEIVED TIME

Change to Attribute: Changed Dataset

The time the REFERRAL REQUEST was received by the Health Care Provider.

REFERRAL TO TREATMENT PERIOD END DATE

Change to Attribute: Changed Dataset
The end date of a REFERRAL TO TREATMENT PERIOD.

This is a specific type of the attribute ACTIVITY DATE.

REFERRAL TO TREATMENT PERIOD END DATE will be one of the following:

- the ACTIVITY DATE:
  - when the PATIENT is admitted for First Definitive Treatment. If the start of a PATIENT's treatment is cancelled (by the Health Care Provider or PATIENT) after admission, the REFERRAL TO TREATMENT PERIOD will continue.
  - for First Definitive Treatment undertaken in an outpatient setting.
  - for First Definitive Treatment undertaken by an NHS Allied Health Professional Service (Referral To Treatment Measurement).
  - when the decision not to treat is made, with no further action at this time communicated to the PATIENT. This will include Discharge After Patient Did Not Attend and discharge back to primary care for treatment.
  - when the PATIENT declines offered treatment.
  - when the PATIENT did not attend for the first ACTIVITY during a REFERRAL TO TREATMENT PERIOD. See REFERRAL TO TREATMENT PERIOD for guidance on PATIENTS who do not attend.

- the clinical decision is made (and agreed with the PATIENT) that Active Monitoring will begin. If a PATIENT subsequently requires further treatment this decision would start a new REFERRAL TO TREATMENT PERIOD as part of the same PATIENT PATHWAY. This includes any treatment that is planned for a specific date in the future as ongoing monitoring.
- a clinical decision is made and has been communicated to the PATIENT, and subsequently their GENERAL PRACTITIONER and/or other referring CARE PROFESSIONAL without undue delay, to add the PATIENT to a transplant list.

or

- the PERSON DEATH DATE.

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

REFERRAL TO TREATMENT PERIOD END TIME

Change to Attribute: New Attribute

The end time of a REFERRAL TO TREATMENT PERIOD.

This attribute is also known by these names:

Context	Alias
plural	REFERRAL TO TREATMENT PERIOD END TIMES

REFERRAL TO TREATMENT PERIOD END TIME

Change to Attribute: New Attribute

REFERRAL TO TREATMENT PERIOD END TIME

Data Elements:

REFERRAL TO TREATMENT PERIOD END TIME

REFERRAL TO TREATMENT PERIOD START DATE

Change to Attribute: Changed Dataset, Description

The start date of a REFERRAL TO TREATMENT PERIOD.

This is a specific type of the attribute ACTIVITY DATE.

A REFERRAL TO TREATMENT PERIOD START DATE will be one of the following:

- **Initial Referral:**
  - the REFERRAL REQUEST RECEIVED DATE of a SERVICE REQUEST for a particular condition.
  - This will include a PATIENT being re-referred in to a Consultant Led Service or an Interface Service or an NHS Allied Health Professional Service (Referral To Treatment Measurement) as a new referral including after a Discharge After Patient Did Not Attend. The REFERRAL TO TREATMENT PERIOD STATUS is '*National Code 10 - first activity*'
- **Following an APPOINTMENT that the PATIENT did not attend:**
  - the APPOINTMENT ACCEPTED DATE (or the INVITATION OFFER DATE SENT of the first APPOINTMENT OFFER where the APPOINTMENT OFFER is sent) for the first APPOINTMENT following the PATIENT not attending an APPOINTMENT or elective admission. See REFERRAL TO TREATMENT PERIOD and Discharge After Patient Did Not Attend for guidance on PATIENTS who do not attend
  - The APPOINTMENT DATE of the APPOINTMENT that the PATIENT did not attend should be used where it is not possible to identify the APPOINTMENT ACCEPTED DATE or the INVITATION OFFER DATE SENT. The REFERRAL TO TREATMENT PERIOD STATUS is '*National Code 10 - first activity*'
- **Following active monitoring:**
  - the ACTIVITY DATE of a CARE ACTIVITY when a decision to treat was made following Active Monitoring and the REFERRAL TO TREATMENT PERIOD STATUS is '*National Code 11 - active monitoring end*'
  - This will include a decision to start a substantively new or different treatment that does not already form part of that PATIENT's agreed CARE PLAN.
- **On identifying a separate condition:**
  - the REFERRAL REQUEST RECEIVED DATE of a SERVICE REQUEST when a decision has been made to refer the PATIENT directly to a Consultant Led Service or an NHS Allied Health Professional Service (Referral To Treatment Measurement) for a separate condition (the REFERRAL TO TREATMENT PERIOD STATUS for the first CARE ACTIVITY with the new CONSULTANT or NHS Allied Health Professional Service (Referral To Treatment Measurement) is '*National Code 12 - consultant or NHS Allied Health Professional Service (Referral To Treatment) referral*').

Referral To Treatment Consultant Led Waiting Times:

For most PATIENTS, the start of the REFERRAL TO TREATMENT PERIOD begins with a SERVICE REQUEST from a GENERAL MEDICAL PRACTITIONER to a CONSULTANT.

SERVICE REQUESTS to CONSULTANTS who provide care SERVICES in community settings also start REFERRAL TO TREATMENT PERIODS and the REFERRAL REQUEST RECEIVED DATE will be the start of the REFERRAL TO TREATMENT PERIOD.

A REFERRAL TO TREATMENT PERIOD may also start from SERVICE REQUESTS to CONSULTANTS from GENERAL DENTAL PRACTITIONERS, Practitioners with Special Interests, OPTOMETRISTS and Orthoptists, National Screening Programmes, Specialist NURSES, other CARE PROFESSIONALS where commissioning Organisations have approved these mechanisms locally.

An 18-week clock also starts upon a self referral by a PATIENT to the above services, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a CARE PROFESSIONAL.

A REFERRAL TO TREATMENT PERIOD will also start where PATIENTS are transferred to an elective Consultant Led Service through SERVICE REQUESTS from Accident and Emergency Departments including Minor injuries units and Walk In Centres.

Allied Health Professional Referral To Treatment Measurement:

Further guidance relating to the Allied Health Professional Referral To Treatment can be found on the Department of Health and Social Care part of the gov.uk website at: Allied health professional referral to treatment revised guide.

Intermediate Care Measurement:

Further guidance relating to the Intermediate Care Waiting Time Measurements can be found on the NHS Digital website at: Community Services Data Set user guidance.

REFERRAL TO TREATMENT PERIOD START TIME

Change to Attribute: New Attribute

The start time of a REFERRAL TO TREATMENT PERIOD.

This attribute is also known by these names:

Context	Alias
plural	REFERRAL TO TREATMENT PERIOD START TIMES

REFERRAL TO TREATMENT PERIOD START TIME

Change to Attribute: New Attribute

REFERRAL TO TREATMENT PERIOD START TIME

Data Elements:

REFERRAL TO TREATMENT PERIOD START TIME

REFERRAL TO TREATMENT PERIOD STATUS

Change to Attribute: Changed Dataset
The status of an ACTIVITY (or anticipated ACTIVITY) for the REFERRAL TO TREATMENT PERIOD decided by the lead CARE PROFESSIONAL.

National Codes:

The first ACTIVITY in a REFERRAL TO TREATMENT PERIOD where the First Definitive Treatment will be a subsequent ACTIVITY

10 first ACTIVITY - first ACTIVITY in a REFERRAL TO TREATMENT PERIOD

11 Active Monitoring end - first ACTIVITY at the start of a new REFERRAL TO TREATMENT PERIOD following Active Monitoring

12 CONSULTANT or NHS Allied Health Professional Service (Referral To Treatment Measurement) referral - the first ACTIVITY at the start of a new REFERRAL TO TREATMENT PERIOD following a decision to refer directly to the CONSULTANT or NHS Allied Health Professional Service (Referral To Treatment Measurement) for a separate condition

Subsequent ACTIVITY during a REFERRAL TO TREATMENT PERIOD

20 subsequent ACTIVITY during a REFERRAL TO TREATMENT PERIOD - further ACTIVITIES anticipated

21 transfer to another Health Care Provider - subsequent ACTIVITY by another Health Care Provider during a REFERRAL TO TREATMENT PERIOD anticipated

ACTIVITY that ends the REFERRAL TO TREATMENT PERIOD

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

33 Did not attend - the PATIENT did not attend the first CARE ACTIVITY after the referral[1]

34 decision not to treat - decision not to treat made or no further contact required[2]

35 PATIENT declined offered treatment

36 PATIENT died before treatment

ACTIVITY that is not part of a REFERRAL TO TREATMENT PERIOD

90 after treatment - First Definitive Treatment occurred previously (e.g. admitted as an emergency from A&E or the ACTIVITY is after the start of treatment)

91 Active Monitoring - CARE ACTIVITY during Active Monitoring

92 not yet referred - not yet referred for treatment, undergoing diagnostic tests by GENERAL PRACTITIONER before referral

98 not applicable - ACTIVITY not applicable to REFERRAL TO TREATMENT PERIODS

ACTIVITY where the REFERRAL TO TREATMENT PERIOD STATUS is not yet known

99 not yet known

Where the REFERRAL TO TREATMENT PERIOD STATUS is National Code 99 - "not yet known" the status is treated as if the ACTIVITY is a subsequent ACTIVITY during a REFERRAL TO TREATMENT PERIOD. In this case the REFERRAL TO TREATMENT PERIOD STATUS should be corrected once it is possible to determine the correct value.

[1] **PATIENTS who do not attend an appointment**

National code 33 - "Did not attend - the PATIENT did not attend the first CARE ACTIVITY after the referral" may only be used where

- the PATIENT did not attend their first APPOINTMENT following the REFERRAL REQUEST that started the REFERRAL TO TREATMENT PERIOD, provided that the Health Care Provider can demonstrate that the APPOINTMENT was clearly communicated to the PATIENT.

  REFERRAL TO TREATMENT PERIODS with REFERRAL TO TREATMENT PERIOD STATUS of National code 33 are excluded from the measurement of the 18 weeks Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement and the count of Allied Health Professional Referral To Treatment Measurement REFERRAL TO TREATMENT PERIODS

[2] Decision not to treat

National Code 34 - "decision not to treat - decision not to treat made or no further contact required" includes

- a Discharge After Patient Did Not Attend the second or a subsequent CARE ACTIVITY after the referral.
- a change resulting in care no longer being commissioned by the English NHS.
- a referral to a Consultant Led Service during a Referral To Treatment Period Excluded From Target for the same condition, disease or injury. A new REFERRAL TO TREATMENT PERIOD will start.

REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH AND COMMUNITY CARE

Change to Attribute: Changed Dataset

The staff group of a CARE PROFESSIONAL who referred a PATIENT to a Community Health Service or Mental Health Service.

National Codes:

	Allied Health Professionals
A01	Art Therapist
A02	Clinical Psychologist
A03	Dietitian
A04	Drama Therapist
A05	Music Therapist
A06	Occupational Therapist
A07	Orthotist
A08	Physiotherapist
A09	Podiatrist
A10	Prosthetist
A11	Psychotherapist
A12	Radiographer
A13	Speech and Language Therapist
A14	Orthoptist

	Medical/Dental
M01	Community Dentist
M02	CONSULTANT
M03	GENERAL MEDICAL PRACTITIONER
M04	General Practitioner With A Special Interest
	Nursing, Health Visiting and Midwifery
N01	MIDWIFE
N02	District NURSE
N03	Health Visitor
N04	Macmillan NURSE
N05	School Nurse
N06	Specialist Nursing - Active Case Management (Community Matrons)
N07	Specialist Nursing - Arthritis Nursing/Liaison
N08	Specialist Nursing - Asthma and Respiratory Nursing/Liaison
N09	Specialist Nursing - Breast Care Nursing/Liaison
N10	Specialist Nursing - Cancer Related
N11	Specialist Nursing - Cardiac Nursing/Liaison
N12	Specialist Nursing - Children's Services
N13	Specialist Nursing - Community Cystic Fibrosis
N14	Specialist Nursing - Continence Services
N15	Specialist Nursing - Diabetic Nursing/Liaison
N16	Specialist Nursing - Enteral Feeding Nursing Services
N17	Specialist Nursing - Haemophilia Nursing Services
N18	Specialist Nursing - HIV/AIDS Nursing Services (Retired 01 September 2015)
N19	Specialist Nursing - Infectious Diseases
N20	Specialist Nursing - Intensive Care Nursing
N21	Specialist Nursing - Palliative/Respite Care
N22	Specialist Nursing - Parkinson's and Alzheimers Nursing/Liaison
N23	Specialist Nursing - Rehabilitation Nursing
N24	Specialist Nursing - Stoma Care Services
N25	Specialist Nursing - Tissue Viability Nursing/Liaison
N26	Specialist Nursing - Transplantation Patients Nursing Services
N27	Specialist Nursing - Treatment Room Nursing Services
N28	Specialist Nursing - Tuberculosis Specialist Nursing
N29	Specialist Nursing - Other Specialist Nursing
N30	Specialist Nursing - Safeguarding
N31	Practice Nursing
N32	Staff NURSE
N33	Other Registered NURSE
N34	Public Health NURSE
	Other Care Professionals
C01	Appliances Technician
C02	Audiologist

C03	Counsellor
C04	Nursery Nurse
C06	Play Therapist
C07	Social Worker
C08	Voluntary Care Worker
C09	Screener (in a National Screening Programme)
C10	Health Trainer (Non Clinical) *
C11	Health Trainer (Clinical) *
C12	Health Care Assistant *
C13	Health Care Support Worker *
C99	Other CARE PROFESSIONAL (not listed)

* Note: National Codes C10, C11, C12 and C13 are **only valid** for use in the Community Services Data Set.

RELATIONSHIP TO PERSON FOR CHILDREN AND YOUNG PEOPLE

Change to Attribute: Changed Dataset, Description

The relationship of the second PERSON to the first PERSON (the PATIENT) as used in the Community Services Data Set.

This is used to identify, for example, with whom the Child or Young Person is living in a permanent context or the relationship with the main Carer etc.

Note that Organisations may choose to collect the RELATIONSHIP TO PERSON FOR CHILDREN AND YOUNG PEOPLE codes at the high level (shown in **bold**) or at the more detailed level below each high-level code.

This item is not referenced in a data set in the NHS Data Model and Dictionary. It has been retained as the item is used by the Healthy Child Programme.

National Codes:

BPX	**Biological Parent**
BPM	Biological mother
BPF	Biological father
SPX	**Step-Parent**
SPM	Stepmother
SPF	Stepfather
GPX	**Grandparent**
GPM	Grandmother
GPF	Grandfather
ORX	**Other Relative**

ORA	Aunt
ORU	Uncle
ORS	Sister
ORB	Brother
ORO	Other (not listed)
APX	**Adoptive Parent**
APM	Adoptive mother
APF	Adoptive father
FPX	**Foster Parent**
FPM	Foster mother
FPF	Foster father
RCX	**Residential Carer**
OTX	**Other**
NOX	**None - Lives Alone**

RELATIONSHIP TO PERSON FOR COMMUNITY

Change to Attribute: New Attribute

The relationship of the second PERSON to the first PERSON (the PATIENT) as used in the Community Services Data Set.

Note that Organisations may choose to collect the RELATIONSHIP TO PERSON FOR COMMUNITY codes at the high level (shown in **bold**) or at the more detailed level below each high-level code.

National Codes:

BPX	**Biological Parent**
BPM	Biological Mother
BPF	Biological Father
SPX	**Step-Parent**
SPM	Stepmother
SPF	Stepfather
PIX	**Parents-in-Law**
PIF	Father-in-Law
PIM	Mother-in-Law
CHX	**Children**
CHS	Son
CHD	Daughter
CIX	**Children-in-Law**
CIS	Son-in-Law
CID	Daughter-in-Law

GPX	**Grandparent**
GPM	Grandmother
GPF	Grandfather
GCX	**Grandchild**
GCS	Grandson
GCD	Granddaugther
ORX	**Other Relative**
ORA	Aunt
ORU	Uncle
ORS	Sister
ORB	Brother
ORO	Other (not listed)
APX	**Adoptive Parent**
APM	Adoptive Mother
APF	Adoptive Father
FPX	**Foster Parent**
FPM	Foster Mother
FPF	Foster Father
RCX	**Residential Carer**
OTX	**Other**
NOX	**None - Lives Alone**

This attribute is also known by these names:

Context	Alias
plural	RELATIONSHIPS TO PERSON FOR COMMUNITY

RELATIONSHIP TO PERSON FOR COMMUNITY

Change to Attribute: New Attribute

RELATIONSHIP TO PERSON FOR COMMUNITY

Data Elements:

PERSON RELATIONSHIP (MAIN CARER)

REPORTING PERIOD END DATE

Change to Attribute: Changed Dataset

The date that a REPORTING PERIOD ends.

REPORTING PERIOD END TIME

Change to Attribute: New Attribute

The time that a REPORTING PERIOD ends.

This attribute is also known by these names:

Context	Alias
plural	REPORTING PERIOD END TIMES

REPORTING PERIOD START DATE

Change to Attribute: Changed Dataset

The date that a REPORTING PERIOD begins.

REPORTING PERIOD START TIME

Change to Attribute: New Attribute

The time that a REPORTING PERIOD begins.

This attribute is also known by these names:

Context	Alias
plural	REPORTING PERIOD START TIMES

SAFEGUARDING VULNERABILITY FACTORS INDICATOR

Change to Attribute: Changed Dataset

An indication of whether there are any Child Safeguarding vulnerability factors.

National Codes:

- Y Yes - Child Safeguarding vulnerability factors present
- N No - Child Safeguarding vulnerability factors not present

SAFEGUARDING VULNERABILITY FACTORS TYPE

Change to Attribute: Changed Dataset

The type of Child Safeguarding vulnerability factors identified.

National Codes:

01	Repeat Accident and Emergency Attendances
02	Concerning parent child interaction
03	Worrying parent behaviour / Mental Health concerns
04	Worrying child behaviour
05	Self harm
06	Genital injury (excluding Female Genital Mutilation (FGM))
07	Referral from Social Services or Police
08	Previously known to Social Services
09	Significant injury in child (in the last 12 months)
10	Domestic abuse
11	History inconsistent with injuries
12	Disclosure of abuse
13	Bullying
14	Delay in presentation (Children with frequent minor injuries and there is a delay in presentation to medical staff)
15	Other (Retired 01 September 2015)
16	Female Genital Mutilation (FGM)
98	Other (not listed)

SAMPLE COLLECTION DATE

Change to Attribute: Changed Dataset

The date that a SAMPLE collection takes place or the start of a period for SAMPLE collection.

SERVICE OR TEAM TYPE REFERRED TO FOR COMMUNITY CARE

Change to Attribute: Changed Dataset, Description

The type of SERVICE or Multidisciplinary Team within a Community Health Service that a PATIENT was referred to.

For further information relating to the SERVICE OR TEAM TYPES REFERRED TO FOR COMMUNITY CARE, see the NHS Digital website at: Community Services Data Set user guidance.

National Codes:

01	Appliances Service

02 Arts Therapy Service
03 Cancer Service
04 Cardiac Service
05 Community Dental Service
06 Community Paediatrics Service
07 Continence Service
08 Contraception and Sexual Health Service (Retired 01 September 2015)
09 Counselling Service
10 Dermatology Service
11 Diabetes Service
12 District Nursing Service
13 Ear, Nose and Throat Service
14 End of Life Care Service
15 Gastrointestinal Service
16 Health Visiting Service
17 Hearing Service
~~18 Intermediate Care Service~~
18 Intermediate Care Service (Retired 01 April 2020)
19 Long Term Conditions Case Management Service
20 Musculoskeletal Service
21 Neurology Service
22 Nutrition and Dietetics Service
23 Occupational Therapy Service
24 Orthoptist Service
25 Pain Management Service
26 Physiotherapy Service
27 Podiatry Service
28 Public Health and Lifestyle Service
29 Rehabilitation Service
30 Respiratory Service
31 Rheumatology Service
32 School Nursing Service
33 Speech and Language Therapy Service
34 Vulnerable Children's Service
35 Vulnerable Adult's Service
36 Respite Care Service
37 Clinical Psychology Service
38 Children's Community Nursing Service
39 Diagnostic Service
40 Treatment Room Nursing Service
41 Haematology Service
42 Phlebotomy Service
43 Tissue Viability Service

44 Family Support Service
45 Integrated Multidisciplinary Team (jointly commissioned)
46 Prosthetic Service
47 Specialist Palliative Care Service
48 Enablement Service
49 Urgent Care Service
50 Wheelchair Service
51 Crisis Response Intermediate Care Service
52 Reablement Intermediate Care Service
53 Home-based Intermediate Care Service
54 Community Bed-based Intermediate Care Service

SERVICE REQUEST DATE

Change to Attribute: Changed Dataset

The date a SERVICE REQUEST for an APPOINTMENT was made and recorded.

SERVICE REQUEST IDENTIFIER

Change to Attribute: Changed Dataset
The unique identifier for a SERVICE REQUEST.

SERVICE TYPE

Change to Attribute: Changed Description

The type of SERVICE.

National Codes:

01 Ambulance Service
02 Cancer Service
03 Community Health Service
04 Consultant Led Service
05 Direct Access Service
06 Enhanced Sexual Health Service (Retired November 2014)
07 HIV Service
08 Hospital At Home Service
09 Improving Access to Psychological Therapies Service
10 Interface Service
11 Non-Consultant Led Service
12 Professional Staff Group Service (Retired 01 January 2016)

13 Sexual and Reproductive Health Service
14 Stop Smoking Service
15 Contraceptive Service (Retired 01 April 2014)
16 Radiotherapy Service
17 Sexual Health Service
18 Mental Health Service
19 Regional Clinical Genetics Service
20 Children and Young People's Mental Health Service
21 Screening Service
22 Sexually Transmitted Infection Service
23 Maternity Service
24 Health Visiting Service
25 Systemic Anti-Cancer Therapy Service
Intermediate Care Service
Community Bed-based Intermediate Care Service
Crisis Response Intermediate Care Service
Home-based Intermediate Care Service
Reablement Intermediate Care Service

SESSION DATE

Change to Attribute: Changed Dataset

The date of a SESSION such as Group Session, Operating Theatre Session or Consultant Clinic Session.

SETTLED ACCOMMODATION INDICATOR

Change to Attribute: Changed Description

An indication of whether the main/permanent residence of a PATIENT is settled ACCOMMODATION.

Settled ACCOMMODATION refers to secure, medium to long term ACCOMMODATION. The principle characteristic is that the occupier has security of tenure/residence in their usual accommodation in the medium to long term, or is part of a household whose head holds such security or tenure/residence.

~~Non-settled ACCOMMODATION refers to ACCOMMODATION arrangements that are precarious, or where the PERSON has no or low security of tenure/residence in their usual ACCOMMODATION and so may be required to leave at very short notice.~~Non-settled ACCOMMODATION refers to ACCOMMODATION arrangements that are precarious, or where the PATIENT has no or low security of tenure/residence in their usual ACCOMMODATION and so may be required to leave at very short notice.

National Codes:

Y	Yes - Settled ACCOMMODATION
N	No - Non-settled ACCOMMODATION
~~Z~~	~~Not Stated (PERSON asked but declined to provide a response)~~
Z	Not Stated (PATIENT asked but declined to provide a response)

SOURCE OF REFERRAL FOR COMMUNITY

Change to Attribute: Changed Dataset

The source of a SERVICE REQUEST to a Community Health Service.

National Codes:

01	General Medical Practitioner Practice
02	Self referral
03	Carer/Relative
04	Employer
05	Accident and Emergency Department (including Minor Injuries Units and Walk In Centres)
06	Acute Hospital Inpatient/Outpatient Department
07	Community Health Service (same or other Health Care Provider)
08	Dental Practice
09	National Screening Programme
10	Educational Establishment
11	Local Authority Social Services
12	Hospice
13	Care Home
14	Police
15	Courts
16	Probation Service
17	Prison Health Service
18	Asylum Service
19	Telephone or Electronic Access Service
20	Voluntary Sector
21	Independent Sector
22	Ambulance Service
23	Mental Health Service

SPECIAL EDUCATIONAL NEED TYPE

Change to Attribute: Changed Dataset

The type of Special Education Needs of a PERSON.

National Codes:

01	Specific Learning Disability
02	Learning Difficulty
03	Emotional and Behavioural Difficulty
04	Speech and Communication Difficulty
05	Hearing Impairment
06	Visual Impairment
07	Physical DISABILITY
08	Other Difficulty / DISABILITY
ZZ	Not Stated (PERSON asked but declined to provide a response)

UCUM UNIT OF MEASUREMENT

Change to Attribute: Changed Dataset

The UNIT OF MEASUREMENT using the Unified Code for Units of Measure (UCUM) code system.

For further information on the Unified Code for Units of Measure (UCUM) code system, see the Unified Code for Units of Measure website.

UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)

Change to Attribute: Changed Dataset
The unique booking reference number assigned by the Choose and Book system when a PATIENT accepts an APPOINTMENT DATE OFFERED of an APPOINTMENT OFFER where the offer was made via the Choose and Book system.

When a PATIENT accepts an APPOINTMENT DATE OFFERED, the unique booking reference number issued and used during the booking process is considered to be 'converted' i.e. an APPOINTMENT has been created and recorded; and the PATIENT has been placed on an Out-Patient Waiting List even if subsequently the PATIENT does not attend or cancels the APPOINTMENT.

UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) should only be recorded where the type of booking system is the Choose and Book system.

WAITING TIME MEASUREMENT TYPE

Change to Attribute: Changed Dataset, Description

The type of waiting time measurement methodology which may be applied during a PATIENT PATHWAY.

The methodology applied may be for one part of a PATIENT PATHWAY, such as the measurement of a REFERRAL TO TREATMENT PERIOD, or other parts of the PATIENT PATHWAY according to Department of Health and Social Care policy.

National Codes:

~~01~~ ~~Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement~~
01 Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement **
02 Allied Health Professional Referral To Treatment Measurement
03 Improving Access to Psychological Therapies Referral To Treatment Measurement *
04 Early Intervention in Psychosis Waiting Time Measurement *
~~09~~ ~~Other Referral To Treatment Measurement Type~~
05 Crisis Response Intermediate Care Within 2 Hours Waiting Time Measurement ***
06 Other Intermediate Care Within 2 Days Waiting Time Measurement ***
07 Crisis Response Intermediate Care Waiting Time Measurement ***
08 Other Intermediate Care Waiting Time Measurement ***
09 Other Referral To Treatment Measurement Type (not listed)

Notes:

- * National Codes 03 and 04 relate to the Waiting Time Measurements in the Improving Access to Psychological Therapies Data Set and Mental Health Services Data Set **only**. Other Data Sets which include WAITING TIME MEASUREMENT TYPE will not report National Codes 03 and 04.
- ~~** National Code 01 is also not valid for the Mental Health Services Data Set.~~
- ** National Code 01 is also not valid for the Mental Health Services Data Set
- *** National Codes 05, 06, 07 and 08 relate to the Waiting Time Measurements in the Community Services Data Set **only**. Other Data Sets which include WAITING TIME MEASUREMENT TYPE will not report National Codes 05, 06, 07 and 08.

WEEKLY HOURS WORKED

Change to Attribute: Changed Dataset
A code to identify the number of hours worked per week by a PERSON.

National Codes:

01 30+ hours
02 16-29 hours
03 5-15 hours
04 1-4 hours

97 Not Stated (PERSON asked but declined to provide a response)

ACCOMMODATION STATUS CODE

Change to Data Element: Changed Dataset

Format/Length:	an4
National Codes:	See ACCOMMODATION STATUS CODE
Default Codes:	OC97 - Not specified
	OC98 - Not applicable
	OC99 - Not Known (Not Recorded)

Notes:
ACCOMMODATION STATUS CODE is the same as attribute ACCOMMODATION STATUS CODE.

ACCOMMODATION STATUS RECORDED DATE

Change to Data Element: Changed Dataset

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

Notes:
ACCOMMODATION STATUS RECORDED DATE is the same as attribute PERSON PROPERTY RECORDED DATE.

ACCOMMODATION STATUS RECORDED DATE is the date when the ACCOMMODATION STATUS CODE was recorded.

ACTIVITY LOCATION TYPE CODE

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	See ACTIVITY LOCATION TYPE CODE
Default Codes:	

Notes:
ACTIVITY LOCATION TYPE CODE is the same as attribute ACTIVITY LOCATION TYPE CODE.

Use in Commissioning Data Set Version 6-2 onwards

Where Out-Patient Clinics are held on WARDS (such as Pre-assessment Clinics), these should be categorised as ACTIVITY LOCATION TYPE CODE National Code E01 'Out-Patient Clinic' and not National Code E02 'WARD'. This will allow Ward Attendances to be differentiated from Out-Patient Clinics in the CDS V6-2 Type 020 - Outpatient Commissioning Data Set flow.

For ACTIVITY falling under Allied Health Professional Referral To Treatment Measurement, ACTIVITY LOCATION TYPE CODE may be submitted to allow identification of Allied Health Professional ACTIVITY taking place on WARDS, which is not related to the Hospital Provider Spell for the PATIENT being seen by the Allied Health Professional. For example, if a Podiatrist were asked to see a PATIENT who was currently admitted for a condition where the agreed care pathway did not include Podiatry services, then an Out-Patient Appointment Non-Consultant should be recorded, with the ACTIVITY LOCATION TYPE CODE of E02 'WARD'.

ADMINISTRATIVE CATEGORY CODE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See ADMINISTRATIVE CATEGORY CODE
Default Codes:	98 - Not applicable
	99 - Not known: a validation error

Notes:
ADMINISTRATIVE CATEGORY CODE is the same as ADMINISTRATIVE CATEGORY CODE.

ASSESSMENT TOOL COMPLETION DATE

Change to Data Element: Changed Dataset

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

Notes:
ASSESSMENT TOOL COMPLETION DATE is the date the ASSESSMENT TOOL was completed.

ASSISTIVE TECHNOLOGY FINDING (SNOMED CT)

Change to Data Element: Changed Dataset, Description

Format/Length:	See SNOMED CT CODE
National Codes:	
Default Codes:	

Notes:
ASSISTIVE TECHNOLOGY FINDING (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

~~ASSISTIVE TECHNOLOGY FINDING (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the finding relating to the Assistive Technology that a PERSON is dependent on.~~ASSISTIVE TECHNOLOGY FINDING (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the finding relating to the Assistive Technology that a PATIENT is dependent on.

ATTENDED OR DID NOT ATTEND CODE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See ATTENDED OR DID NOT ATTEND
Default Codes:	

Notes:
ATTENDED OR DID NOT ATTEND CODE is the same as attribute ATTENDED OR DID NOT ATTEND.

Use in the Future Outpatient CDS:

- Where the attendance is in the future (and has not been cancelled) use value 0 (zero) - *not applicable* - APPOINTMENT *occurs in the future*.
- Where the future attendance has been ***cancelled***, use the appropriate value from the national codes (see ATTENDED OR DID NOT ATTEND).

BLOOD SPOT CARD COMPLETION DATE

Change to Data Element: Changed Dataset

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

Notes:
BLOOD SPOT CARD COMPLETION DATE is the blood SAMPLE COLLECTION DATE for a Newborn Blood Spot Test for a Neonate.

BREASTFEEDING STATUS

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See BREASTFEEDING STATUS
Default Codes:	

Notes:
BREASTFEEDING STATUS is the same as attribute BREASTFEEDING STATUS.

CARE ACTIVITY IDENTIFIER

Change to Data Element: Changed Dataset

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
CARE ACTIVITY IDENTIFIER is the ACTIVITY IDENTIFIER for a CARE ACTIVITY.

CARE CONTACT CANCELLATION DATE

Change to Data Element: Changed Dataset

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

Notes:
CARE CONTACT CANCELLATION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Care Contact Cancellation Date'*.

CARE CONTACT CANCELLATION REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See CARE CONTACT CANCELLATION REASON
Default Codes:	

Notes:
CARE CONTACT CANCELLATION REASON is the same as attribute CARE CONTACT CANCELLATION REASON.

CARE CONTACT DATE

Change to Data Element: Changed Dataset

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

Notes:
CARE CONTACT DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Care Contact Date'*.

CARE CONTACT IDENTIFIER

Change to Data Element: Changed Dataset

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
CARE CONTACT IDENTIFIER is the ACTIVITY IDENTIFIER for a CARE CONTACT.

CARE CONTACT SUBJECT

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See CARE CONTACT SUBJECT
Default Codes:	

Notes:
CARE CONTACT SUBJECT is the same as attribute CARE CONTACT SUBJECT.

CARE CONTACT TIME

Change to Data Element: Changed Dataset

Format/Length:	an8 HH:MM:SS
National Codes:	
Default Codes:	

Notes:
CARE CONTACT TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code *'Care Contact Time'*.

CARE PLAN AGREED BY

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See CARE PLAN AGREED BY
Default Codes:	

Notes:
CARE PLAN AGREED BY is the same as attribute CARE PLAN AGREED BY.

CARE PLAN AGREED DATE

Change to Data Element: Changed Dataset

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

Notes:
CARE PLAN AGREED DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Care Plan Agreed Date'*.

CARE PLAN AGREED TIME

Change to Data Element: Changed Dataset

Format/Length:	an8 HH:MM:SS
National Codes:	
Default Codes:	

Notes:
CARE PLAN AGREED TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code *'Care Plan Agreed Time'*.

CARE PLAN CREATION DATE

Change to Data Element: Changed Dataset

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

Notes:
CARE PLAN CREATION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Care Plan Creation Date'*.

CARE PLAN CREATION TIME

Change to Data Element: Changed Dataset

Format/Length:	an8 HH:MM:SS
National Codes:	
Default Codes:	

Notes:
CARE PLAN CREATION TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code *'Care Plan Creation Time'*.

CARE PLAN IDENTIFIER

Change to Data Element: Changed Dataset

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
CARE PLAN IDENTIFIER is the same as attribute CARE PLAN IDENTIFIER.

CARE PLAN IMPLEMENTATION DATE

Change to Data Element: Changed Dataset

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

Notes:
CARE PLAN IMPLEMENTATION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Care Plan Implementation Date'*.

CARE PLAN LAST UPDATED DATE

Change to Data Element: Changed Dataset, Description

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

Notes:
CARE PLAN LAST UPDATED DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Care Plan Last Updated Date'*.

~~For the Mental Health Services Data Set, where the CARE PLAN has not been updated since its creation, the CARE PLAN LAST UPDATED DATE will be the same as CARE PLAN CREATION DATE.~~For the Community Services Data Set and Mental Health Services Data Set, where the CARE PLAN has not been updated since its creation, the CARE PLAN LAST UPDATED DATE will be the same as CARE PLAN CREATION DATE.

CARE PLAN LAST UPDATED TIME

Change to Data Element: Changed Dataset, Description

Format/Length:	an8 HH:MM:SS
National Codes:	
Default Codes:	

Notes:
CARE PLAN LAST UPDATED TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code *'Care Plan Last Updated Time'*.

~~For the Mental Health Services Data Set, where the CARE PLAN has not been updated since its creation, the CARE PLAN LAST UPDATED TIME will be the same as CARE PLAN CREATION TIME.~~For the Community Services Data Set and Mental Health Services Data Set, where the CARE PLAN has not been updated since its creation, the CARE PLAN LAST UPDATED TIME will be the same as CARE PLAN CREATION TIME.

CARE PLAN TYPE (COMMUNITY CARE)

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See CARE PLAN TYPE FOR COMMUNITY CARE

Default Codes:

Notes:
CARE PLAN TYPE (COMMUNITY CARE) is the same as attribute CARE PLAN TYPE FOR COMMUNITY CARE.

This data element is also known by these names:

Context	Alias
plural	CARE PLAN TYPES (COMMUNITY CARE)

CARE PLAN TYPE (COMMUNITY CARE)

Change to Data Element: New Data Element

CARE PLAN TYPE (COMMUNITY CARE)

Attribute:

CARE PLAN TYPE FOR COMMUNITY CARE

CARE PROFESSIONAL (JOB ROLE CODE)

Change to Data Element: Changed Dataset

Format/Length:	an5
National Codes:	See JOB ROLE CODE
Default Codes:	

Notes:
CARE PROFESSIONAL (JOB ROLE CODE) is the same as attribute JOB ROLE CODE.

CARE PROFESSIONAL LOCAL IDENTIFIER

Change to Data Element: Changed Dataset

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
CARE PROFESSIONAL LOCAL IDENTIFIER is the same as attribute CARE PROFESSIONAL IDENTIFIER.

CARE PROFESSIONAL LOCAL IDENTIFIER is a unique local CARE PROFESSIONAL IDENTIFIER within a Health Care Provider and may be assigned automatically by the computer system.

CARE PROFESSIONAL STAFF GROUP (COMMUNITY CARE)

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	See CARE PROFESSIONAL STAFF GROUP FOR COMMUNITY CARE
Default Codes:	

Notes:
CARE PROFESSIONAL STAFF GROUP (COMMUNITY CARE) is the same as attribute CARE PROFESSIONAL STAFF GROUP FOR COMMUNITY CARE.

CARE PROFESSIONAL TEAM LOCAL IDENTIFIER

Change to Data Element: Changed Dataset

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
CARE PROFESSIONAL TEAM LOCAL IDENTIFIER is the same as attribute CARE PROFESSIONAL TEAM IDENTIFIER.

CARE PROFESSIONAL TEAM LOCAL IDENTIFIER is a unique local CARE PROFESSIONAL TEAM IDENTIFIER within a Health Care Provider and may be assigned automatically by the computer system.

CHILDHOOD IMMUNISATION TYPE (CHILDREN AND YOUNG PEOPLE'S HEALTH SERVICES)

Change to Data Element: Changed Dataset, Description

Format/Length:	an3
National Codes:	
Default Codes:	

Notes:
CHILDHOOD IMMUNISATION TYPE (CHILDREN AND YOUNG PEOPLE'S HEALTH SERVICES) is the same as attribute CHILDHOOD IMMUNISATION TYPE for a Child or Young Person in the Community Services Data Set.

Permitted National Codes:

010	Diphtheria
020	Pertussis
030	Tetanus
040	Polio
050	Haemophilus influenzae type b
060	Measles, Mumps, Rubella (MMR)

070	Meningococcal serogroup C (MenC)
090	Pneumococcal (PCV)
100	Low dose Diphtheria
110	Human papillomavirus (HPV)
120	Rotavirus
130	Hepatitis B (Hep B)
140	Tuberculosis (BCG)
150	Meningococcal serogroup B (MenB)
160	Meningococcal ACWY
170	Nasal Flu Vaccination

CHILD PROTECTION PLAN END DATE

Change to Data Element: Changed Dataset

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

Notes:
CHILD PROTECTION PLAN END DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'End Date'*.

CHILD PROTECTION PLAN END DATE is the date on which a Child or Young Person is removed from a Child Protection Plan.

CHILD PROTECTION PLAN INDICATION CODE

Change to Data Element: Changed Description

Format/Length:	an1
National Codes:	See CHILD PROTECTION PLAN INDICATION CODE
~~Default Codes:~~	~~X - Not Known whether the PERSON is or has ever been the subject of a Child Protection Plan~~
Default Codes:	X - Not Known whether the PATIENT is or has ever been the subject of a Child Protection Plan

Notes:
CHILD PROTECTION PLAN INDICATION CODE is the same as attribute CHILD PROTECTION PLAN INDICATION CODE.

CHILD PROTECTION PLAN REASON CODE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See CHILD PROTECTION PLAN REASON CODE
Default Codes:	

Notes:
CHILD PROTECTION PLAN REASON CODE is the same as attribute CHILD PROTECTION PLAN REASON CODE.

CHILD PROTECTION PLAN START DATE

Change to Data Element: Changed Dataset

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

Notes:
CHILD PROTECTION PLAN START DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Start Date'*.

CHILD PROTECTION PLAN START DATE is the date on which a Child or Young Person is placed on a Child Protection Plan.

CLINICAL CONTACT DURATION OF CARE ACTIVITY

Change to Data Element: Changed Dataset

Format/Length:	max n4
National Codes:	
Default Codes:	

Notes:
CLINICAL CONTACT DURATION OF CARE ACTIVITY is the duration of a CARE ACTIVITY in minutes, excluding any administration time prior to or after the CARE ACTIVITY and the CARE PROFESSIONAL's travelling time to the LOCATION where the CARE ACTIVITY was provided.

CLINICAL CONTACT DURATION OF CARE ACTIVITY is calculated from the Start Time and End Time of the CARE ACTIVITY.

CLINICAL CONTACT DURATION OF CARE CONTACT

Change to Data Element: Changed Dataset

Format/Length:	max n4
National Codes:	
Default Codes:	

Notes:
CLINICAL CONTACT DURATION OF CARE CONTACT is the total duration of the direct clinical contact at CARE CONTACT in minutes, excluding any administration time prior to or after the CARE CONTACT and the CARE PROFESSIONAL's travelling time to the CARE CONTACT.

CLINICAL CONTACT DURATION OF CARE CONTACT includes the time spent on the different CARE ACTIVITIES that may be performed in a single CARE CONTACT. The duration of each CARE ACTIVITY is recorded in CLINICAL CONTACT DURATION OF CARE ACTIVITY.

CLINICAL CONTACT DURATION OF CARE CONTACT is calculated from the Start Time and End Time of the CARE CONTACT.

CLINICAL CONTACT DURATION OF GROUP SESSION

Change to Data Element: Changed Dataset

Format/Length:	max n4
National Codes:	
Default Codes:	

Notes:
CLINICAL CONTACT DURATION OF GROUP SESSION is the duration of a Group Session in minutes, excluding any administration time prior to or after the Group Session and the CARE PROFESSIONAL's travelling time to the LOCATION where the Group Session was provided.

CLINICAL CONTACT DURATION OF GROUP SESSION is calculated from the Start Time and End Time of the Group Session.

CODED ASSESSMENT TOOL TYPE (SNOMED CT)

Change to Data Element: Changed Dataset

Format/Length:	See SNOMED CT CODE
National Codes:	
Default Codes:	

Notes:

CODED ASSESSMENT TOOL TYPE (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

CODED ASSESSMENT TOOL TYPE (SNOMED CT) is the SNOMED CT® concept ID which is used to identify an ASSESSMENT TOOL.

Nationally published SNOMED CT Refset Metadata can be found on the Data Dictionary for Care (DD4C) website at: Published Subset Metadata.

CODED FINDING (CODED CLINICAL ENTRY)

Change to Data Element: Changed Dataset

Format/Length:	min an4 max an18
National Codes:	
Default Codes:	

Notes:
CODED FINDING (CODED CLINICAL ENTRY) is the same as attribute CLINICAL CLASSIFICATION CODE or CLINICAL TERMINOLOGY CODE.

CODED FINDING (CODED CLINICAL ENTRY) is the CODED CLINICAL ENTRY which is used to identify a finding.

For further information on findings, see the SNOMED CT® information at:

- Clinical finding
- SNOMED CT Concept Model: Clinical finding.

CODED OBSERVATION (CLINICAL TERMINOLOGY)

Change to Data Element: Changed Dataset

Format/Length:	min an5 max an18
National Codes:	
Default Codes:	

Notes:
CODED OBSERVATION (CLINICAL TERMINOLOGY) is the same as attribute CLINICAL TERMINOLOGY CODE.

CODED OBSERVATION (CLINICAL TERMINOLOGY) is the CLINICAL TERMINOLOGY CODE which is used to identify an observation.

For further information on observations, see the SNOMED CT® Glossary at: 2.4.5 Observable Entity.

CODED PROCEDURE (CLINICAL TERMINOLOGY)

Change to Data Element: Changed Dataset

Format/Length:	min an5 max an18
National Codes:	

Default Codes:

Notes:
CODED PROCEDURE (CLINICAL TERMINOLOGY) is the same as attribute CLINICAL TERMINOLOGY CODE.

CODED PROCEDURE (CLINICAL TERMINOLOGY) is the CLINICAL TERMINOLOGY CODE which is used to identify a Patient Procedure.

For further information on Patient Procedures, see the SNOMED CT® information at: SNOMED CT Concept Model: Procedure.

COMMUNITY CARE ACTIVITY TYPE renamed from COMMUNITY CARE ACTIVITY TYPE CODE

Change to Data Element: Changed Dataset, Name

Format/Length:	an2
~~National Codes:~~	~~See COMMUNITY CARE ACTIVITY TYPE CODE~~
National Codes:	See COMMUNITY CARE ACTIVITY TYPE
Default Codes:	

Notes:
~~COMMUNITY CARE ACTIVITY TYPE CODE is the same as attribute COMMUNITY CARE ACTIVITY TYPE CODE.~~COMMUNITY CARE ACTIVITY TYPE is the same as attribute COMMUNITY CARE ACTIVITY TYPE.

COMMUNITY CARE ACTIVITY TYPE renamed from COMMUNITY CARE ACTIVITY TYPE CODE

Change to Data Element: Changed Dataset, Name

- null
- Changed Name from Data_Dictionary.Data_Field_Notes.C.Co.COMMUNITY_CARE_ACTIVITY_TYPE_CODE to Data_Dictionary.Data_Field_Notes.C.Co.COMMUNITY_CARE_ACTIVITY_TYPE

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR
Default Codes:	

Notes:

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR is the same as attribute CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR.

CONSULTATION MEDIUM USED

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See CONSULTATION MEDIUM USED
Default Codes:	

Notes:
CONSULTATION MEDIUM USED is the same as attribute CONSULTATION MEDIUM USED.

CONSULTATION TYPE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See CONSULTATION TYPE
Default Codes:	

Notes:
CONSULTATION TYPE is the same as attribute CONSULTATION TYPE.

DATA SET VERSION NUMBER

Change to Data Element: Changed Dataset

Format/Length:	max n2.max n2
National Codes:	
Default Codes:	

Notes:
DATA SET VERSION NUMBER is the same as attribute DATA SET VERSION NUMBER.

DATE AND TIME DATA SET CREATED

Change to Data Element: Changed Dataset

Format/Length:	an19 YYYY-MM-DDThh:mm:ss
National Codes:	
Default Codes:	

Notes:
DATE AND TIME DATA SET CREATED is the same as attribute EVENT DATE and EVENT TIME.

DATE AND TIME DATA SET CREATED is the date and time a data set was created.

DEATH LOCATION TYPE CODE (ACTUAL)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See DEATH LOCATION TYPE CODE
Default Codes:	

Notes:
DEATH LOCATION TYPE CODE (ACTUAL) is the same as attribute DEATH LOCATION TYPE CODE.

DEATH LOCATION TYPE CODE (ACTUAL) is the actual LOCATION where the PERSON died.

DEATH LOCATION TYPE CODE (PREFERRED)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See DEATH LOCATION TYPE CODE
Default Codes:	99 - The CARE PROFESSIONAL did not discuss the preferred LOCATION of death prior to the death of the PATIENT

Notes:
DEATH LOCATION TYPE CODE (PREFERRED) is the same as attribute DEATH LOCATION TYPE CODE.

DEATH LOCATION TYPE CODE (PREFERRED) is the preferred LOCATION of death as specified by the PATIENT, Patient Proxy or Carer.

DEATH NOT AT PREFERRED LOCATION REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See DEATH NOT AT PREFERRED LOCATION REASON
Default Codes:	99 - Not Known why the PATIENT did not die at their preferred LOCATION of death

Notes:
DEATH NOT AT PREFERRED LOCATION REASON is the same as attribute DEATH NOT AT PREFERRED LOCATION REASON.

DIAGNOSIS DATE

Change to Data Element: Changed Dataset

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

Notes:
DIAGNOSIS DATE is the PERSON PROPERTY OBSERVED DATE for the PATIENT DIAGNOSIS.

DIAGNOSIS SCHEME IN USE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See DIAGNOSIS SCHEME IN USE
Default Codes:	

Notes:
DIAGNOSIS SCHEME IN USE is the same as attribute DIAGNOSIS SCHEME IN USE.

DISABILITY CODE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See DISABILITY CODE
Default Codes:	

Notes:
DISABILITY CODE is the same as attribute DISABILITY CODE.

DISABILITY IMPACT PERCEPTION

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See DISABILITY IMPACT PERCEPTION
Default Codes:	

Notes:
DISABILITY IMPACT PERCEPTION is the same as attribute DISABILITY IMPACT PERCEPTION.

DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)

Change to Data Element: Changed Dataset

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

Notes:
DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Discharge Letter Issued Date (Mental Health and Community Care)'*.

EARLIEST CLINICALLY APPROPRIATE DATE

Change to Data Element: Changed Dataset

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

Notes:
EARLIEST CLINICALLY APPROPRIATE DATE is the earliest date that it was clinically appropriate for an ACTIVITY to take place.

For the Radiotherapy Data Set, EARLIEST CLINICALLY APPROPRIATE DATE is the:

- first date that the PATIENT would have been clinically fit to start Radiotherapy and
- same as the DECISION TO TREAT DATE unless there was an elective delay, i.e. a clinical reason, such as the PATIENT was not fit.

For the Community Services Data Set, Mental Health Services Data Set and Commissioning Data Sets (version 6-2 onwards), the EARLIEST CLINICALLY APPROPRIATE DATE may be used locally to inform waiting time calculations. It can be used to account for periods of time where it is not appropriate to treat the PATIENT for clinical reasons, for example:

- where the PATIENT has been admitted to hospital for an unrelated condition and the SERVICE cannot commence planned treatment until the PATIENT has been discharged
- where the PATIENT is frail and cannot be treated until their condition improves, but it is not appropriate to discharge the PATIENT from the SERVICE.

EARLIEST REASONABLE OFFER DATE

Change to Data Element: Changed Dataset

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

Notes:
EARLIEST REASONABLE OFFER DATE is the date of the earliest of the Reasonable Offers made to a PATIENT for an APPOINTMENT or Elective Admission. It should only be included on the Commissioning Data Sets where the PATIENT has declined at least two Reasonable Offers, and a Patient Pause is to be applied to the length of wait calculation performed by the Secondary Uses Service.

- For an APPOINTMENT this is the earliest of the APPOINTMENT DATES OFFERED where the APPOINTMENT OFFER is a *'Reasonable Offer'*.
- For an OFFER OF ADMISSION this is the earliest of the OFFERED FOR ADMISSION DATES where the OFFER OF ADMISSION is a *'Reasonable Offer'*.

Patient Cancellations
Where, for any reason, a PATIENT cancels or does not attend an APPOINTMENT or an OFFER OF ADMISSION the EARLIEST REASONABLE OFFER DATE for the rearranged APPOINTMENT or

OFFER OF ADMISSION will be the EARLIEST REASONABLE OFFER DATE of the cancelled APPOINTMENT or OFFER OF ADMISSION.

Provider Cancellations
Where, for any reason, any Health Care Provider cancels and re-arranges an APPOINTMENT or an OFFER OF ADMISSION, the EARLIEST REASONABLE OFFER DATE for the re-arranged APPOINTMENT or OFFER OF ADMISSION will be the date of the earliest Reasonable Offer made following the cancellation.

Patients who are unavailable
Where a PATIENT makes themself unavailable for a longer period of time, for example a PATIENT who is a teacher who wishes to delay their admission until the summer holidays, making a Reasonable Offer may be inappropriate.

In these circumstances, so long as the Health Care Provider could have made at least two Reasonable Offers, the EARLIEST REASONABLE OFFER DATE will be the date of the earliest Reasonable Offer that the provider could have offered the PATIENT. This must be communicated to the PATIENT.

Use in Commissioning Data Set version 6-0 onwards for Referral To Treatment Consultant-Led Waiting Times:

If the Commissioning Data Set record:

- relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement

  and

- includes the REFERRAL TO TREATMENT PERIOD END DATE of the REFERRAL TO TREATMENT PERIOD

  and

- is of the following Commissioning Data Set Types:
  - CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode CDS
  - CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode CDS

then EARLIEST REASONABLE OFFER DATE must be populated in the Commissioning Data Set record if a Patient Pause (the PATIENT is paused on the ELECTIVE ADMISSION LIST because they have made themselves unavailable for treatment for a specified period (for non-clinical reasons)) is to be applied to a REFERRAL TO TREATMENT PERIOD by the Secondary Uses Service.

Failure to include EARLIEST REASONABLE OFFER DATE in the Admitted Patient Care General Episode Commissioning Data Set record carrying the REFERRAL TO TREATMENT PERIOD END DATE, will mean no Patient Pause is applied to the duration of wait calculation for the REFERRAL TO TREATMENT PERIOD performed by the Secondary Uses Service.

Use in the Community Services Data Set, Mental Health Services Data Set, Commissioning Data Sets (version 6-2 onwards) for Allied Health Professional Referral To Treatment:

For the Community Services Data Set, Mental Health Services Data Set and the Commissioning Data Sets (version 6-2 onwards) the EARLIEST REASONABLE OFFER DATE may be used locally to inform waiting time calculations for Allied Health Professional Referral To Treatment Measurement. It can be used to account for periods of time where the PATIENT has not accepted the first available APPOINTMENT OFFER and this has extended the Allied Health Professional Referral To Treatment Measurement waiting time, for example:

- where a PATIENT who is a child has been offered an APPOINTMENT but their parent/Carer states that they wish to wait until the school holidays commence. The SERVICE cannot commence planned treatment until the PATIENT is available.
- where the PATIENT works away and cannot attend for a period of time, but it is not appropriate to discharge the PATIENT from the SERVICE.

EDUCATIONAL ASSESSMENT OUTCOME

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See EDUCATIONAL ASSESSMENT OUTCOME
Default Codes:	

Notes:
EDUCATIONAL ASSESSMENT OUTCOME is the same as attribute EDUCATIONAL ASSESSMENT OUTCOME.

EMPLOYMENT STATUS

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See EMPLOYMENT STATUS
Default Codes:	

Notes:
EMPLOYMENT STATUS is the same as attribute EMPLOYMENT STATUS.

EMPLOYMENT STATUS RECORDED DATE

Change to Data Element: Changed Dataset

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

Notes:
EMPLOYMENT STATUS RECORDED DATE is the same as attribute PERSON PROPERTY RECORDED DATE.

EMPLOYMENT STATUS RECORDED DATE is the date when the EMPLOYMENT STATUS was recorded.

END DATE (GMP PATIENT REGISTRATION)

Change to Data Element: Changed Dataset

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

Notes:
END DATE (GMP PATIENT REGISTRATION) is the same as attribute PERSON PROPERTY EFFECTIVE END DATE.

END DATE (GMP PATIENT REGISTRATION) is the date on which the PERSON ceased to be registered with a General Medical Practitioner Practice.

ETHNIC CATEGORY

Change to Data Element: Changed Dataset

Format/Length:	an2
NWDS ID:	PETH
NWDS Field Name:	Ethnic Category
ESR Field Name:	Ethnic Origin
National Codes:	See ETHNIC CATEGORY CODE
Default Codes:	99 - Not known*

Notes:
ETHNIC CATEGORY is the same as attribute ETHNIC CATEGORY CODE.

The 16+1 ethnic data categories defined in the 2001 census is the national mandatory standard for the collection and analysis of ethnicity.

The national code must be transmitted as the first character in the 2 character field. The second character is optional for use locally. It must, however, be able to be grouped consistently with the 16 main categories.

National code Z should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to. Default code 99 should be used where the PERSON's ETHNIC CATEGORY is not known.

*For the Stop Smoking Services Quarterly Data Set default code 99 *'Not Known'* is **NOT** valid.

FINDING SCHEME IN USE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See FINDING SCHEME IN USE
Default Codes:	

Notes:
FINDING SCHEME IN USE is the same as attribute FINDING SCHEME IN USE.

GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)

Change to Data Element: Changed Dataset

Format/Length:	an6
National Codes:	
ODS Default Codes:	V81997 - No Registered GP Practice
	V81998 - GP Practice Code not applicable
	V81999 - GP Practice Code not known

Notes:
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION) is the same as attribute ORGANISATION CODE.

The data for GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION) is supplied by the NHS Prescription Services.

GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION) is the ORGANISATION CODE of the GP Practice that the PATIENT is registered with.

Use of Organisation Data Service Default Codes

- **V81997** should be used when a PATIENT presents, who is not currently registered at a GP Practice, *but is eligible to be registered should they wish to.*
- **V81998** should be used where a PATIENT should not have a registered GP Practice, due for instance to them having only recently entered the country.
- **V81999** should be used where it is not possible to determine a PATIENT's registered GP Practice code, but it is known that they should have one, or where it is impossible to determine whether they should or shouldn't have a registered practice (for instance the PATIENT cannot communicate and is unidentified).

GROUP SESSION DATE

Change to Data Element: Changed Dataset

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

Notes:
GROUP SESSION DATE is the same as attribute SESSION DATE of the Group Session.

GROUP SESSION IDENTIFIER

Change to Data Element: Changed Dataset

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
GROUP SESSION IDENTIFIER is the ACTIVITY IDENTIFIER for a Group Session.

GROUP SESSION TYPE (COMMUNITY CARE) renamed from GROUP SESSION TYPE CODE (COMMUNITY CARE)

Change to Data Element: Changed Dataset, Name

Format/Length:	an2
~~National Codes:~~	~~See GROUP SESSION TYPE CODE FOR COMMUNITY CARE~~
National Codes:	See GROUP SESSION TYPE FOR COMMUNITY CARE
Default Codes:	

Notes:
~~GROUP SESSION TYPE CODE (COMMUNITY CARE) is the same as attribute GROUP SESSION TYPE CODE FOR COMMUNITY CARE.~~GROUP SESSION TYPE (COMMUNITY CARE) is the same as attribute GROUP SESSION TYPE FOR COMMUNITY CARE.

GROUP SESSION TYPE (COMMUNITY CARE) renamed from GROUP SESSION TYPE CODE (COMMUNITY CARE)

Change to Data Element: Changed Dataset, Name

- null
- Changed Name from Data_Dictionary.Data_Field_Notes.G.Gr.GROUP_SESSION_TYPE_CODE_(COMMUNITY_CARE) to Data_Dictionary.Data_Field_Notes.G.Gr.GROUP_SESSION_TYPE_(COMMUNITY_CARE)

GROUP THERAPY INDICATOR

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See GROUP THERAPY INDICATOR
Default Codes:	Z - Not Known if the ACTIVITY was Group Therapy

Notes:
GROUP THERAPY INDICATOR is the same as attribute GROUP THERAPY INDICATOR.

HEALTH VISITOR FIRST ANTENATAL VISIT DATE

Change to Data Element: Changed Dataset, Description

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

Notes:
HEALTH VISITOR FIRST ANTENATAL VISIT DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Care Contact Date*'.

~~HEALTH VISITOR FIRST ANTENATAL VISIT DATE is the date of the first antenatal CARE CONTACT between the Health Visitor and the pregnant woman.~~HEALTH VISITOR FIRST ANTENATAL VISIT DATE is the date of the first antenatal CARE CONTACT between the Health Visitor and the pregnant PERSON.

IMMUNISATION DATE

Change to Data Element: Changed Dataset

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

Notes:
IMMUNISATION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Clinical Intervention Date'*.

IMMUNISATION DATE is the date on which the immunisation was carried out.

IMMUNISATION PROCEDURE (CLINICAL TERMINOLOGY)

Change to Data Element: Changed Dataset

Format/Length:	min an5 max an18
National Codes:	
Default Codes:	

Notes:
IMMUNISATION PROCEDURE (CLINICAL TERMINOLOGY) is the same as attribute CLINICAL TERMINOLOGY CODE.

IMMUNISATION PROCEDURE (CLINICAL TERMINOLOGY) is the CLINICAL TERMINOLOGY CODE which is used to identify an immunisation.

INFANT PHYSICAL EXAMINATION DATE

Change to Data Element: Changed Dataset

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

Notes:
INFANT PHYSICAL EXAMINATION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Clinical Intervention Date'*.

INFANT PHYSICAL EXAMINATION DATE is the date of the Infant Physical Examination.

INFANT PHYSICAL EXAMINATION RESULT (EYES)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See INVESTIGATION EXAMINATION RESULT
Default Codes:	

Notes:
INFANT PHYSICAL EXAMINATION RESULT (EYES) is the same as attribute INVESTIGATION EXAMINATION RESULT where the Clinical Investigation is the Infant Physical Examination of the eyes.

INFANT PHYSICAL EXAMINATION RESULT (HEART)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See INVESTIGATION EXAMINATION RESULT
Default Codes:	

Notes:
INFANT PHYSICAL EXAMINATION RESULT (HEART) is the same as attribute INVESTIGATION EXAMINATION RESULT where the Clinical Investigation is the Infant Physical Examination of the heart.

INFANT PHYSICAL EXAMINATION RESULT (HIPS)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See INVESTIGATION EXAMINATION RESULT
Default Codes:	

Notes:

INFANT PHYSICAL EXAMINATION RESULT (HIPS) is the same as attribute INVESTIGATION EXAMINATION RESULT where the Clinical Investigation is the Infant Physical Examination of the hips.

INFANT PHYSICAL EXAMINATION RESULT (TESTES)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See INVESTIGATION EXAMINATION RESULT
Default Codes:	

Notes:
INFANT PHYSICAL EXAMINATION RESULT (TESTES) is the same as attribute INVESTIGATION EXAMINATION RESULT where the Clinical Investigation is the Infant Physical Examination of the testes.

LANGUAGE CODE (PREFERRED)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See LANGUAGE CODE
Default Codes:	

Notes:
LANGUAGE CODE (PREFERRED) is the same as the attribute LANGUAGE CODE.

LANGUAGE CODE (PREFERRED) is the language the PATIENT, Patient Proxy or Carer prefers to use for communication with a Health Care Provider.

LOCAL PATIENT IDENTIFIER (EXTENDED)

Change to Data Element: Changed Dataset

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
LOCAL PATIENT IDENTIFIER (EXTENDED) is the same as attribute LOCAL PATIENT IDENTIFIER.

LOCAL PATIENT IDENTIFIER (EXTENDED) is used where IT systems have a LOCAL PATIENT IDENTIFIER which is longer than 10 characters and LOCAL PATIENT IDENTIFIER cannot be used for data submission.

LOOKED AFTER CHILD INDICATOR

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See LOOKED AFTER CHILD INDICATOR
Default Codes:	X - Not known if the PERSON is a Looked After Child

Notes:
LOOKED AFTER CHILD INDICATOR is the same as attribute LOOKED AFTER CHILD INDICATOR.

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (CONGENITAL HYPOTHYROIDISM)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:
NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (CONGENITAL HYPOTHYROIDISM) is the same as attribute NEWBORN BLOOD SPOT TEST OUTCOME STATUS.

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (CONGENITAL HYPOTHYROIDISM) is the result of screening for Congenital Hypothyroidism (CHT).

Permitted National Codes:

01	Specimen received in Laboratory
02	Screening declined
03	Repeat/Further Sample Required
04	Condition not suspected
07	Condition not suspected, other disorders follow up
08	Condition suspected
09	Not screened/screening incomplete

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (CYSTIC FIBROSIS)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:
NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (CYSTIC FIBROSIS) is the same as attribute NEWBORN BLOOD SPOT TEST OUTCOME STATUS.

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (CYSTIC FIBROSIS) is the result of screening for Cystic Fibrosis (CF).

Permitted National Codes:

01 Specimen received in Laboratory
02 Screening declined
03 Repeat/Further Sample Required
04 Condition not suspected
05 Carrier
07 Condition not suspected, other disorders follow up
08 Condition suspected
09 Not screened/screening incomplete

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (GLUTARIC ACIDURIA TYPE 1)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:
NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (GLUTARIC ACIDURIA TYPE 1) is the same as attribute NEWBORN BLOOD SPOT TEST OUTCOME STATUS.

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (GLUTARIC ACIDURIA TYPE 1) is the result of screening for Glutarid Aciduria Type (GA1).

Permitted National Codes:

01 Specimen received in Laboratory
02 Screening declined
03 Repeat/Further Sample Required
04 Condition not suspected
07 Condition not suspected, other disorders follow up
08 Condition suspected
09 Not screened/screening incomplete

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (HOMOCYSTINURIA)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:
NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (HOMOCYSTINURIA) is the same as attribute NEWBORN BLOOD SPOT TEST OUTCOME STATUS.

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (HOMOCYSTINURIA) is the result of screening for Homocystinuria (HCU).

Permitted National Codes:

01	Specimen received in Laboratory
02	Screening declined
03	Repeat/Further Sample Required
04	Condition not suspected
07	Condition not suspected, other disorders follow up
08	Condition suspected
09	Not screened/screening incomplete

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (ISOVALERIC ACIDURIA)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:
NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (ISOVALERIC ACIDURIA) is the same as attribute NEWBORN BLOOD SPOT TEST OUTCOME STATUS.

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (ISOVALERIC ACIDURIA) is the result of screening for Isovaleric Aciduria (IVA).

Permitted National Codes:

01	Specimen received in Laboratory
02	Screening declined
03	Repeat/Further Sample Required
04	Condition not suspected
07	Condition not suspected, other disorders follow up
08	Condition suspected
09	Not screened/screening incomplete

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (MAPLE SYRUP URINE DISEASE)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:
NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (MAPLE SYRUP URINE DISEASE) is the same as attribute NEWBORN BLOOD SPOT TEST OUTCOME STATUS.

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (MAPLE SYRUP URINE DISEASE) is the result of screening for Maple Syrup Urine Disease (MSUD).

Permitted National Codes:

01	Specimen received in Laboratory
02	Screening declined
03	Repeat/Further Sample Required
04	Condition not suspected
07	Condition not suspected, other disorders follow up
08	Condition suspected
09	Not screened/screening incomplete

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (MEDIUM CHAIN ACYL-COA DEHYDROGENASE DEFICIENCY)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:
NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (MEDIUM CHAIN ACYL-COA DEHYDROGENASE DEFICIENCY) is the same as attribute NEWBORN BLOOD SPOT TEST OUTCOME STATUS.

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (MEDIUM CHAIN ACYL-COA DEHYDROGENASE DEFICIENCY) is the result of screening for Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCADD).

Permitted National Codes:

01	Specimen received in Laboratory
02	Screening declined
03	Repeat/Further Sample Required
04	Condition not suspected
05	Carrier
07	Condition not suspected, other disorders follow up
08	Condition suspected
09	Not screened/screening incomplete

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (PHENYLKETONURIA)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:
NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (PHENYLKETONURIA) is the same as attribute NEWBORN BLOOD SPOT TEST OUTCOME STATUS.

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (PHENYLKETONURIA) is the result of screening for Phenylketonuria (PKU).

Permitted National Codes:

01	Specimen received in Laboratory
02	Screening declined
03	Repeat/Further Sample Required
04	Condition not suspected
07	Condition not suspected, other disorders follow up
08	Condition suspected
09	Not screened/screening incomplete

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (SICKLE CELL DISEASE)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See NEWBORN BLOOD SPOT TEST OUTCOME STATUS
Default Codes:	

Notes:
NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (SICKLE CELL DISEASE) is the same as attribute NEWBORN BLOOD SPOT TEST OUTCOME STATUS.

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (SICKLE CELL DISEASE) is the result of screening for Sickle Cell Disease (SCD).

NEWBORN BLOOD SPOT TEST RESULT RECEIVED DATE

Change to Data Element: Changed Dataset

Format/Length:	an10 CCYY-MM-DD

National Codes:	
Default Codes:	

Notes:
NEWBORN BLOOD SPOT TEST RESULT RECEIVED DATE is the same as attribute CLINICAL INVESTIGATION RESULT RECEIVED DATE.

NEWBORN BLOOD SPOT TEST RESULT RECEIVED DATE is the date the Newborn Blood Spot Test result was received from the Laboratory by the Health Care Provider.

NEWBORN HEARING AUDIOLOGY OUTCOME

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See NEWBORN HEARING AUDIOLOGY OUTCOME
Default Codes:	

Notes:
NEWBORN HEARING AUDIOLOGY OUTCOME is the same as attribute NEWBORN HEARING AUDIOLOGY OUTCOME.

NEWBORN HEARING SCREENING OUTCOME

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See NEWBORN HEARING SCREENING OUTCOME
Default Codes:	

Notes:
NEWBORN HEARING SCREENING OUTCOME is the same as attribute NEWBORN HEARING SCREENING OUTCOME.

NHS NUMBER

Change to Data Element: Changed Dataset

Format/Length:	n10
National Codes:	
Default Codes:	

Notes:
NHS NUMBER is the same as attribute NHS NUMBER.

For the AIDC for Patient Identification Data Set, NHS NUMBER must be displayed in accordance with the NHS Common User Interface Information Standard - NHS Number Input and Display (ISB 1504).

NHS NUMBER (MOTHER)

Change to Data Element: Changed Dataset

Format/Length:	n10
National Codes:	
Default Codes:	

Notes:
NHS NUMBER (MOTHER) is the same as attribute NHS NUMBER for the mother.

NHS NUMBER STATUS INDICATOR CODE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See NHS NUMBER STATUS INDICATOR CODE
Default Codes:	

Notes:
NHS NUMBER STATUS INDICATOR CODE is the same as attribute NHS NUMBER STATUS INDICATOR CODE.

NHS NUMBER STATUS INDICATOR CODE (MOTHER)

Change to Data Element: Changed Dataset

Format/Length:	See NHS NUMBER STATUS INDICATOR CODE
National Codes:	See NHS NUMBER STATUS INDICATOR CODE
Default Codes:	

Notes:
NHS NUMBER STATUS INDICATOR CODE (MOTHER) is the same as attribute NHS NUMBER STATUS INDICATOR CODE of the NHS NUMBER (MOTHER).

NHS SERVICE AGREEMENT LINE NUMBER

Change to Data Element: Changed Dataset

Format/Length:	an10
National Codes:	
Default Codes:	

Notes:
NHS SERVICE AGREEMENT LINE NUMBER is the same as attribute NHS SERVICE AGREEMENT LINE NUMBER.

The NHS SERVICE AGREEMENT LINE NUMBERS may be used to identify a specific NHS SERVICE AGREEMENT reference where the main identifier refers to a general omnibus agreement.

NUMBER OF GROUP SESSION PARTICIPANTS

Change to Data Element: Changed Dataset

Format/Length:	max n3
National Codes:	
Default Codes:	

Notes:
NUMBER OF GROUP SESSION PARTICIPANTS is the number of PERSON's who participate in a Group Session (excluding the CARE PROFESSIONALS responsible for the Group Session).

OBSERVATION SCHEME IN USE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See OBSERVATION SCHEME IN USE
Default Codes:	

Notes:
OBSERVATION SCHEME IN USE is the same as attribute OBSERVATION SCHEME IN USE.

OBSERVATION VALUE

Change to Data Element: Changed Dataset

Format/Length:	max an10
National Codes:	
Default Codes:	

Notes:
OBSERVATION VALUE is the same as attribute OBSERVATION VALUE.

OCCUPATION CODE

Change to Data Element: Changed Dataset

Format/Length:	an3
NWDS ID:	GROC
NWDS Field Name:	Occupation Code
National Codes:	
Default Codes:	

Notes:
OCCUPATION CODE is the same as attribute NHS OCCUPATION CODE.

ONWARD REFERRAL DATE

Change to Data Element: Changed Dataset

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

Default Codes:

Notes:
ONWARD REFERRAL DATE is the same as attribute ACTIVITY SERVICE REQUEST DATE.

ONWARD REFERRAL DATE is the date the PATIENT was referred from one SERVICE to another SERVICE, which may be in the same or a different Organisation.

ONWARD REFERRAL REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See ONWARD REFERRAL REASON
Default Codes:	98 - Onward Referral Reason Not Applicable
	99 - Not Known (Not Recorded)

Notes:
ONWARD REFERRAL REASON is the same as attribute ONWARD REFERRAL REASON.

ORGANISATION CODE (CODE OF COMMISSIONER)

Change to Data Element: Changed Dataset

Format/Length:	an3 or an5
National Codes:	
ODS Default Codes:	VPP00 - Private PATIENTS / Overseas Visitor liable for charge
	XMD00 - Commissioner Code for Ministry of Defence (MoD) Healthcare
	YDD82 - Episodes funded directly by the National Commissioning Group for England (Retired September 2018)

Notes:
ORGANISATION CODE (CODE OF COMMISSIONER) is the same as attribute ORGANISATION CODE.

ORGANISATION CODE (CODE OF COMMISSIONER) is the ORGANISATION CODE of the Organisation commissioning health care.

For Commissioning Data Sets, the ORGANISATION CODE (CODE OF COMMISSIONER) should always be the ORGANISATION CODE of the original commissioner to support the National Tariff Payment System.

The NHS England document "Who pays? Determining responsibility for payments to providers" sets out a framework for establishing responsibility for commissioning an individual's care within the NHS, (i.e. determining who pays for a PATIENT's care.)

The document includes information on the following:

- General Rules
- Applying the rules to Clinical Commissioning Group and NHS England commissioned services
- Exceptions to the general rules
- Examples to help clarify the boundaries of responsibility between commissioning Organisations.

For further information on this document contact NHS England at "Contact us".

Where NHS England is the responsible commissioner for a specialised SERVICE, based on the NHS England Commissioner Assignment Method (CAM), one of the Specialised Commissioning Hub ORGANISATION CODES should be used depending on which Health Care Provider delivered the SERVICE, e.g. NHS Trust, Independent Sector Healthcare Provider.

The NHS Digital website provides a mapping list of which Health Care Providers map to which Specialised Commissioning Hub. The mapping can be found on the Organisation Data Service web pages at: Provider to Commissioning Hub Mapping.

ORGANISATION CODE (CODE OF COMMISSIONER) will be replaced with ORGANISATION IDENTIFIER (CODE OF COMMISSIONER), when it has been approved for use in national information standards.

ORGANISATION CODE (CODE OF PROVIDER)

Change to Data Element: Changed Dataset

Format/Length:	an3, an5 or an6
National Codes:	
ODS Default Codes:	89997 - Non-UK provider where no ORGANISATION CODE has been issued 89999 - Non-NHS UK provider where no ORGANISATION CODE has been issued

Notes:
ORGANISATION CODE (CODE OF PROVIDER) is the same as the attribute ORGANISATION CODE.

ORGANISATION CODE (CODE OF PROVIDER) is the ORGANISATION CODE of the Organisation acting as a Health Care Provider.

For Commissioning Data Sets, the ORGANISATION CODE (CODE OF PROVIDER) should always be the ORGANISATION CODE of the Health Care Provider receiving the National Tariff Payment System income.

ORGANISATION CODE (CODE OF PROVIDER) is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

ORGANISATION CODE (CODE OF PROVIDER) will be replaced with ORGANISATION IDENTIFIER (CODE OF PROVIDER), when it has been approved for use in national information standards.

ORGANISATION CODE (CODE OF SUBMITTING ORGANISATION)

Change to Data Element: Changed Dataset

Format/Length:	max an6
National Codes:	
Default Codes:	

Notes:
ORGANISATION CODE (CODE OF SUBMITTING ORGANISATION) is the same as attribute ORGANISATION CODE.

ORGANISATION CODE (CODE OF SUBMITTING ORGANISATION) is the ORGANISATION CODE of the Organisation acting as the physical sender of a Data Set submission.

ORGANISATION CODE (CODE OF SUBMITTING ORGANISATION) will be replaced with ORGANISATION IDENTIFIER (CODE OF SUBMITTING ORGANISATION), when it has been approved for use in national information standards.

ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT) (RETIRED) renamed from ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)

Change to Data Element: Changed status to Retired, Dataset, Description, Name, linked Attribute

~~Format/Length:~~	~~min an5 max an8~~
~~National Codes:~~	
~~Default Codes:~~	

~~**Notes:**~~
~~ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT) is the same as attribute ORGANISATION CODE.~~

~~ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT) is the ORGANISATION CODE of the Educational Establishment, including Schools.~~**This item has been retired from the NHS Data Model and Dictionary.**

~~**ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT) will be replaced with ORGANISATION IDENTIFIER (EDUCATIONAL ESTABLISHMENT), when it has been approved for use in national information standards.**~~**The last live version of this item is available in the ?**????? release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT) (RETIRED)_ renamed from ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)

Change to Data Element: Changed status to Retired, Dataset, Description, Name, linked Attribute

~~ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)~~

~~**Attribute:**~~

~~ORGANISATION CODE~~

ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT) (RETIRED)_ renamed from ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)

Change to Data Element: Changed status to Retired, Dataset, Description, Name, linked Attribute

- Retired ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)
- null
- Changed Description
- Changed Name from Data_Dictionary.Data_Field_Notes.O.Org.ORGANISATION_CODE_ (EDUCATIONAL_ESTABLISHMENT) to Retired.Data_Dictionary.Data_Field_Notes.O.ORGANISATION_CODE_ (EDUCATIONAL_ESTABLISHMENT)
- null

ORGANISATION CODE (GP PRACTICE RESPONSIBILITY) (RETIRED)_ renamed from ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)

Change to Data Element: Changed status to Retired, Dataset, Description, Name, linked Attribute

~~Format/Length:~~	~~an3~~
~~National Codes:~~	
~~ODS Default Codes:~~	~~Q99 - High Level Health Geography/Primary Care Organisation of Residence Not Known~~ ~~X98 - Primary Care Organisation Not Applicable (Overseas Visitors)~~

~~**Notes:**~~

~~ORGANISATION CODE (GP PRACTICE RESPONSIBILITY) is the same as attribute ORGANISATION CODE.~~

~~ORGANISATION CODE (GP PRACTICE RESPONSIBILITY) is the ORGANISATION CODE of the Organisation responsible for the GP Practice where the PATIENT is registered, irrespective of whether~~

~~they reside within the boundary of the Clinical Commissioning Group.~~**This item has been retired from the NHS Data Model and Dictionary.**

~~**ORGANISATION CODE (GP PRACTICE RESPONSIBILITY) will be replaced with ORGANISATION IDENTIFIER (GP PRACTICE RESPONSIBILITY), when it has been approved for use in national information standards.**~~**The last live version of this item is available in the ?**????? release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ORGANISATION CODE (GP PRACTICE RESPONSIBILITY) (RETIRED)_ renamed from ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)

Change to Data Element: Changed status to Retired, Dataset, Description, Name, linked Attribute

~~ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)~~

~~**Attribute:**~~

~~ORGANISATION CODE~~

ORGANISATION CODE (GP PRACTICE RESPONSIBILITY) (RETIRED)_ renamed from ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)

Change to Data Element: Changed status to Retired, Dataset, Description, Name, linked Attribute

- Retired ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)
- null
- Changed Description
- Changed Name from Data_Dictionary.Data_Field_Notes.O.Org.ORGANISATION_CODE_(GP_PRACTICE_RESPONSIBILITY) to Retired.Data_Dictionary.Data_Field_Notes.O.ORGANISATION_CODE_(GP_PRACTICE_RESPONSIBILITY)
- null

ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION) (RETIRED)_ renamed from ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION)

Change to Data Element: Changed status to Retired, Dataset, Description, Name, linked Attribute

~~Format/Length:~~	~~max an6~~
~~National Codes:~~	
~~Default Codes:~~	

~~**Notes:**~~

~~ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION)~~ ~~is the same as attribute~~ ~~ORGANISATION CODE~~.

~~ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION)~~ ~~is the~~ ~~ORGANISATION CODE~~ ~~of the~~ ~~Organisation~~ ~~carrying out the immunisation.~~**This item has been retired from the NHS Data Model and Dictionary.**

~~ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION)~~ **~~will be replaced with~~** **~~ORGANISATION IDENTIFIER (IMMUNISATION RESPONSIBLE ORGANISATION)~~**, **~~when it has been approved for use in national information standards.~~****The last live version of this item is available in the ?**????? release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION) (RETIRED) renamed from ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION)

Change to Data Element: Changed status to Retired, Dataset, Description, Name, linked Attribute

~~ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION)~~

~~**Attribute:**~~

~~ORGANISATION CODE~~

ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION) (RETIRED) renamed from ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION)

Change to Data Element: Changed status to Retired, Dataset, Description, Name, linked Attribute

- Retired ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION)
- null
- Changed Description
- Changed Name from Data_Dictionary.Data_Field_Notes.O.Org.ORGANISATION_CODE_ (IMMUNISATION_RESPONSIBLE_ORGANISATION) to Retired.Data_Dictionary.Data_Field_Notes.O.ORGANISATION_CODE_ (IMMUNISATION_RESPONSIBLE_ORGANISATION)
- null

ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)

Change to Data Element: Changed Dataset

Format/Length:	an3 or an5
National Codes:	
Default Codes:	

Notes:
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER) is the same as attribute ORGANISATION CODE.

ORGANISATION CODE (LOCAL PATIENT IDENTIFIER) is the ORGANISATION CODE of the Organisation that assigned the LOCAL PATIENT IDENTIFIER.

ORGANISATION CODE (LOCAL PATIENT IDENTIFIER) will be replaced with ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER), when it has been approved for use in national information standards.

ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)

Change to Data Element: Changed Dataset

Format/Length:	max an5
National Codes:	
Default Codes:	

Notes:
ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) is the same as attribute ORGANISATION CODE.

ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) is the ORGANISATION CODE of the Organisation issuing the PATIENT PATHWAY IDENTIFIER.

Where Choose and Book has been used, the ORGANISATION CODE 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

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), when it has been approved for use in national information standards.

ORGANISATION CODE (RECEIVING)

Change to Data Element: Changed Dataset

Format/Length:	an3 or an5
National Codes:	
Default Codes:	ZZ201 - Not applicable (not discharged to another Organisation) *

Notes:
ORGANISATION CODE (RECEIVING) is the same as the attribute ORGANISATION CODE.

ORGANISATION CODE (RECEIVING) is the ORGANISATION CODE of the Organisation that is receiving the PATIENT from another Health Care Provider.

For the National Neonatal Data Set - Episodic and Daily Care, this is the ORGANISATION CODE of the Organisation where a baby is transferred to on discharge from the neonatal critical care.

* Note: default code ZZ201 is ONLY valid for the National Neonatal Data Set - Episodic and Daily Care.

ORGANISATION CODE (RECEIVING) will be replaced with ORGANISATION IDENTIFIER (RECEIVING), when it has been approved for use in national information standards.

ORGANISATION CODE (RESIDENCE RESPONSIBILITY)

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	
ODS Default Codes:	Q99 - High Level Health Geography/Primary Care Organisation of Residence Not Known Note: This code must not be used in the Commissioning Data Set header. It is not a default commissioner code. X98 - Primary Care Organisation Not Applicable (Overseas Visitors) Note: this code must not be used in the Commissioning Data Set (CDS) header. It is not a default Commissioner code.

Notes:
ORGANISATION CODE (RESIDENCE RESPONSIBILITY) is the same as attribute ORGANISATION CODE.

ORGANISATION CODE (RESIDENCE RESPONSIBILITY) is the ORGANISATION CODE derived from the PATIENT's POSTCODE OF USUAL ADDRESS, where they reside within the boundary of a:

- Clinical Commissioning Group
- Care Trust
- Local Health Board (Wales)
- Scottish Health Board
- Northern Ireland Local Commissioning Group: *Guidance on the use of Northern Ireland codes can be found in Data Set Change Notice 19/2009*
- Primary Healthcare Directorate (Isle of Man)
- Local Authority.

ORGANISATION CODES can be downloaded from Technology Reference Data Update Distribution (TRUD). For further information, see Organisation Data Service.

For PATIENTS who are Overseas Visitors: Organisation Data Service Default Code X98 '*Primary Care Organisation Not Applicable (Overseas Visitors)*' should be reported.
Note: A review of Organisation Data Service Default Codes is planned to be carried out and this default code will be updated as part of that.

For the purposes of sending Commissioning Data Set messages to the Secondary Uses Service (regardless of how local systems hold the data), it is essential at present to continue using a 3 character field, using the first 3 characters of the ORGANISATION CODE (RESIDENCE RESPONSIBILITY) and following the same update rules relating to Prime Recipient as are currently in place. This is necessary, primarily to preserve the integrity of the current Commissioning Data Set message and the CDS PRIME RECIPIENT IDENTITY which is derived from the ORGANISATION CODE (RESIDENCE RESPONSIBILITY).

The Organisation Data Service provides postcode files which link postcodes to the Clinical Commissioning Group. See NHS Postcode Directory.

ORGANISATION CODE (RESIDENCE RESPONSIBILITY) will be replaced with ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY), when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)

Change to Data Element: Changed Dataset

Format/Length:	min an3 max an5
National Codes:	
ODS Default Codes:	VPP00 - Private PATIENTS / Overseas Visitor liable for charge XMD00 - Commissioner Code for Ministry of Defence (MoD) Healthcare YDD82 - Episodes funded directly by the National Commissioning Group for England (Retired September 2018)

Notes:

ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) is the same as attribute ORGANISATION IDENTIFIER.

ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) is the ORGANISATION IDENTIFIER of the Organisation commissioning health care.

For Commissioning Data Sets, the ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) should always be the ORGANISATION IDENTIFIER of the original commissioner to support the National Tariff Payment System.

The NHS England document "Who pays? Determining responsibility for payments to providers" sets out a framework for establishing responsibility for commissioning an individual's care within the NHS, (i.e. determining who pays for a PATIENT's care.)

The document includes information on the following:

- General Rules
- Applying the rules to Clinical Commissioning Group and NHS England commissioned services
- Exceptions to the general rules
- Examples to help clarify the boundaries of responsibility between commissioning Organisations.

For further information on this document contact NHS England at "Contact us".

Where NHS England is the responsible commissioner for a specialised SERVICE, based on the NHS England Commissioner Assignment Method (CAM), one of the Specialised Commissioning Hub ORGANISATION IDENTIFIERS should be used depending on which Health Care Provider delivered the SERVICE, e.g. NHS Trust, Independent Sector Healthcare Provider.

The NHS Digital website provides a mapping list of which Health Care Providers map to which Specialised Commissioning Hub. The mapping can be found on the Organisation Data Service web pages at: Provider to Commissioning Hub Mapping.

ORGANISATION CODE (CODE OF COMMISSIONER) will be replaced with ORGANISATION IDENTIFIER (CODE OF COMMISSIONER), when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (CODE OF PROVIDER)

Change to Data Element: Changed Dataset

Format/Length:	min an3 max an6
National Codes:	
ODS Default Codes:	89997 - Non-UK provider where no ORGANISATION IDENTIFIER has been issued 89999 - Non-NHS UK provider where no ORGANISATION IDENTIFIER has been issued

Notes:
ORGANISATION IDENTIFIER (CODE OF PROVIDER) is the same as the attribute ORGANISATION IDENTIFIER.

ORGANISATION IDENTIFIER (CODE OF PROVIDER) is the ORGANISATION IDENTIFIER of the Organisation acting as a Health Care Provider.

For Commissioning Data Sets, the ORGANISATION IDENTIFIER (CODE OF PROVIDER)) should always be the ORGANISATION IDENTIFIER of the Health Care Provider receiving the National Tariff Payment System income.

ORGANISATION CODE (CODE OF PROVIDER) is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

ORGANISATION CODE (CODE OF PROVIDER) will be replaced with ORGANISATION IDENTIFIER (CODE OF PROVIDER), when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (CODE OF SUBMITTING ORGANISATION)

Change to Data Element: Changed Dataset

Format/Length:	min an3 max an6
National Codes:	
Default Codes:	

Notes:
ORGANISATION IDENTIFIER (CODE OF SUBMITTING ORGANISATION) is the same as attribute ORGANISATION IDENTIFIER.

ORGANISATION IDENTIFIER (CODE OF SUBMITTING ORGANISATION) is the ORGANISATION IDENTIFIER of the Organisation acting as the physical sender of a Data Set submission.

ORGANISATION CODE (CODE OF SUBMITTING ORGANISATION) will be replaced with ORGANISATION IDENTIFIER (CODE OF SUBMITTING ORGANISATION), when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (EDUCATIONAL ESTABLISHMENT)

Change to Data Element: Changed Dataset, Description

Format/Length:	min an5 max an8

National Codes:	
Default Codes:	

Notes:
ORGANISATION IDENTIFIER (EDUCATIONAL ESTABLISHMENT) is the same as attribute ORGANISATION IDENTIFIER.

ORGANISATION IDENTIFIER (EDUCATIONAL ESTABLISHMENT) is the ORGANISATION IDENTIFIER of the Educational Establishment, including Schools.

~~**ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT) will be replaced with ORGANISATION IDENTIFIER (EDUCATIONAL ESTABLISHMENT), when it has been approved for use in national information standards.**~~

ORGANISATION IDENTIFIER (GP PRACTICE RESPONSIBILITY)

Change to Data Element: Changed Dataset, Description

Format/Length:	min an3 max an5
National Codes:	
ODS Default Codes:	Q99 - High Level Health Geography/Primary Care Organisation of Residence Not Known X98 - Primary Care Organisation Not Applicable (Overseas Visitors)

Notes:
ORGANISATION IDENTIFIER (GP PRACTICE RESPONSIBILITY) is the same as attribute ORGANISATION IDENTIFIER.

ORGANISATION IDENTIFIER (GP PRACTICE RESPONSIBILITY) is the ORGANISATION IDENTIFIER of the Organisation responsible for the GP Practice where the PATIENT is registered, irrespective of whether they reside within the boundary of the Clinical Commissioning Group.

~~**ORGANISATION CODE (GP PRACTICE RESPONSIBILITY) will be replaced with ORGANISATION IDENTIFIER (GP PRACTICE RESPONSIBILITY), when it has been approved for use in national information standards.**~~

ORGANISATION IDENTIFIER (IMMUNISATION RESPONSIBLE ORGANISATION)

Change to Data Element: Changed Dataset, Description

Format/Length:	min an3 max an6
National Codes:	

Default Codes:

Notes:
ORGANISATION IDENTIFIER (IMMUNISATION RESPONSIBLE ORGANISATION) is the same as attribute ORGANISATION IDENTIFIER.

ORGANISATION IDENTIFIER (IMMUNISATION RESPONSIBLE ORGANISATION) is the ORGANISATION IDENTIFIER of the Organisation carrying out the immunisation.

~~**ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION) will be replaced with ORGANISATION IDENTIFIER (IMMUNISATION RESPONSIBLE ORGANISATION), when it has been approved for use in national information standards.**~~

ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)

Change to Data Element: Changed Dataset

Format/Length:	min an3 max an5
National Codes:	
Default Codes:	

Notes:
ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) is the same as attribute ORGANISATION IDENTIFIER.

ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) is the ORGANISATION IDENTIFIER of the Organisation that assigned the LOCAL PATIENT IDENTIFIER.

ORGANISATION CODE (LOCAL PATIENT IDENTIFIER) will be replaced with ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER), when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)

Change to Data Element: Changed Dataset

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

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), when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (RECEIVING)

Change to Data Element: Changed Dataset

Format/Length:	min an3 max an5
National Codes:	
Default Codes:	

Notes:
ORGANISATION IDENTIFIER (RECEIVING) is the same as the attribute ORGANISATION IDENTIFIER.

ORGANISATION IDENTIFIER (RECEIVING) is the ORGANISATION IDENTIFIER of the Organisation that is receiving the PATIENT from another Health Care Provider.

ORGANISATION CODE (RECEIVING) will be replaced with ORGANISATION IDENTIFIER (RECEIVING), when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (REFERRING)

Change to Data Element: Changed Dataset

Format/Length:	min an3 max an6
National Codes:	
ODS Default Codes:	X99998 - Referring ORGANISATION IDENTIFIER not applicable X99999 - Referring ORGANISATION IDENTIFIER not known

Notes:
ORGANISATION IDENTIFIER (REFERRING) is the same as attribute ORGANISATION IDENTIFIER.

ORGANISATION IDENTIFIER (REFERRING) is the ORGANISATION IDENTIFIER of the Organisation from which the referral is made, such as a GP Practice, NHS Trust or NHS Foundation Trust.

This information is essential for managing service agreements which are based on patterns of referral.

REFERRING ORGANISATION CODE will be replaced with ORGANISATION IDENTIFIER (REFERRING), when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)

Change to Data Element: Changed Dataset

Format/Length:	min an3 max an5
National Codes:	
ODS Default Codes:	Q99 - High Level Health Geography/Primary Care Organisation of Residence Not Known Note: This code must not be used in the Commissioning Data Set header. It is not a default commissioner code. X98 - Primary Care Organisation Not Applicable (Overseas Visitors) Note: this code must not be used in the Commissioning Data Set (CDS) header. It is not a default Commissioner code.

Notes:
ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) is the same as attribute ORGANISATION IDENTIFIER.

ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) is the ORGANISATION IDENTIFIER derived from the PATIENT's POSTCODE OF USUAL ADDRESS, where they reside within the boundary of a:

- Clinical Commissioning Group

- Care Trust
- Local Health Board (Wales)
- Scottish Health Board
- Northern Ireland Local Commissioning Group: *Guidance on the use of Northern Ireland codes can be found in Data Set Change Notice 19/2009*
- Primary Healthcare Directorate (Isle of Man)
- Local Authority.

For PATIENTS who are Overseas Visitors: Organisation Data Service Default Code X98 '*Primary Care Organisation Not Applicable (Overseas Visitors)*' should be reported.
Note: A review of Organisation Data Service Default Codes is planned to be carried out and this default code will be updated as part of that.

For the purposes of sending Commissioning Data Set messages to the Secondary Uses Service (regardless of how local systems hold the data), it is essential at present to continue using a 3 character field, using the first 3 characters of the ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) and following the same update rules relating to Prime Recipient as are currently in place. This is necessary, primarily to preserve the integrity of the current Commissioning Data Set message and the CDS PRIME RECIPIENT IDENTITY which is derived from the ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY).

ORGANISATION CODE (RESIDENCE RESPONSIBILITY) will be replaced with ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY),when it has been approved for use in national information standards.

ORGANISATION SITE IDENTIFIER (OF TREATMENT)

Change to Data Element: Changed Dataset

Format/Length:	min an5 max an9
National Codes:	
ODS Default Codes:	R9998 - Not a hospital site 89999 - Non-NHS UK Provider where no ORGANISATION IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION IDENTIFIER has been issued

Notes:
ORGANISATION SITE IDENTIFIER (OF TREATMENT) is the same as attribute ORGANISATION IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF TREATMENT) is the ORGANISATION IDENTIFIER of the Organisation Site where the PATIENT was treated, i.e. it should enable the treating Organisation to be identified.

ORGANISATION SITE IDENTIFIER (OF TREATMENT) identifies the Organisation Site within the Organisation on which the PATIENT was treated, since facilities may vary on different hospital sites.

The code recorded should always be the national code; if the treatment is sub-commissioned to another NHS Health Care Provider or an independent UK provider, the ORGANISATION SITE IDENTIFIER (OF TREATMENT) used should be the ORGANISATION IDENTIFIER of the Health Care Provider actually carrying out the work.

Where treatment is sub-commissioned to an overseas provider the Organisation Data Service Default Code 89997 *'Non-UK Provider where no ORGANISATION IDENTIFIER has been issued'* is applicable.

Each Organisation has a unique ORGANISATION IDENTIFIER. However, where an Organisation has more than one site from which it provides SERVICES, then each site is uniquely identified. These sites are Organisation Sites and are uniquely identified by an ORGANISATION IDENTIFIER.

For out-patients, ACTIVITY may take place outside the hospital, such as in the PATIENT'S home; in such cases, raising a site code is impractical. Therefore, code R9998 *'Not a hospital site'* would be used in these circumstances.
Note: LOCATION CLASS is used in the Commissioning Data Set (CDS) message to indicate the classification of the physical LOCATION within which the ACTIVITY occurred.

Use in the Future Outpatient CDS:
If the INTENDED SITE CODE (OF TREATMENT) is not known, this data element should be omitted.

SITE CODE (OF TREATMENT) will be replaced with ORGANISATION SITE IDENTIFIER (OF TREATMENT), when it has been approved for use in national information standards.

OTHER REASON FOR REFERRAL (COMMUNITY CARE)

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	See REASON FOR REFERRAL TO COMMUNITY CARE
Default Codes:	999 - Reason for referral not known

Notes:
OTHER REASON FOR REFERRAL (COMMUNITY CARE) is the same as attribute REASON FOR REFERRAL TO COMMUNITY CARE.

OTHER REASON FOR REFERRAL (COMMUNITY CARE) is the secondary presenting condition or symptom for which the PATIENT was referred to a Community Health Service.

PATIENT PATHWAY IDENTIFIER

Change to Data Element: Changed Dataset

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 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.

PERSON AT RISK OF UNEXPECTED DEATH INDICATOR

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See PERSON AT RISK OF UNEXPECTED DEATH INDICATOR
Default Codes:	

Notes:
PERSON AT RISK OF UNEXPECTED DEATH INDICATOR is the same as attribute PERSON AT RISK OF UNEXPECTED DEATH INDICATOR.

PERSON BIRTH DATE

Change to Data Element: Changed Dataset

Format/Length:	an10 CCYY-MM-DD
NWDS ID:	PEBD
NWDS Field Name:	Date of Birth
National Codes:	
Default Codes:	

Notes:
PERSON BIRTH DATE is the same as attribute PERSON BIRTH DATE.

PERSON DEATH DATE

Change to Data Element: Changed Dataset

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

Notes:
PERSON DEATH DATE is the same as attribute PERSON DEATH DATE.

PERSON HEIGHT IN METRES

Change to Data Element: Changed Dataset

Format/Length:	n1.max n2
National Codes:	
Default Codes:	

Notes:
PERSON HEIGHT IN METRES is the result of the Clinical Investigation which measures the PATIENT's Height, where the UCUM UNIT OF MEASUREMENT is *'Metres (m)'*.

For the Systemic Anti-Cancer Therapy Data Set, PERSON HEIGHT IN METRES is the Height at the start of the Systemic Anti-Cancer Therapy Drug Regimen.

PERSON LENGTH IN CENTIMETRES

Change to Data Element: Changed Dataset

Format/Length:	max n2.n1
National Codes:	
Default Codes:	99.9 - Length unknown

Notes:
PERSON LENGTH IN CENTIMETRES records the Length of a baby, where the UNIT OF MEASUREMENT is *'Centimetres'*.

PERSON RELATIONSHIP (MAIN CARER)

Change to Data Element: Changed Dataset, Description, linked Attribute

Format/Length:	an3
~~National Codes:~~	~~See RELATIONSHIP TO PERSON FOR CHILDREN AND YOUNG PEOPLE~~

National Codes:	See RELATIONSHIP TO PERSON FOR COMMUNITY
Default Codes:	

Notes:
~~PERSON RELATIONSHIP (MAIN CARER) is the same as attribute RELATIONSHIP TO PERSON FOR CHILDREN AND YOUNG PEOPLE.~~PERSON RELATIONSHIP (MAIN CARER) is the same as attribute RELATIONSHIP TO PERSON FOR COMMUNITY.

PERSON RELATIONSHIP (MAIN CARER) is the relationship between the PATIENT and the PERSON who undertakes the main caring role for them.

PERSON RELATIONSHIP (MAIN CARER)

Change to Data Element: Changed Dataset, Description, linked Attribute

PERSON RELATIONSHIP (MAIN CARER)

Attribute:

~~RELATIONSHIP TO PERSON FOR CHILDREN AND YOUNG PEOPLE~~
RELATIONSHIP TO PERSON FOR COMMUNITY

PERSON SCORE

Change to Data Element: Changed Dataset

Format/Length:	max an5
National Codes:	
Default Codes:	

Notes:
PERSON SCORE is the same as attribute PERSON SCORE.

PERSON STATED GENDER CODE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See PERSON STATED GENDER CODE
Default Codes:	X - Not Known (PERSON STATED GENDER CODE not recorded)

Notes:
PERSON STATED GENDER CODE is the same as attribute PERSON STATED GENDER CODE.

PERSON GENDER CODE CURRENT will be replaced with PERSON STATED GENDER CODE or PERSON PHENOTYPIC SEX, which is the most recent approved national information standard to describe the required definition.

PERSON WEIGHT

Change to Data Element: Changed Dataset

Format/Length:	max n3.max n3
National Codes:	
Default Codes:	

Notes:
PERSON WEIGHT is the result of the Clinical Investigation which measures the PATIENT's Weight, where the UCUM UNIT OF MEASUREMENT is '*Kilograms (kg)*'.

Notes:

- For the **Commissioning Data Sets**, PERSON WEIGHT must be padded to match the Format/Length pattern of n3.n3, for example 001.100 is a valid entry (1.1 is invalid)
- For **Neonatal Critical Care Minimum Data Set**, PERSON WEIGHT will be the last recorded Weight on a particular ACTIVITY DATE (CRITICAL CARE)
- For the **Systemic Anti-Cancer Therapy Data Set**, PERSON WEIGHT is the Weight at the start of the:
  - Systemic Anti-Cancer Therapy Drug Regimen and Systemic Anti-Cancer Therapy Drug Cycle.

POSTCODE OF USUAL ADDRESS

Change to Data Element: Changed Dataset

Format/Length:	See POSTCODE
National Codes:	
Default Codes:	

Notes:
POSTCODE OF USUAL ADDRESS is the same as data element POSTCODE.

POSTCODE OF USUAL ADDRESS is the POSTCODE of the ADDRESS nominated by the PATIENT where the ADDRESS ASSOCIATION TYPE is *'Main Permanent Residence'* or *'Other Permanent Residence'.*

For further information on POSTCODES, see POSTCODE.

PREFERRED DEATH LOCATION DISCUSSED INDICATOR

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See PREFERRED DEATH LOCATION DISCUSSED INDICATOR
Default Codes:	

Notes:
PREFERRED DEATH LOCATION DISCUSSED INDICATOR is the same as attribute PREFERRED DEATH LOCATION DISCUSSED INDICATOR.

PRESCRIPTION DATE (ASSISTIVE TECHNOLOGY)

Change to Data Element: Changed Dataset

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

Notes:
PRESCRIPTION DATE (ASSISTIVE TECHNOLOGY) is the same as attribute PRESCRIPTION DATE for the prescription of *Assistive Technology*.

PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: Changed Dataset

Format/Length:	min an4 max an18
National Codes:	
Default Codes:	

Notes:
PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY) is the same as attribute CLINICAL CLASSIFICATION CODE or CLINICAL TERMINOLOGY CODE.

PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY) is the CODED CLINICAL ENTRY used to identify the previous PATIENT DIAGNOSIS.

PRIMARY DATA COLLECTION SYSTEM IN USE

Change to Data Element: Changed Dataset

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
PRIMARY DATA COLLECTION SYSTEM IN USE is the same as attribute PRIMARY DATA COLLECTION SYSTEM IN USE.

PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: Changed Dataset

Format/Length:	min an4 max an18
National Codes:	
Default Codes:	

Notes:
PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY) is the same as attribute CLINICAL CLASSIFICATION CODE or CLINICAL TERMINOLOGY CODE.

PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY) is the CODED CLINICAL ENTRY used to identify the PRIMARY DIAGNOSIS.

PRIMARY REASON FOR REFERRAL (COMMUNITY CARE)

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	See REASON FOR REFERRAL TO COMMUNITY CARE
Default Codes:	999 - Reason for referral not known

Notes:
PRIMARY REASON FOR REFERRAL (COMMUNITY CARE) is the same as attribute REASON FOR REFERRAL TO COMMUNITY CARE.

PRIMARY REASON FOR REFERRAL (COMMUNITY CARE) is the primary presenting condition or symptom for which the PATIENT was referred to a Community Health Service.

PRIORITY TYPE CODE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See PRIORITY TYPE
Default Codes:	

Notes:
PRIORITY TYPE CODE is the same as attribute PRIORITY TYPE.

PRIORITY TYPE CODES can be defined more precisely if this is needed for local purposes, as long as the classifications can be mapped back to the National Codes.

PROCEDURE DATE (NEWBORN HEARING AUDIOLOGY)

Change to Data Element: Changed Dataset

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

Notes:
PROCEDURE DATE (NEWBORN HEARING AUDIOLOGY) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Procedure Date'* of the Newborn Hearing Audiology Test.

PROCEDURE SCHEME IN USE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See PROCEDURE SCHEME IN USE
Default Codes:	

Notes:
PROCEDURE SCHEME IN USE is the same as attribute PROCEDURE SCHEME IN USE.

PROFESSIONAL REGISTRATION BODY CODE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See PROFESSIONAL REGISTRATION BODY CODE
Default Codes:	

Notes:
PROFESSIONAL REGISTRATION BODY CODE is the same as attribute PROFESSIONAL REGISTRATION BODY CODE.

PROFESSIONAL REGISTRATION ENTRY IDENTIFIER

Change to Data Element: Changed Dataset

Format/Length:	max an32
NWDS ID:	EPRN
NWDS Field Name:	Professional Registration Number
National Codes:	
Default Codes:	

Notes:
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER is the same as attribute PROFESSIONAL REGISTRATION ENTRY IDENTIFIER.

PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: Changed Dataset

Format/Length:	min an4 max an18
National Codes:	

Default Codes:

Notes:
PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY) is the same as attribute CLINICAL CLASSIFICATION CODE or CLINICAL TERMINOLOGY CODE.

PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY) is the CODED CLINICAL ENTRY used to identify the PROVISIONAL DIAGNOSIS.

PROVISIONAL DIAGNOSIS DATE

Change to Data Element: Changed Dataset

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

Notes:
PROVISIONAL DIAGNOSIS DATE is the date on which a PROVISIONAL DIAGNOSIS was made.

REFERRAL CLOSURE DATE

Change to Data Element: Changed Dataset

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

Notes:
REFERRAL CLOSURE DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Referral Closure Date'*.

REFERRAL CLOSURE REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See REFERRAL CLOSURE REASON
Default Codes:	

Notes:
REFERRAL CLOSURE REASON is the same as attribute REFERRAL CLOSURE REASON.

REFERRAL REJECTION DATE

Change to Data Element: Changed Dataset

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

Notes:
REFERRAL REJECTION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Referral Rejection Date'*.

REFERRAL REJECTION REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See REFERRAL REJECTION REASON
Default Codes:	

Notes:
REFERRAL REJECTION REASON is the same as attribute REFERRAL REJECTION REASON.

REFERRAL REQUEST RECEIVED DATE

Change to Data Element: Changed Dataset

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

Notes:
REFERRAL REQUEST RECEIVED DATE is the same as attribute REFERRAL REQUEST RECEIVED DATE.

For the purposes of the National Cancer Waiting Times Monitoring Data Set, REFERRAL REQUEST RECEIVED DATE is used to derive the CANCER REFERRAL TO TREATMENT PERIOD START DATE.

REFERRAL REQUEST RECEIVED TIME

Change to Data Element: Changed Dataset

Format/Length:	an8 HH:MM:SS
National Codes:	
Default Codes:	

Notes:
REFERRAL REQUEST RECEIVED TIME is the same as attribute REFERRAL REQUEST RECEIVED TIME.

REFERRAL TO TREATMENT PERIOD END DATE

Change to Data Element: Changed Dataset

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 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 END TIME

Change to Data Element: New Data Element

Format/Length:	an8 HH:MM:SS
National Codes:	
Default Codes:	

Notes:
REFERRAL TO TREATMENT PERIOD END TIME is the same as attribute REFERRAL TO TREATMENT PERIOD END TIME.

This data element is also known by these names:

Context	Alias
plural	REFERRAL TO TREATMENT PERIOD END TIMES

REFERRAL TO TREATMENT PERIOD END TIME

Change to Data Element: New Data Element

REFERRAL TO TREATMENT PERIOD END TIME

Attribute:

REFERRAL TO TREATMENT PERIOD END TIME

REFERRAL TO TREATMENT PERIOD START DATE

Change to Data Element: Changed Dataset

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 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 START TIME

Change to Data Element: New Data Element

Format/Length:	an8 HH:MM:SS
National Codes:	
Default Codes:	

Notes:
REFERRAL TO TREATMENT PERIOD START TIME is the same as attribute REFERRAL TO TREATMENT PERIOD START TIME.

This data element is also known by these names:

Context	Alias
plural	REFERRAL TO TREATMENT PERIOD START TIMES

REFERRAL TO TREATMENT PERIOD START TIME

Change to Data Element: New Data Element

REFERRAL TO TREATMENT PERIOD START TIME

Attribute:

REFERRAL TO TREATMENT PERIOD START TIME

REFERRAL TO TREATMENT PERIOD STATUS

Change to Data Element: Changed Dataset

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 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.

REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE)

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	See REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH AND COMMUNITY CARE
Default Codes:	

Notes:
REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE) is the same as attribute REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH AND COMMUNITY CARE.

REFERRING ORGANISATION CODE

Change to Data Element: Changed Dataset

Format/Length:	max an6
National Codes:	
ODS Default Codes:	X99998 - Referring ORGANISATION CODE not applicable
	X99999 - Referring ORGANISATION CODE not known

Notes:
REFERRING ORGANISATION CODE is the same as attribute ORGANISATION CODE.

REFERRING ORGANISATION CODE is the ORGANISATION CODE of the Organisation from which the referral is made, such as a GP Practice, NHS Trust or NHS Foundation Trust.

This information is essential for managing service agreements which are based on patterns of referral.

REFERRING ORGANISATION CODE will be replaced with ORGANISATION IDENTIFIER (REFERRING), when it has been approved for use in national information standards.

REPLACEMENT APPOINTMENT BOOKED DATE

Change to Data Element: Changed Dataset

Format/Length:	an10 CCYY-MM-DD

National Codes:	
Default Codes:	

Notes:
REPLACEMENT APPOINTMENT BOOKED DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Replacement Appointment Booked Date*'.

REPLACEMENT APPOINTMENT DATE OFFERED

Change to Data Element: Changed Dataset

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

Notes:
REPLACEMENT APPOINTMENT DATE OFFERED is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Replacement Appointment Date Offered*'.

REPORTING PERIOD END DATE

Change to Data Element: Changed Dataset

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

Notes:
REPORTING PERIOD END DATE is the same as attribute REPORTING PERIOD END DATE.

REPORTING PERIOD END DATE is the end date of the REPORTING PERIOD and is used in conjunction with REPORTING PERIOD START DATE to specify the actual period the reported information relates to.

The date should not be before the REPORTING PERIOD START DATE although it can be the same if the period being reported only covers 1 day.

REPORTING PERIOD START DATE

Change to Data Element: Changed Dataset

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

Notes:
REPORTING PERIOD START DATE is the same as attribute REPORTING PERIOD START DATE.

REPORTING PERIOD START DATE is the start date of the REPORTING PERIOD and is used in conjunction with REPORTING PERIOD END DATE to specify the actual period the reported information relates to.

The date should not be after the REPORTING PERIOD END DATE although it can be the same if the period being reported only covers 1 day.

SAFEGUARDING VULNERABILITY FACTORS INDICATOR

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See SAFEGUARDING VULNERABILITY FACTORS INDICATOR
Default Codes:	

Notes:
SAFEGUARDING VULNERABILITY FACTORS INDICATOR is the same as attribute SAFEGUARDING VULNERABILITY FACTORS INDICATOR.

SAFEGUARDING VULNERABILITY FACTORS TYPE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See SAFEGUARDING VULNERABILITY FACTORS TYPE
Default Codes:	

Notes:
SAFEGUARDING VULNERABILITY FACTORS TYPE is the same as attribute SAFEGUARDING VULNERABILITY FACTORS TYPE.

SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: Changed Dataset

Format/Length:	min an4 max an18
National Codes:	
Default Codes:	

Notes:
SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY) is the same as attribute CLINICAL CLASSIFICATION CODE or CLINICAL TERMINOLOGY CODE.

SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY) is the CODED CLINICAL ENTRY used to identify the secondary PATIENT DIAGNOSIS.

SERVICE DISCHARGE DATE

Change to Data Element: Changed Dataset

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

Notes:
SERVICE DISCHARGE DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Discharge Date'*.

SERVICE DISCHARGE DATE is the date a PATIENT was discharged from a SERVICE.

SERVICE OR TEAM TYPE REFERRED TO (COMMUNITY CARE)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See SERVICE OR TEAM TYPE REFERRED TO FOR COMMUNITY CARE
Default Codes:	

Notes:
SERVICE OR TEAM TYPE REFERRED TO (COMMUNITY CARE) is the same as attribute SERVICE OR TEAM TYPE REFERRED TO FOR COMMUNITY CARE.

SERVICE REQUEST DATE (NEWBORN HEARING AUDIOLOGY)

Change to Data Element: Changed Dataset, Description, linked Attribute

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

Notes:
~~SERVICE REQUEST DATE (NEWBORN HEARING AUDIOLOGY) is the same as data element SERVICE REQUEST DATE.~~SERVICE REQUEST DATE (NEWBORN HEARING AUDIOLOGY) is the same as attribute ACTIVITY SERVICE REQUEST DATE.

SERVICE REQUEST DATE (NEWBORN HEARING AUDIOLOGY) is the date on which a referral for a Newborn Hearing Audiology Test was made.

SERVICE REQUEST DATE (NEWBORN HEARING AUDIOLOGY)

Change to Data Element: Changed Dataset, Description, linked Attribute

SERVICE REQUEST DATE (NEWBORN HEARING AUDIOLOGY)

Attribute:

~~SERVICE REQUEST DATE~~
ACTIVITY SERVICE REQUEST DATE

SERVICE REQUEST IDENTIFIER

Change to Data Element: Changed Dataset

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
SERVICE REQUEST IDENTIFIER is the same as attribute SERVICE REQUEST IDENTIFIER.

SITE CODE (OF TREATMENT)

Change to Data Element: Changed Dataset

Format/Length:	min an5 max an9
National Codes:	
ODS Default Codes:	R9998 - Not a hospital site 89999 - Non-NHS UK Provider where no ORGANISATION SITE CODE has been issued 89997 - Non-UK Provider where no ORGANISATION SITE CODE has been issued

Notes:
SITE CODE (OF TREATMENT) is the same as attribute ORGANISATION SITE CODE.

SITE CODE (OF TREATMENT) is the ORGANISATION SITE CODE of the Organisation where the PATIENT was treated, i.e. it should enable the treating Organisation to be identified.

This identifies the Organisation Site within the Organisation on which the PATIENT was treated, since facilities may vary on different hospital sites.

The code recorded should always be the national code; if the treatment is sub-commissioned to another NHS Health Care Provider or an independent UK provider, the SITE CODE (OF TREATMENT) used should be the ORGANISATION SITE CODE of the Health Care Provider actually carrying out the work.

Where treatment is sub-commissioned to an overseas provider the Organisation Data Service Default Code 89997 *'Non-UK Provider where no ORGANISATION SITE CODE has been issued'* is applicable.

Each Organisation has a unique ORGANISATION CODE. However, where an Organisation has more than one site from which it provides SERVICES, then each site is uniquely identified. These sites are Organisation Sites and are uniquely identified by ORGANISATION SITE CODE. The ORGANISATION

SITE CODE contains the first 3 digits of the ORGANISATION CODE with the last two digits being the site identifier.

Example:

RA700	ORGANISATION CODE of the Organisation
RA701	ORGANISATION SITE CODE of the first identified Organisation Site within the Organisation
RA702	ORGANISATION SITE CODE of the second identified Organisation Site within the Organisation

For out-patients, ACTIVITY may take place outside the hospital, such as in the PATIENT'S home; in such cases, raising a site code is impractical. Therefore, code R9998 *'Not a hospital site'* would be used in these circumstances.
Note: LOCATION CLASS is used in the Commissioning Data Set (CDS) message to indicate the classification of the physical LOCATION within which the ACTIVITY occurred.

Use in the Future Outpatient CDS:
If the INTENDED SITE CODE (OF TREATMENT) is not known, this data element should be omitted.

SITE CODE (OF TREATMENT) will be replaced with ORGANISATION SITE IDENTIFIER (OF TREATMENT), when it has been approved for use in national information standards.

SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT)

Change to Data Element: Changed Dataset

Format/Length:	See SNOMED CT CODE
National Codes:	
Default Codes:	

Notes:
SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT) is the SNOMED CT® concept ID which is used to identify a social and personal circumstance for a PERSON.

SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED DATE

Change to Data Element: Changed Dataset

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

Notes:

SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED DATE is the same as attribute PERSON PROPERTY RECORDED DATE.

SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED DATE is the date when the SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT) was recorded.

SOURCE OF REFERRAL FOR COMMUNITY

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See SOURCE OF REFERRAL FOR COMMUNITY
Default Codes:	99 - Source of referral not known

Notes:
SOURCE OF REFERRAL FOR COMMUNITY is the same as attribute SOURCE OF REFERRAL FOR COMMUNITY.

SPECIAL EDUCATIONAL NEED TYPE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See SPECIAL EDUCATIONAL NEED TYPE
Default Codes:	

Notes:
SPECIAL EDUCATIONAL NEED TYPE is the same as attribute SPECIAL EDUCATIONAL NEED TYPE.

START DATE (GMP PATIENT REGISTRATION)

Change to Data Element: Changed Dataset

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

Notes:
START DATE (GMP PATIENT REGISTRATION) is the same as attribute PERSON PROPERTY EFFECTIVE START DATE.

START DATE (GMP PATIENT REGISTRATION) is the date on which the PERSON registered with a General Medical Practitioner Practice.

UCUM UNIT OF MEASUREMENT

Change to Data Element: Changed Dataset

Format/Length:	max an10
National Codes:	
Default Codes:	

Notes:
UCUM UNIT OF MEASUREMENT is the same as attribute UCUM UNIT OF MEASUREMENT.

UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)

Change to Data Element: Changed Dataset

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 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

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See WAITING TIME MEASUREMENT TYPE
Default Codes:	

Notes:
WAITING TIME MEASUREMENT TYPE is the same as attribute WAITING TIME MEASUREMENT TYPE.

Note: National Codes 01, 03 and 04 are not valid for the Referral To Treatment (RTT) data group in the Mental Health Services Data Set.

WEEKLY HOURS WORKED

Change to Data Element: Changed Dataset, Description

Format/Length:	an2
National Codes:	See WEEKLY HOURS WORKED
~~Default Codes:~~	~~98 - Not applicable (PATIENT not employed)~~
Default Codes:	98 - Not applicable (PERSON not employed)
	99 - Number of hours worked not known

Notes:
WEEKLY HOURS WORKED is the same as attribute WEEKLY HOURS WORKED.

COMMUNITY SERVICES DATA SET CONSTRAINTS

Change to XML Schema Constraint: New XML Schema Constraint

Data Set constraints applied to the Community Services Data Set.

Data Element	Format/Length	Range	Pattern Match	Reason / Comment
ETHNIC CATEGORY	max an2	None	None	Existing Format/Length means fixed length which is incorrect. Unable to change this as it is used in other data sets. Data Set allows max an2
NHS SERVICE AGREEMENT LINE NUMBER	max an10	None	None	Existing Format/Length means fixed length which is incorrect. Unable to change this as it is used in other data sets. Data Set allows max an10

For enquiries about this Change Request, please email information.standards@nhs.net


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