NHS Digital

NHS Data Model and Dictionary Service

Type:	Change Request
Reference:	1598
Version No:	1.0
Subject:	Commissioning Data Set Type 011 Emergency Care
Effective Date:	1 October 2017
Reason for Change:	Change to Information Standards
Publication Date:	12 April 2017

Background:

The Commissioning Data Sets (CDS) are the primary mechanism for the reporting of NHS funded care activity via the Secondary Uses Service (SUS). They support a variety of high profile national requirements including National Tariff and Referral to Treatment (RTT) as well as national reporting of activity through Hospital Episode Statistics (HES).

The Commissioning Data Sets have been updated to include a new Commissioning Data Set type, CDS 011 - Emergency Care Data Set alongside the existing Commissioning Data Sets version 6.2, which will eventually replace the existing Commissioning Data Set Type 010 Accident and Emergency. The new CDS type introduces new data items, amends existing data items, and removes other data items, compared to the current CDS Type 010 Accident and Emergency data set.

A new Commissioning Data Set XML schema pack version 6-2-1, containing only XML schemas for the new CDS Type 011 and the Header and Trailer CDS types, will be made available via the TRUD release mechanism. Minor changes to the allowed values in certain header data items (such as CDS TYPE CODE and CDS BULK REPLACEMENT GROUP CODE) have been made to facilitate the submission of CDS type 011. The existing CDS XML Schema release version 6-2, remains valid for all existing CDS types such as Admitted Patient Care.

Note that provision has been made within some NHS Business Definitions and Data Elements for collection of Ambulatory Emergency Care data (although Ambulatory Emergency Care activity definitions have not yet been agreed). Values associated with these items should not be used until notified by a future Information Standard, unless formal piloting activities are being undertaken.

This Change Request adds the Commissioning Data Set type 011 - Emergency Care and supporting definitions to the NHS Data Model and Dictionary to support the Information Standard.

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:

Data Set	
CDS V6-2-1 TYPE 001 - CDS INTERCHANGE HEADER	New Data Set
CDS V6-2-1 TYPE 002 - CDS INTERCHANGE TRAILER	New Data Set
CDS V6-2-1 TYPE 003 - CDS MESSAGE HEADER	New Data Set
CDS V6-2-1 TYPE 004 - CDS MESSAGE TRAILER	New Data Set
CDS V6-2-1 TYPE 005B - CDS TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL	New Data Set
CDS V6-2-1 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL	New Data Set
CDS V6-2-1 TYPE 011 - EMERGENCY CARE CDS	New Data Set

Supporting Information	
ACCIDENT AND EMERGENCY DIAGNOSIS TABLES	Changed Description
CDS TYPE	Changed Description
CDS V6-2-1 TYPE 001 - CDS INTERCHANGE HEADER OVERVIEW	New Supporting Information
CDS V6-2-1 TYPE 002 - CDS INTERCHANGE TRAILER OVERVIEW	New Supporting Information
CDS V6-2-1 TYPE 003 - CDS MESSAGE HEADER OVERVIEW	New Supporting Information
CDS V6-2-1 TYPE 004 - CDS MESSAGE TRAILER OVERVIEW	New Supporting Information
CDS V6-2-1 TYPE 005B - CDS TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL OVERVIEW	New Supporting Information
CDS V6-2-1 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL OVERVIEW	New Supporting Information
CDS V6-2-1 TYPE 011 - EMERGENCY CARE CDS OVERVIEW	New Supporting Information
CDS VERSION 6-2 MENU	Changed Description
COMMISSIONING DATA SET BUSINESS RULES	Changed Dataset
COMMISSIONING DATA SET MANDATED DATA FLOWS	Changed Description
COMMISSIONING DATA SET NOTATION	Changed Dataset
COMMISSIONING DATA SETS MENU	Changed Description
COMMISSIONING DATA SET VERSION 6-2 TYPE LIST	Changed Description
COMMISSIONING DATA SET VERSIONS	Changed Description
EMERGENCY CARE ARRIVAL DATE	New Supporting Information

EMERGENCY CARE ARRIVAL TIME	New Supporting Information
EMERGENCY CARE ATTENDANCE	New Supporting Information
EMERGENCY CARE ATTENDANCE CONCLUSION DATE	New Supporting Information
EMERGENCY CARE ATTENDANCE CONCLUSION TIME	New Supporting Information
EMERGENCY CARE DATE SEEN FOR TREATMENT	New Supporting Information
EMERGENCY CARE DEPARTMENT	New Supporting Information
EMERGENCY CARE DEPARTURE DATE	New Supporting Information
EMERGENCY CARE DEPARTURE TIME	New Supporting Information
EMERGENCY CARE INITIAL ASSESSMENT DATE	New Supporting Information
EMERGENCY CARE INITIAL ASSESSMENT TIME	New Supporting Information
EMERGENCY CARE TIME SEEN FOR TREATMENT	New Supporting Information
INJURY DATE	New Supporting Information
INJURY TIME	New Supporting Information
PROCEDURE TIME	New Supporting Information
REFERENCED ORGANISATIONS MENU	Changed Description
REFERRED TO SERVICE ASSESSMENT DATE	New Supporting Information
REFERRED TO SERVICE ASSESSMENT TIME	New Supporting Information
ROYAL COLLEGE OF EMERGENCY MEDICINE	New Supporting Information
SECONDARY USES SERVICE	Changed Dataset
XML SCHEMA TRUD DOWNLOAD	Changed Description, Dataset

Class Definitions

ACTIVITY GROUP	Changed Attributes
ADDRESS STRUCTURED	Changed Dataset
ADDRESS UNSTRUCTURED	Changed Dataset
CARE PROFESSIONAL	Changed Attributes
CODED CLINICAL ENTRY	Changed Attributes
DECISION TO ADMIT	Changed Attributes
ORGANISATION	Changed Attributes
OVERSEAS VISITOR STATUS	Changed Attributes
PERSON NAME STRUCTURED	Changed Dataset
PERSON NAME UNSTRUCTURED	Changed Dataset
SERVICE REQUEST	Changed Attributes

Attribute Definitions

ACTIVITY DATE	Changed Dataset
ACTIVITY DATE TYPE	Changed Description
ACTIVITY IDENTIFIER	Changed Dataset
ACTIVITY SERVICE REQUEST DATE	New Attribute
ACTIVITY SERVICE REQUEST TIME	New Attribute
ACTIVITY TIME	Changed Dataset
ACTIVITY TIME TYPE	Changed Description
CARE CONTACT TYPE	Changed Description
CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR FOR EMERGENCY CARE	New Attribute
CARE PROFESSIONAL TIER FOR EMERGENCY CARE	New Attribute
CLINICAL TERMINOLOGY CODE	Changed Dataset
CLINICAL TRIAL IDENTIFIER	Changed Description, Dataset
CODED CLINICAL ENTRY SEQUENCE NUMBER	New Attribute
COMMISSIONER REFERENCE NUMBER	Changed Dataset
DECIDED TO ADMIT DATE	Changed Dataset
DECIDED TO ADMIT TIME	New Attribute
EMERGENCY CARE ATTENDANCE CATEGORY	New Attribute
EMERGENCY CARE DEPARTMENT TYPE	New Attribute
ETHNIC CATEGORY CODE	Changed Dataset
GENERAL MEDICAL PRACTITIONER PPD CODE	Changed Dataset
LOCAL PATIENT IDENTIFIER	Changed Dataset
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE	Changed Description, Dataset
NHS NUMBER	Changed Dataset
NHS SERVICE AGREEMENT LINE NUMBER	Changed Dataset
NHS SERVICE AGREEMENT NUMBER	Changed Dataset
ORGANISATION CODE	Changed Dataset
ORGANISATION IDENTIFIER	Changed Dataset
OVERSEAS VISITOR CHARGING CATEGORY	New Attribute
PATIENT JOURNEY NUMBER	Changed Dataset
PATIENT PATHWAY IDENTIFIER	Changed Dataset
PERSON BIRTH DATE	Changed Dataset
PERSON OBSERVATION TEXT STRING	Changed Dataset
PERSON PROPERTY EFFECTIVE END DATE	Changed Dataset
PERSON PROPERTY EFFECTIVE END TIME	Changed Dataset
PERSON STATED GENDER CODE	Changed Dataset

POSTCODE	Changed Dataset
PROFESSIONAL REGISTRATION BODY CODE	Changed Dataset
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER	Changed Dataset
REFERRAL TO TREATMENT PERIOD END DATE	Changed Dataset
REFERRAL TO TREATMENT PERIOD START DATE	Changed Dataset
REFERRAL TO TREATMENT PERIOD STATUS	Changed Dataset
TREATMENT FUNCTION CODE	Changed Dataset
UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	Changed Dataset
WAITING TIME MEASUREMENT TYPE	Changed Dataset

Data Elements

ACCESSIBLE INFORMATION PROFESSIONAL REQUIRED CODE (SNOMED CT)	Changed Dataset
ACCOMMODATION STATUS (SNOMED CT)	New Data Element
ACTIVITY SERVICE REQUEST DATE (EMERGENCY CARE)	New Data Element
ACTIVITY SERVICE REQUEST TIME (EMERGENCY CARE)	New Data Element
ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT)	New Data Element
AGE AT CDS ACTIVITY DATE	Changed Dataset
AMBULANCE INCIDENT NUMBER	Changed Dataset
CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR (EMERGENCY CARE)	New Data Element
CARE PROFESSIONAL TIER (EMERGENCY CARE)	New Data Element
CDS ACTIVITY DATE	Changed Description, Dataset
CDS APPLICABLE DATE	Changed Dataset
CDS APPLICABLE TIME	Changed Dataset
CDS BULK REPLACEMENT GROUP CODE	Changed Description, Dataset
CDS COPY RECIPIENT IDENTITY	Changed Dataset
CDS EXTRACT DATE	Changed Dataset
CDS EXTRACT TIME	Changed Dataset
CDS INTERCHANGE APPLICATION REFERENCE	Changed Dataset
CDS INTERCHANGE CONTROL COUNT	Changed Dataset
CDS INTERCHANGE CONTROL REFERENCE	Changed Dataset
CDS INTERCHANGE DATE OF PREPARATION	Changed Dataset
CDS INTERCHANGE RECEIVER IDENTITY	Changed Dataset
CDS INTERCHANGE SENDER IDENTITY	Changed Dataset
CDS INTERCHANGE TEST INDICATOR	Changed Dataset
CDS INTERCHANGE TIME OF PREPARATION	Changed Dataset
CDS MESSAGE REFERENCE	Changed Dataset
CDS MESSAGE TYPE	Changed Dataset
CDS MESSAGE VERSION NUMBER	Changed Description, Dataset
CDS PRIME RECIPIENT IDENTITY	Changed Dataset
CDS PROTOCOL IDENTIFIER CODE	Changed Dataset
CDS RECORD IDENTIFIER	Changed Dataset
CDS REPORT PERIOD END DATE	Changed Dataset
CDS REPORT PERIOD START DATE	Changed Dataset
CDS SENDER IDENTITY	Changed Dataset
CDS TYPE CODE	Changed Description, Dataset
CDS UNIQUE IDENTIFIER	Changed Dataset
CDS UPDATE TYPE	Changed Dataset
CLINICAL TRIAL IDENTIFIER	New Data Element
CODED CLINICAL ENTRY SEQUENCE NUMBER	New Data Element
COMMISSIONER REFERENCE NUMBER	Changed Dataset
COMMISSIONING SERIAL NUMBER	Changed Dataset
COMORBIDITY (SNOMED CT)	New Data Element
DECIDED TO ADMIT DATE	Changed Dataset
DECIDED TO ADMIT TIME	New Data Element
DISEASE OUTBREAK NOTIFICATION	New Data Element
EMERGENCY CARE ACUITY (SNOMED CT)	New Data Element
EMERGENCY CARE ARRIVAL DATE	New Data Element
EMERGENCY CARE ARRIVAL MODE (SNOMED CT)	New Data Element
EMERGENCY CARE ARRIVAL TIME	New Data Element
EMERGENCY CARE ATTENDANCE CATEGORY	New Data Element
EMERGENCY CARE ATTENDANCE CONCLUSION DATE	New Data Element
EMERGENCY CARE ATTENDANCE CONCLUSION TIME	New Data Element
EMERGENCY CARE ATTENDANCE IDENTIFIER	New Data Element
EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT)	New Data Element
EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT)	New Data Element
EMERGENCY CARE CLINICAL INVESTIGATION (SNOMED CT)	New Data Element
EMERGENCY CARE DATE SEEN FOR TREATMENT	New Data Element
EMERGENCY CARE DEPARTMENT TYPE	New Data Element
EMERGENCY CARE DEPARTURE DATE	New Data Element
EMERGENCY CARE DEPARTURE TIME	New Data Element

EMERGENCY CARE DIAGNOSIS (SNOMED CT)	New Data Element
EMERGENCY CARE DIAGNOSIS QUALIFIER (SNOMED CT)	New Data Element
EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT)	New Data Element
EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT)	New Data Element
EMERGENCY CARE DISCHARGE INFORMATION GIVEN (SNOMED CT)	New Data Element
EMERGENCY CARE DISCHARGE STATUS (SNOMED CT)	New Data Element
EMERGENCY CARE INITIAL ASSESSMENT DATE	New Data Element
EMERGENCY CARE INITIAL ASSESSMENT TIME	New Data Element
EMERGENCY CARE INJURY ACTIVITY STATUS (SNOMED CT)	New Data Element
EMERGENCY CARE INJURY ACTIVITY TYPE (SNOMED CT)	New Data Element
EMERGENCY CARE INJURY ALCOHOL OR DRUG INVOLVEMENT (SNOMED CT)	New Data Element
EMERGENCY CARE INJURY INTENT (SNOMED CT)	New Data Element
EMERGENCY CARE INJURY MECHANISM (SNOMED CT)	New Data Element
EMERGENCY CARE PLACE OF INJURY (LATITUDE)	New Data Element
EMERGENCY CARE PLACE OF INJURY (LONGITUDE)	New Data Element
EMERGENCY CARE PLACE OF INJURY (SNOMED CT)	New Data Element
EMERGENCY CARE PROCEDURE (SNOMED CT)	New Data Element
EMERGENCY CARE TIME SEEN FOR TREATMENT	New Data Element
ETHNIC CATEGORY	Changed Dataset
EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	Changed Dataset
EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	Changed Dataset
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	Changed Dataset
GENERAL MEDICAL PRACTITIONER (SPECIFIED)	Changed Dataset
INJURY DATE	New Data Element
INJURY TIME	New Data Element
INTERPRETER LANGUAGE (SNOMED CT)	New Data Element
LOCAL PATIENT IDENTIFIER (EXTENDED)	Changed Dataset
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE	Changed Dataset
NHS NUMBER	Changed Dataset
NHS NUMBER STATUS INDICATOR CODE	Changed Dataset
NHS SERVICE AGREEMENT LINE NUMBER	Changed Dataset
ORGANISATION CODE (CONVEYING AMBULANCE TRUST)	Changed Description
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	Changed Dataset
ORGANISATION IDENTIFIER (CODE OF PROVIDER)	Changed Dataset
ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST)	New Data Element
ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	Changed Dataset
ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	Changed Dataset
ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	Changed Dataset
ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE)	New Data Element
ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE)	New Data Element
ORGANISATION SITE IDENTIFIER (OF TREATMENT)	Changed Dataset
OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE	New Data Element
PATIENT NAME	Changed Dataset
PATIENT PATHWAY IDENTIFIER	Changed Dataset
PATIENT USUAL ADDRESS	Changed Dataset
PERSON BIRTH DATE	Changed Dataset
PERSON STATED GENDER CODE	Changed Dataset
POSTCODE OF USUAL ADDRESS	Changed Dataset
PREFERRED SPOKEN LANGUAGE (SNOMED CT)	New Data Element
PROCEDURE DATE (EMERGENCY CARE CLINICAL INVESTIGATION)	New Data Element
PROCEDURE DATE (EMERGENCY CARE PROCEDURE)	New Data Element
PROCEDURE TIME	New Data Element
PROCEDURE TIME (EMERGENCY CARE CLINICAL INVESTIGATION)	New Data Element
PROCEDURE TIME (EMERGENCY CARE PROCEDURE)	New Data Element
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER	Changed Dataset
PROFESSIONAL REGISTRATION ISSUER CODE	Changed Dataset
PROVIDER REFERENCE NUMBER	Changed Dataset
REFERRAL TO TREATMENT PERIOD END DATE	Changed Dataset
REFERRAL TO TREATMENT PERIOD START DATE	Changed Dataset
REFERRAL TO TREATMENT PERIOD STATUS	Changed Dataset
REFERRED TO SERVICE (SNOMED CT)	New Data Element
REFERRED TO SERVICE ASSESSMENT DATE	New Data Element
REFERRED TO SERVICE ASSESSMENT TIME	New Data Element
SAFEGUARDING CONCERN (SNOMED CT)	New Data Element
START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	Changed Dataset
START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	Changed Dataset
UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	Changed Dataset
WAITING TIME MEASUREMENT TYPE	Changed Dataset
WITHHELD IDENTITY REASON	Changed Dataset

XML Schema Constraint

COMMISSIONING DATA SET VERSION 6-2-1 XML SCHEMA CONSTRAINTS	New XML Schema Constraint
COMMISSIONING DATA SET VERSION 6-2 XML SCHEMA CONSTRAINTS	Changed Description

Date: 12 April 2017
Sponsor: Tim Donohoe, Domain H Sponsor, Department of Health

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

CDS V6-2-1 TYPE 001 - CDS INTERCHANGE HEADER

Change to Data Set: New Data Set

CDS V6-2-1 Type 001 - Commissioning Data Set Interchange Header Overview

Click CDS V6-2-1 Type 001 - Commissioning Data Set Interchange Header for a "Full Screen" view.

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

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

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-2-1 XML Schema Constraints.

Notation		DATA GROUP: CDS V6-2-1 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER			
Group Status M	Group Repeats 1..1	FUNCTION: To carry the details of the mandatory identity and addressing information for the Commissioning Data Set submission. One per Interchange submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.			
M	1..1	Data Element Components			Rules
		M	1..1	CDS INTERCHANGE SENDER IDENTITY	F S8
		M	1..1	CDS INTERCHANGE RECEIVER IDENTITY	F S8
		M	1..1	CDS INTERCHANGE CONTROL REFERENCE	F S8
		M	1..1	CDS INTERCHANGE DATE OF PREPARATION	F S8 S13
		M	1..1	CDS INTERCHANGE TIME OF PREPARATION	F S8 S14
		M	1..1	CDS INTERCHANGE APPLICATION REFERENCE	F S8
		O	0..1	CDS INTERCHANGE TEST INDICATOR	F

CDS V6-2-1 TYPE 002 - CDS INTERCHANGE TRAILER

Change to Data Set: New Data Set

CDS V6-2-1 Type 002 - Commissioning Data Set Interchange Trailer Overview

Click CDS V6-2-1 Type 002 - Commissioning Data Set Interchange Trailer for a "Full Screen" view.

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

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

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-2-1 XML Schema Constraints.

Notation		DATA GROUP: CDS V6-2-1 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER			
Group Status M	Group Repeats 1..1	FUNCTION: To carry the details of the mandatory identity and addressing information for the Commissioning Data Set submission. One per Interchange submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.			
M	1..1	Data Element Components			Rules
		M	1..1	CDS INTERCHANGE CONTROL REFERENCE	F S8
		M	1..1	CDS INTERCHANGE CONTROL COUNT	F S8
		O	0..1	CDS INTERCHANGE SENDER IDENTITY	F

		O	0..1	CDS INTERCHANGE RECEIVER IDENTITY	F

CDS V6-2-1 TYPE 003 - CDS MESSAGE HEADER

Change to Data Set: New Data Set

CDS V6-2-1 Type 003 - Commissioning Data Set Message Header Overview

Click CDS V6-2-1 Type 003 - CDS Message Header for a "Full Screen" view.

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

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

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-2-1 XML Schema Constraints.

Notation		DATA GROUP: CDS V6-2-1 TYPE 003 - COMMISSIONING DATA SET MESSAGE HEADER			
Group Status M	Group Repeats 1..1	FUNCTION: To carry the details of the mandatory identity controls for each Commissioning Data Set Message. One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.			
M	1..1	Data Element Components			Rules
		M	1..1	CDS MESSAGE TYPE	V
		M	1..1	CDS MESSAGE VERSION NUMBER	F
		M	1..1	CDS MESSAGE REFERENCE	F
		O	0..1	CDS RECORD IDENTIFIER	F

CDS V6-2-1 TYPE 004 - CDS MESSAGE TRAILER

Change to Data Set: New Data Set

CDS V6-2-1 Type 004 - Commissioning Data Set Message Trailer Overview

Click CDS V6-2-1 Type 004 - Commissioning Data Set Message Trailer for a "Full Screen" view.

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

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

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-2-1 XML Schema Constraints.

Notation		DATA GROUP: CDS V6-2-1 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER			
Group Status M	Group Repeats 1..1	FUNCTION: To carry the details of the mandatory identity controls for each Commissioning Data Set Message. One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.			
M	1..1	Data Element Components			Rules
		M	1..1	CDS MESSAGE REFERENCE	F

CDS V6-2-1 TYPE 005B - CDS TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL

Change to Data Set: New Data Set

CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol Overview

Click CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol for a "Full Screen" view.

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

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

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-2-1 XML Schema Constraints.

Notation		DATA GROUP: CDS V6-2-1 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL			
Group Status M	Group Repeats 1..1	FUNCTION: To carry the details of the mandatory Commissioning Data Set Submission Protocol controls for when using the Bulk Update mechanism. One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.			
M	1..1	Data Element Components			Rules
		M	1..1	CDS TYPE CODE	V
		M	1..1	CDS PROTOCOL IDENTIFIER CODE	V

		O	0..1	CDS UNIQUE IDENTIFIER	F S9
		M	**1..1**	CDS BULK REPLACEMENT GROUP CODE	V
		M	**1..1**	CDS EXTRACT DATE	F S13
		M	**1..1**	CDS EXTRACT TIME	F S14
		M	**1..1**	CDS REPORT PERIOD START DATE	F S6 S13
		M	**1..1**	CDS REPORT PERIOD END DATE	F S6 S13
		M	**1..1**	CDS ACTIVITY DATE	F S6 S10 S11 S13
		M	**1..1**	CDS SENDER IDENTITY	F S5
		M	**1..1**	CDS PRIME RECIPIENT IDENTITY	F S5 S7
		O	1..7	CDS COPY RECIPIENT IDENTITY	F S5 S7

CDS V6-2-1 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL

Change to Data Set: New Data Set

CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol Overview

Click CDS V6-2-1 Type 005N - CDS Transaction Header Group - Net Change Protocol for a "Full Screen" view.

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

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

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-2-1 XML Schema Constraints.

Notation		**DATA GROUP: CDS V6-2-1 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL**			
Group Status M	**Group Repeats 1..1**	**FUNCTION:** **To carry the details of the mandatory Commissioning Data Set Submission Protocol controls for when using the Net Change mechanism.** **One per Commissioning Data Set Message submitted to the Secondary Uses Service.** **Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.**			
M	**1..1**	**Data Element Components**			**Rules**
		M	**1..1**	CDS TYPE CODE	V
		M	**1..1**	CDS PROTOCOL IDENTIFIER CODE	V
		M	**1..1**	CDS UNIQUE IDENTIFIER	F S9
		M	**1..1**	CDS UPDATE TYPE	V
		M	**1..1**	CDS APPLICABLE DATE	F S8 S13
		M	**1..1**	CDS APPLICABLE TIME	F S8 S14
		M	**1..1**	CDS ACTIVITY DATE	F S6 S10 S11 S13
		M	**1..1**	CDS SENDER IDENTITY	F S5
		M	**1..1**	CDS PRIME RECIPIENT IDENTITY	F S5 S7 S15
		O	1..7	CDS COPY RECIPIENT IDENTITY	F S5 S7

CDS V6-2-1 TYPE 011 - EMERGENCY CARE CDS

Change to Data Set: New Data Set

CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set Overview

Click CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set for a "Full Screen" view.

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

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

For guidance on the XML Schema constraints, see the Commissioning Data Set Version 6-2-1 XML Schema Constraints.

CDS V6-2-1 TYPE 011 - EMERGENCY CARE COMMISSIONING DATA SET
FUNCTION: To support the details of an Emergency Care Attendance.

Notation	**DATA GROUP: CDS V6-2-1 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER**
Group Status / **Group Repeats**	**FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.**
M	**1..1**	**DATA GROUP: CDS V6-2-1 Type 001 - Commissioning Data Set Interchange Header** One per Interchange submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange

Notation	**DATA GROUP: CDS V6-2 -1 TYPE 003 - COMMISSIONING DATA SET MESSAGE HEADER**
Group Status / **Group Repeats**	**FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.**
M	**1..1**	**DATA GROUP: CDS V6-2-1 Type 003 - Commissioning Data Set Message Header** One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange

ONE OF THE FOLLOWING TWO OPTIONS MUST BE USED

Notation	**DATA GROUP: CDS V6-2-1 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL**
Group Status / **Group Repeats**	**FUNCTION: To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of the Bulk Replacement Update Mechanism of the Commissioning Data Set Submission Protocol.**
M	**1..1**	**DATA GROUP: CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol** One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

OR

Notation	**DATA GROUP: CDS V6-2-1 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL**
Group Status / **Group Repeats**	**FUNCTION: To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of the Net Change Update Mechanism of the Commissioning Data Set Submission Protocol.**
M	**1..1**	**DATA GROUP: CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol** One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

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

Notation	**DATA GROUP: PATIENT IDENTITY**
Group Status / **Group Repeats**	**FUNCTION: To carry the Identity of the Patient.** **See Note: S3 in Commissioning Data Set Business Rules.**
M	**1..1**
One of the following DATA GROUPS must be used:	
1..1	

	DATA GROUP: WITHHELD IDENTITY STRUCTURE **Must be used where the Commissioning Data Set record has been anonymised**				
M	**1..1**	**Data Element Components**			**Rules**
		M	**1..1**	NHS NUMBER STATUS INDICATOR CODE	V
		R	0..1	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	F
		R	0..1	WITHHELD IDENTITY REASON	V
OR					
1..1	**DATA GROUP: VERIFIED IDENTITY STRUCTURE** **Must be used where the NHS NUMBER STATUS INDICATOR CODE National Code = 01 (Number present and verified)**				
R	0..1	DATA GROUP: LOCAL IDENTIFIER STRUCTURE			**Rules**
		M	**1..1**	LOCAL PATIENT IDENTIFIER (EXTENDED)	F S3
		M	**1..1**	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	F
M	**1..1**	**Data Element Components**			**Rules**
		M	**1..1**	NHS NUMBER	F S3
		M	**1..1**	NHS NUMBER STATUS INDICATOR CODE	V
		M	**1..1**	POSTCODE OF USUAL ADDRESS	F S3
		R	0..1	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	F
		R	0..1	PERSON BIRTH DATE	F S3 S12
OR					
1..1	**DATA GROUP: UNVERIFIED IDENTITY STRUCTURE** **Must be used for all other values of the NHS NUMBER STATUS INDICATOR CODE NOT included in the above**				
R	0..1	DATA GROUP: LOCAL IDENTIFIER STRUCTURE			**Rules**
		M	**1..1**	LOCAL PATIENT IDENTIFIER (EXTENDED)	F S3
		M	**1..1**	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	F
M	**1..1**	**Data Element Components**			**Rules**
		R	0..1	NHS NUMBER	F
		M	**1..1**	NHS NUMBER STATUS INDICATOR CODE	V
		O	0..1	PATIENT NAME - PERSON NAME STRUCTURED *Or* PATIENT NAME - PERSON NAME UNSTRUCTURED	F S3
		O	0..1	PATIENT USUAL ADDRESS - ADDRESS STRUCTURED (Label format Postal Address) *Or* PATIENT USUAL ADDRESS - ADDRESS UNSTRUCTURED (Character string)	F S3
R	0..1	Data Element Components			**Rules**
		R	0..1	POSTCODE OF USUAL ADDRESS	F S3
		R	0..1	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	F
		R	0..1	PERSON BIRTH DATE	F S3 S12

Notation		**DATA GROUP: PATIENT CHARACTERISTICS (EMERGENCY CARE)**			
Group Status **R**	**Group Repeats** **0..1**	**FUNCTION:** **To carry the characteristics of the Patient for an Emergency Care Attendance.**			
R	0..1	Data Element Components			**Rules**
		R	0..1	PERSON STATED GENDER CODE	V
		R	0..1	ETHNIC CATEGORY	V
		R	0..1	ACCOMMODATION STATUS (SNOMED CT)	F
		R	0..1	PREFERRED SPOKEN LANGUAGE (SNOMED CT)	F
		R	0..1	ACCESSIBLE INFORMATION PROFESSIONAL REQUIRED CODE (SNOMED CT)	F
		R	0..1	INTERPRETER LANGUAGE (SNOMED CT)	F
		R	0..1	OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE	V

Notation		**DATA GROUP: MENTAL HEALTH ACT LEGAL STATUS**			
Group Status **R**	**Group Repeats** **0..***	**FUNCTION:** **To carry the patients Mental Health Act Legal Status.**			
R	0..1	**Data Element Components**			**Rules**
		M	**1..1**	START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	F S13
		M	**1..1**	START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	F S14
		R	0..1	EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	

					F S13
		R	0..1	EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	F S14
		M	**1..1**	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE	V

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

Notation		**DATA GROUP: EMERGENCY CARE ATTENDANCE LOCATION**			
Group Status M	**Group Repeats 1..1**	**FUNCTION: To carry the details of the Emergency Care Attendance location.**			
M	**1..1**	**Data Element Components**			**Rules**
		M	**1..1**	ORGANISATION SITE IDENTIFIER (OF TREATMENT)	F
		M	**1..1**	EMERGENCY CARE DEPARTMENT TYPE	F

Notation		**DATA GROUP: AMBULANCE DETAILS**			
Group Status R	**Group Repeats 0..1**	**FUNCTION: To carry ambulance details relating to the patients arrival at Emergency Care.**			
R	0..1	Data Element Components			**Rules**
		R	0..1	AMBULANCE INCIDENT NUMBER	F
		R	0..1	ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST)	F

Notation		**DATA GROUP: EMERGENCY CARE ATTENDANCE ACTIVITY CHARACTERISTICS**			
Group Status M	**Group Repeats 1..1**	**FUNCTION: To carry the characteristics of the Emergency Care Attendance.**			
M	**1..1**	**Data Element Components**			**Rules**
		M	**1..1**	EMERGENCY CARE ATTENDANCE IDENTIFIER	F
		R	0..1	EMERGENCY CARE ARRIVAL MODE (SNOMED CT)	F
		R	0..1	EMERGENCY CARE ATTENDANCE CATEGORY	V
		R	0..1	EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT)	F
		R	0..1	ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE)	F
		M	**1..1**	EMERGENCY CARE ARRIVAL DATE	F S1 S13
		M	**1..1**	EMERGENCY CARE ARRIVAL TIME	F S14
		M	**1..1**	AGE AT CDS ACTIVITY DATE	F S8
		R	0..1	EMERGENCY CARE INITIAL ASSESSMENT DATE	F S13
		R	0..1	EMERGENCY CARE INITIAL ASSESSMENT TIME	F S14
		R	0..1	EMERGENCY CARE ACUITY (SNOMED CT)	F
		R	0..1	EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT)	F
		R	0..1	EMERGENCY CARE DATE SEEN FOR TREATMENT	F S13
		R	0..1	EMERGENCY CARE TIME SEEN FOR TREATMENT	F S14

Notation		**DATA GROUP: INJURY CHARACTERISTICS**			
Group Status R	**Group Repeats 0..1**	**FUNCTION: To carry the details of injuries.**			
R	0..1	**Data Element Components**			**Rules**
		M	**1..1**	INJURY DATE	F S13
		M	**1..1**	INJURY TIME	F S14
		R	0..1	EMERGENCY CARE PLACE OF INJURY (SNOMED CT)	F
		O	0..1	EMERGENCY CARE PLACE OF INJURY (LATITUDE)	F
		O	0..1	EMERGENCY CARE PLACE OF INJURY (LONGITUDE)	F

		R	0..1	EMERGENCY CARE INJURY INTENT (SNOMED CT)	F
		R	0..1	EMERGENCY CARE INJURY ACTIVITY STATUS (SNOMED CT)	F
		R	0..1	EMERGENCY CARE INJURY ACTIVITY TYPE (SNOMED CT)	F
		R	0..1	EMERGENCY CARE INJURY MECHANISM (SNOMED CT)	F
		R	0..*	EMERGENCY CARE INJURY ALCOHOL OR DRUG INVOLVEMENT (SNOMED CT)	F

Notation	DATA GROUP: PATIENT CLINICAL HISTORY			
Group Status R	Group Repeats 0..1	FUNCTION: To carry patient clinical history details.		
R	0..1	Data Element Components		Rules
	R	0..*	COMORBIDITY (SNOMED CT)	F

Notation	DATA GROUP: SERVICE AGREEMENT DETAILS			
Group Status M	Group Repeats 1..1	FUNCTION: To carry the details of the Service Agreement.		
M	1..1	Data Element Components		Rules
	R	0..1	COMMISSIONING SERIAL NUMBER	F
	O	0..1	NHS SERVICE AGREEMENT LINE NUMBER	F
	O	0..1	PROVIDER REFERENCE NUMBER	F
	O	0..1	COMMISSIONER REFERENCE NUMBER	F
	M	1..1	ORGANISATION IDENTIFIER (CODE OF PROVIDER)	F H4
	M	1..1	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	F

Notation	DATA GROUP: CARE PROFESSIONALS (EMERGENCY CARE)			
Group Status R	Group Repeats 0..*	FUNCTION: To carry the details of the Care Professionals active during the Emergency Care Attendance.		
R	0..1	Data Element Components		Rules
	M	1..1	PROFESSIONAL REGISTRATION ISSUER CODE	V
	M	1..1	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER	F
	M	1..1	CARE PROFESSIONAL TIER (EMERGENCY CARE)	V
	M	1..1	CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR (EMERGENCY CARE)	V

Notation	DATA GROUP: EMERGENCY CARE DIAGNOSES (SNOMED CT)			
Group Status R	Group Repeats 0..*	FUNCTION: To carry the details of SNOMED CT coded Clinical Diagnoses.		
R	0..1	Data Element Components		Rules
	M	1..1	EMERGENCY CARE DIAGNOSIS (SNOMED CT)	F H4
	M	1..1	CODED CLINICAL ENTRY SEQUENCE NUMBER	F
	M	1..1	EMERGENCY CARE DIAGNOSIS QUALIFIER (SNOMED CT)	F

Notation	DATA GROUP: EMERGENCY CARE INVESTIGATIONS (SNOMED CT)			
Group Status R	Group Repeats 0..*	FUNCTION: To carry the details of SNOMED CT coded Clinical Investigations.		
R	0..1	Data Element Components		Rules
	M	1..1	EMERGENCY CARE CLINICAL INVESTIGATION (SNOMED CT)	F H4
	R	0..1	PROCEDURE DATE (EMERGENCY CARE CLINICAL INVESTIGATION)	F S13
	R	0..1	PROCEDURE TIME (EMERGENCY CARE CLINICAL INVESTIGATION)	F S14

Notation	DATA GROUP: EMERGENCY CARE TREATMENTS (SNOMED CT)			
Group Status R	Group Repeats 0..*	FUNCTION: To carry the details of SNOMED CT coded Procedures.		
R	0..1	Data Element Components		Rules
	M	1..1	EMERGENCY CARE PROCEDURE (SNOMED CT)	F H4
	R	0..1	PROCEDURE DATE (EMERGENCY CARE PROCEDURE)	F S13
	R	0..1	PROCEDURE TIME (EMERGENCY CARE PROCEDURE)	F S14

Notation		DATA GROUP: REFERRALS TO OTHER SERVICES			
Group Status	Group Repeats	FUNCTION:			
R	0..*	To carry the details of referrals to other services.			
R	0..1	Data Element Components			Rules
	R	0..1	REFERRED TO SERVICE (SNOMED CT)		F
	M	1..1	ACTIVITY SERVICE REQUEST DATE (EMERGENCY CARE)		F S13
	M	1..1	ACTIVITY SERVICE REQUEST TIME (EMERGENCY CARE)		F S14
	R	0..1	REFERRED TO SERVICE ASSESSMENT DATE		F S13
	R	0..1	REFERRED TO SERVICE ASSESSMENT TIME		F S14

Notation		DATA GROUP: DISCHARGE FROM EMERGENCY CARE			
Group Status	Group Repeats	FUNCTION:			
R	0..1	To carry the details of discharge from Emergency Care.			
R	0..1	Data Element Components			Rules
	R	0..1	DECIDED TO ADMIT DATE		F S13
	R	0..1	DECIDED TO ADMIT TIME		F S14
	R	0..1	ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT)		F
	R	0..1	EMERGENCY CARE DISCHARGE STATUS (SNOMED CT)		F H4
	R	0..1	EMERGENCY CARE ATTENDANCE CONCLUSION DATE		F S13 H4
	R	0..1	EMERGENCY CARE ATTENDANCE CONCLUSION TIME		F S14
	R	0..1	EMERGENCY CARE DEPARTURE DATE		F S13
	R	0..1	EMERGENCY CARE DEPARTURE TIME		F S14
	R	0..*	SAFEGUARDING CONCERN (SNOMED CT)		F
	R	0..1	EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT)		F
	R	0..1	ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE)		F
	R	0..1	EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT)		F
	R	0..1	EMERGENCY CARE DISCHARGE INFORMATION GIVEN (SNOMED CT)		F

Notation		DATA GROUP: RESEARCH AND DISEASE OUTBREAK NOTIFICATION			
Group Status	Group Repeats	FUNCTION:			
O	0..1	To carry details of any Research and/or Disease Outbreak Notifications.			
O	0..1	Data Element Components			Rules
	O	0..1	CLINICAL TRIAL IDENTIFIER		F
	O	0..1	DISEASE OUTBREAK NOTIFICATION		F

Notation		DATA GROUP: CDS V6-2-1 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER
Group Status	Group Repeats	FUNCTION:
		To define the mandatory identity and addressing information for a Commissioning Data Set submission.
M	1..1	DATA GROUP: CDS V6-2-1 Type 004 - Commissioning Data Set Message Trailer One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange

Notation		DATA GROUP: CDS V6-2-1 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER
Group Status	Group Repeats	FUNCTION:
		To define the mandatory identity and addressing information for a Commissioning Data Set submission.
M	1..1	DATA GROUP: CDS V6-2-1 Type 002 - Commissioning Data Set Interchange Trailer One per Interchange submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange

ACCIDENT AND EMERGENCY DIAGNOSIS TABLES

Change to Supporting Information: Changed Description

- A broad classification of types of diagnoses which may be made as a result of Accident and Emergency Attendance. The full description is made up of codes from three tables - ACCIDENT AND EMERGENCY DIAGNOSIS, Accident and Emergency Attendance: ANATOMICAL

AREAS and Accident and Emergency Attendance: ANATOMICAL SIDE. ANATOMICAL AREA (a classification of parts of the human body) and ANATOMICAL SIDE (an indication of the side of the human body) together give the Anatomical Site of clinical problems presented at an Accident and Emergency Attendance.

- ~~The Accident and Emergency Diagnosis Tables have been mapped to diagnoses in SNOMED CT®, and are available on request from Technology Reference Data Update Distribution (TRUD).~~

- ~~SNOMED CT Subset Metadata:~~
  - ~~Subset Name: Concepts mapped to Data Dictionary A&E Diagnosis Codes~~
  - ~~Subset Original Id: 28511000000135~~
  - ~~Refset FSN: National Health Service Data Model and Dictionary accident and emergency diagnosis simple map reference set (foundation metadata concept)~~
  - ~~Refset Id : 999001661000000103~~

~~For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Concepts mapped to Data Dictionary A&E Diagnosis Codes.~~

- ~~Certain items are sub-analysed to specify the diagnosis, investigation or treatment more precisely. These are marked with an asterisk. The diagnosis sub-analysis list follows the main diagnosis list, and the treatment sub-analysis list follows the main treatment list.~~

- Certain items are sub-analysed to specify the diagnosis, investigation or treatment more precisely. These are marked with an asterisk. The diagnosis sub-analysis list follows the main diagnosis list, and the treatment sub-analysis list follows the main treatment list.

- It is recommended that computerised systems provide a minimum of six character fields for each category in order to accommodate more detailed information if necessary. Where fewer than six characters are required for coding, such as for investigations and treatments, it is recommended that the codes are left-justified and the unused fields left blank.

- ACCIDENT AND EMERGENCY DIAGNOSIS is a six character code, comprising:

Diagnosis Condition	n2
Sub-Analysis	n1
Accident and Emergency Attendance - ANATOMICAL AREA	n2
Accident and Emergency Attendance - ANATOMICAL SIDE	an1

Accident and Emergency Diagnosis - Diagnosis Condition

Diagnosis Condition	Code
Laceration	01
Contusion/abrasion*	02
Soft tissue inflammation	03
Head injury*	04
Dislocation/fracture/joint injury/amputation*	05
Sprain/ligament injury	06
Muscle/tendon injury	07
Nerve injury	08
Vascular injury	09
Burns and scalds*	10
Electric shock	11
Foreign body	12
Bites/stings	13
Poisoning* (including overdose)	14
Near drowning	15
Visceral injury	16
Infectious disease*	17
Local infection	18
Septicaemia	19
Cardiac conditions*	20
Cerebro-vascular conditions	21
Other vascular conditions	22
Haematological conditions	23
Central Nervous System conditions* (excluding strokes)	24
Respiratory conditions*	25
Gastrointestinal conditions*	26
Urological conditions (including cystitis)	27
Obstetric conditions	28
Gynaecological conditions	29

Diabetes and other endocrinological conditions*	30
Dermatological conditions	31
Allergy (including anaphylaxis)	32
Facio-maxillary conditions	33
ENT conditions	34
Psychiatric conditions	35
Ophthalmological conditions	36
Social problem (includes chronic alcoholism and homelessness)	37
Diagnosis not classifiable	38
Nothing abnormal detected	39

*Item sub-analysed

Accident and Emergency Diagnosis - Sub-analysis

Sub-analysis		Code
Contusion/abrasion	- contusion - abrasion	1 2
Head Injury	- concussion - other head injury	1 2
Dislocation/fracture/joint injury/amputation	- dislocation - open fracture - closed fracture - joint injury - amputation	1 2 3 4 5
Burns and scalds	- electric - thermal - chemical - radiation	1 2 3 4
Poisoning	- prescriptive drugs - proprietary drugs - controlled drugs - other, including alcohol	1 2 3 4
Infectious disease	- notifiable disease - non-notifiable disease	1 2
Cardiac conditions	- myocardial ischaemia & infarction - other non-ischaemia	1 2
Respiratory conditions	- bronchial asthma - other non-asthma	1 2
Central Nervous System conditions	- epilepsy - other non-epilepsy	1 2
Gastrointestinal conditions	- haemorrhage - acute abdominal pain - other	1 2 3
Diabetes and other endocrinological conditions	- diabetic - other non-diabetic	1 2

Anatomical Site

Accident And Emergency Anatomical Area - Area

Anatomical Area	Code
Head and Neck	
Brain	01
Head	02
Face	03
Eye	04
Ear	05
Nose	06
Mouth, Jaw, Teeth	07
Throat	08
Neck	09
Upper Limb	
Shoulder	10
Axilla	11
Upper Arm	12
Elbow	13
Forearm	14
Wrist	15
Hand	16
Digit	17

Trunk	
Cervical spine	18
Thoracic	19
Lumbosacral spine	20
Pelvis	21
Chest	22
Breast	23
Abdomen	24
Back/buttocks	25
Ano/rectal	26
Genitalia	27
Lower Limb	
Hip	28
Groin	29
Thigh	30
Knee	31
Lower leg	32
Ankle	33
Foot	34
Toe	35
Multiple Site	36
Accident and Emergency Anatomical Side	
Left	L
Right	R
Bilateral	B
Not applicable	8

CDS TYPE

Change to Supporting Information: Changed Description

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

The CDS Types are:

010 Accident and Emergency Attendance
011 Emergency Care Attendance
020 Outpatient
(Known in the Schema as Care Activity)
May also be used to submit a Referral To Treatment Clock Stop Administrative Event
021 Future Outpatient
(Known in the Schema as Future Care Activity)
030 Elective Admission List End of Period Census (Standard)
040 Elective Admission List End of Period Census (Old)
050 Elective Admission List End of Period Census (New)
060 Elective Admission List Event During Period (Add)
070 Elective Admission List Event During Period (Remove)
080 Elective Admission List Event During Period (Offer)
090 Elective Admission List Event During Period (Available/Unavailable)
100 Elective Admission List Event During Period (Old Service Agreement)
110 Elective Admission List Event During Period (New Service Agreement)
120 Finished Birth Episode
130 Finished General Episode
140 Finished Delivery Episode
150 Other Birth
160 Other Delivery
170 Detained and/or Long-Term Psychiatric Census
180 Unfinished Birth Episode
190 Unfinished General Episode
200 Unfinished Delivery Episode

CDS V6-2-1 TYPE 001 - CDS INTERCHANGE HEADER OVERVIEW

Change to Supporting Information: New Supporting Information

The CDS V6-2-1 Type 001 - Commissioning Data Set Interchange Header carries mandatory controls for a Commissioning Data Set Interchange and is only used by inclusion in other CDS Types.

Note that the CDS V6-2-1 Type 001 - Commissioning Data Set Interchange Header should only be used when submitting the CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set.

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

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

- CDS V6-2-1 Type 001 - Commissioning Data Set Interchange Header - Mandatory - One per Commissioning Data Set Interchange
- CDS V6-2-1 Type 003 - Commissioning Data Set Message Header - Mandatory - One per Commissioning Data Set Message

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

- CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol - Mandatory, one per CDS Type
  CDS V6-2-1 Type 005N - CDS Transaction Header Group - Net Change Protocol - Mandatory, one per CDS Type

Followed by:

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

Each Commissioning Data Set message ends with:

- CDS V6-2-1 Type 004 - Commissioning Data Set Message Trailer - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- CDS V6-2-1 Type 002 - Commissioning Data Set Interchange Trailer - Mandatory - One per Commissioning Data Set Interchange

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

Data Group Overview

A high-level view of the Data Groups carried in the CDS V6-2-1 Type 001 - Commissioning Data Set Interchange Header is shown below.

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

Notation		DATA GROUP OVERVIEW: CDS V6-2-1 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER
Group Status	**Group Repeats**	**FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set Interchange submission.**
M	**1..1**	**DATA GROUP: CDS V6-2-1 Type 001 - Commissioning Data Set Interchange Header** One per Commissioning Data Set Interchange submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

CDS V6-2-1 TYPE 002 - CDS INTERCHANGE TRAILER OVERVIEW

Change to Supporting Information: New Supporting Information

The CDS V6-2-1 Type 002 - Commissioning Data Set Interchange Trailer carries mandatory controls for a Commissioning Data Set Interchange and is only used by inclusion in other CDS Types.

Note that the CDS V6-2-1 Type 002 - Commissioning Data Set Interchange Trailer should only be used when submitting the CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set.

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

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

- CDS V6-2-1 Type 001 - Commissioning Data Set Interchange Header - Mandatory - One per Commissioning Data Set Interchange
- CDS V6-2-1 Type 003 - Commissioning Data Set Message Header - Mandatory - One per Commissioning Data Set Message

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

- CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol - Mandatory, one per CDS Type
  CDS V6-2-1 Type 005N - CDS Transaction Header Group - Net Change Protocol - Mandatory, one per CDS Type

Followed by:

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

Each Commissioning Data Set message ends with:

- CDS V6-2-1 Type 004 - Commissioning Data Set Message Trailer - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- CDS V6-2-1 Type 002 - Commissioning Data Set Interchange Trailer - Mandatory - One per Commissioning Data Set Interchange

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

Data Group Overview

A high-level view of the Data Groups carried in the CDS V6-2 Type 002 - Commissioning Data Set Interchange Trailer is shown below.

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

Notation	DATA GROUP OVERVIEW: CDS V6-2-1 TYPE 002 - CDS INTERCHANGE TRAILER
Group Status	**Group Repeats**	**FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.**
M	**1..1**	**DATA GROUP: CDS V6-2-1 Type 002 - Commissioning Data Set Interchange Trailer** One per Interchange submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

CDS V6-2-1 TYPE 003 - CDS MESSAGE HEADER OVERVIEW

Change to Supporting Information: New Supporting Information

The CDS V6-2-1 Type 003 - Commissioning Data Set Message Header carries mandatory controls for a Commissioning Data Set Message and is only used by inclusion in other CDS Types.

Note that the CDS V6-2-1 Type 003 - Commissioning Data Set Message Header should only be used when submitting the CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set.

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

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

- CDS V6-2-1 Type 001 - Commissioning Data Set Interchange Header - Mandatory - One per Commissioning Data Set Interchange
- CDS V6-2-1 Type 003 - Commissioning Data Set Message Header - Mandatory - One per Commissioning Data Set Message

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

- CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol - Mandatory, one per CDS Type
- CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol - Mandatory, one per CDS Type

Followed by:

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

Each Commissioning Data Set message ends with:

- CDS V6-2-1 Type 004 - Commissioning Data Set Message Trailer - Mandatory - One per Commissioning Data Set Message

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

Data Group Overview

A high-level view of the Data Groups carried in the CDS V6-2 Type 003 - Commissioning Data Set Message Header is shown below.

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

Notation	DATA GROUP OVERVIEW: CDS V6-2 TYPE 003-1 - CDS MESSAGE HEADER
Group Status	**Group Repeats**	**FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.**
M	**1..***	**DATA GROUP: CDS V6-2-1 Type 003 - Commissioning Data Set Message Header** One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

CDS V6-2-1 TYPE 004 - CDS MESSAGE TRAILER OVERVIEW

Change to Supporting Information: New Supporting Information

The CDS V6-2-1 Type 004 - Commissioning Data Set Message Trailer carries mandatory controls for a Commissioning Data Set Message and is only used by inclusion in other CDS Types.

Note that the CDS V6-2-1 Type 004 - Commissioning Data Set Message Trailer should only be used when submitting the CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set.

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

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

- CDS V6-2-1 Type 001 - Commissioning Data Set Interchange Header - Mandatory - One per Commissioning Data Set Interchange
- CDS V6-2-1 Type 003 - Commissioning Data Set Message Header - Mandatory - One per Commissioning Data Set Message

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

- CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol - Mandatory, one per CDS Type
- CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol - Mandatory, one per CDS Type

Followed by:

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

Each Commissioning Data Set message ends with:

- CDS V6-2-1 Type 004 - Commissioning Data Set Message Trailer - Mandatory - One per Commissioning Data Set Message

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

Data Group Overview

A high-level view of the Data Groups carried in the CDS V6-2-1 Type 004 - Commissioning Data Set Message Trailer is shown below.

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

Notation		DATA GROUP OVERVIEW: CDS V6-2-1 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER
Group Status	Group Repeats	FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.
M	1..*	DATA GROUP: CDS V6-2-1 Type 004 - Commissioning Data Set Message Trailer One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

CDS V6-2-1 TYPE 005B - CDS TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL OVERVIEW

Change to Supporting Information: New Supporting Information

The CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol carries mandatory controls for a Commissioning Data Set Type and is only used by inclusion in other CDS Types.

Note that the CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol should only be used when submitting the CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set.

Commissioning Data Set Interchanges containing Commissioning Data Set Messages submitted to the Secondary Uses Service must use the required Commissioning Data Set Interchange and Message Header and Trailer Controls to provide the correct addressing and identification for the data flows. All CDS Types using the Commissioning Data Set Bulk Replacement Update Mechanism of the Commissioning Data Set Submission Protocol must begin with this Mandatory Data Group.

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

- CDS V6-2-1 Type 001 - Commissioning Data Set Interchange Header - Mandatory - One per Commissioning Data Set Interchange
  CDS V6-2-1 Type 003 - Commissioning Data Set Message Header - Mandatory - One per Commissioning Data Set Message

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

- CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol - Mandatory, one per CDS Type
  CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol - Mandatory, one per CDS Type

Followed by:

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

Each Commissioning Data Set message ends with:

- CDS V6-2-1 Type 004 - Commissioning Data Set Message Trailer - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- CDS V6-2-1 Type 002 - Commissioning Data Set Interchange Trailer - Mandatory - One per Commissioning Data Set Interchange

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

Data Group Overview

A high-level view of the Data Groups carried in the CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol is shown below.

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

Notation		DATA GROUP OVERVIEW: CDS V6-2-1 TYPE 005B - TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL
Group Status	Group Repeats	FUNCTION: To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of one of the Update Mechanisms of the Commissioning Data Set Submission Protocol.
M	1..1	DATA GROUP: CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

CDS V6-2-1 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL OVERVIEW

Change to Supporting Information: New Supporting Information

The CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol carries mandatory controls for a Commissioning Data Set Type and is only used by inclusion in other CDS Types.

Note that the CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol should only be used when submitting the CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set.

Commissioning Data Set Interchanges containing Commissioning Data Set Messages submitted to the Secondary Uses Service must use the required Commissioning Data Set interchange and Message Header and Trailer Controls to provide the correct addressing and identification for the data flows. All CDS Types using the Commissioning Data Set Net Change Update Mechanism of the Commissioning Data Set Submission Protocol must begin with this Mandatory Data Group.

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

- CDS V6-2-1 Type 001 - Commissioning Data Set Interchange Header - Mandatory - One per Commissioning Data Set Interchange
  CDS V6-2-1 Type 003 - Commissioning Data Set Message Header - Mandatory - One per Commissioning Data Set Message

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

- CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol - Mandatory, one per CDS Type
  CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol - Mandatory, one per CDS Type

Followed by:

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

Each Commissioning Data Set message ends with:

- CDS V6-2-1 Type 004 - Commissioning Data Set Message Trailer - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- CDS V6-2-1 Type 002 - Commissioning Data Set Interchange Trailer - Mandatory - One per Commissioning Data Set Interchange

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

Data Group Overview

A high-level view of the Data Groups carried in the CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol is shown below.

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

Notation		DATA GROUP OVERVIEW: CDS V6-2-1 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL
Group Status	Group Repeats	FUNCTION: To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of one of the Update Mechanisms of the Commissioning Data Set Submission Protocol.
M	1..1	DATA GROUP: CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

CDS V6-2-1 TYPE 011 - EMERGENCY CARE CDS OVERVIEW

Change to Supporting Information: New Supporting Information

CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set carries the data for an Emergency Care Attendance.

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

Data Group Overview

A high-level view of the Data Groups carried in the CDS V6-2-1 Type 011 - Emergency Care CDS is shown below.

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

Notation		DATA GROUP OVERVIEW: CDS V6-2-1 TYPE 011 - EMERGENCY CARE COMMISSIONING DATA SET
Group Status	Group Repeats	FUNCTION: To support the details of an Emergency Care Attendance.
M	**1..1**	**DATA GROUP: CDS V6-2-1 Type 001 - Commissioning Data Set Interchange Header** One per Interchange submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.
M	**1..***	**DATA GROUP: CDS V6-2-1 Type 003 - Commissioning Data Set Message Header** One per Commissioning Data Set Message submitted to the Secondary Uses Service.
M	**1..1**	**DATA GROUP: COMMISSIONING DATA SET TRANSACTION HEADER GROUP** Dependent upon the Commissioning Data Set Submission Protocol being used, one of the following must be used per Commissioning Data Set Message submitted to the Secondary Uses Service: CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol Or CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol
O	0..1	DATA GROUP: PATIENT PATHWAY
M	**1..1**	**DATA GROUP: PATIENT IDENTITY**
R	0..1	DATA GROUP: PATIENT CHARACTERISTICS (EMERGENCY CARE)
R	0..*	DATA GROUP: MENTAL HEALTH ACT LEGAL STATUS
R	0..1	DATA GROUP: GP REGISTRATION
R	0..1	DATA GROUP: EMERGENCY CARE ATTENDANCE LOCATION
R	0..1	DATA GROUP: AMBULANCE DETAILS
M	**1..1**	**DATA GROUP: EMERGENCY CARE ATTENDANCE ACTIVITY CHARACTERISTICS**
R	0..1	DATA GROUP: INJURY CHARACTERISTICS
R	0..1	DATA GROUP: PATIENT CLINICAL HISTORY
M	**1..1**	**SERVICE AGREEMENT DETAILS**
R	0..*	DATA GROUP: CARE PROFESSIONALS (EMERGENCY CARE)
R	0..*	DATA GROUP: EMERGENCY CARE DIAGNOSES
R	0..*	DATA GROUP: EMERGENCY CARE INVESTIGATIONS
R	0..*	DATA GROUP: EMERGENCY CARE TREATMENTS
R	0..*	DATA GROUP: REFERRALS TO OTHER SERVICES
R	0..1	DATA GROUP: DISCHARGE FROM EMERGENCY CARE
O	0..1	DATA GROUP: RESEARCH AND DISEASE OUTBREAK NOTIFICATION
M	**1..***	**DATA GROUP: CDS V6-2-1 Type 004 - Commissioning Data Set Message Trailer** One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.
M	**1..1**	**DATA GROUP: CDS V6-2-1 Type 002 - Commissioning Data Set Interchange Trailer** One per Interchange submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

CDS VERSION 6-2 MENU

Change to Supporting Information: Changed Description

Commissioning Data Set Business Rules
Commissioning Data Set Notation

CDS Data Flow Controls - (Mandatory for every CDS Interchange):
CDS V6-2 Type 001 - CDS Interchange Header
CDS V6-2 Type 002 - CDS Interchange Trailer
CDS V6-2 Type 003 - CDS Message Header
CDS V6-2 Type 004 - CDS Message Trailer
CDS V6-2-1 Type 001 - CDS Interchange Header
CDS V6-2-1 Type 002 - CDS Interchange Trailer
CDS V6-2-1 Type 003 - CDS Message Header
CDS V6-2-1 Type 004 - CDS Message Trailer

CDS Transaction Header Group - (Mandatory for every CDS TYPE):
CDS V6-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol **or**
CDS V6-2 Type 005N - CDS Transaction Header Group - Net Change Protocol
CDS V6-2-1 Type 005B - CDS Transaction Header Group - Bulk Update Protocol **or**
CDS V6-2-1 Type 005N - CDS Transaction Header Group - Net Change Protocol

CDS TYPES:
~~**Accident and Emergency:**~~**Emergency Care:**
CDS V6-2 Type 010 - Accident and Emergency CDS
CDS V6-2-1 Type 011 - Emergency Care CDS

Outpatient Care:
CDS V6-2 Type 020 - Outpatient CDS
CDS V6-2 Type 021 - Future Outpatient CDS

Admitted Patient Care:
CDS V6-2 Type 120 - Admitted Patient Care - Finished Birth Episode CDS
CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode CDS
CDS V6-2 Type 140 - Admitted Patient Care - Finished Delivery Episode CDS
CDS V6-2 Type 150 - Admitted Patient Care - Other Birth Event CDS
CDS V6-2 Type 160 - Admitted Patient Care - Other Delivery Event CDS
CDS V6-2 Type 170 - Admitted Patient Care - Detained and/or Long Term Psychiatric Census CDS
CDS V6-2 Type 180 - Admitted Patient Care - Unfinished Birth Episode CDS
CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode CDS
CDS V6-2 Type 200 - Admitted Patient Care - Unfinished Delivery Episode CDS

Elective Admission List - End Of Period Census Types:
CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) CDS
CDS V6-2 Type 040 - Elective Admission List - End Of Period Census (Old) CDS
CDS V6-2 Type 050 - Elective Admission List - End Of Period Census (New) CDS

Elective Admission List - Event During Period Types:
CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) CDS
CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) CDS
CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) CDS
CDS V6-2 Type 090 - Elective Admission List - Event During Period (Available or Unavailable) CDS
CDS V6-2 Type 100 - Elective Admission List - Event During Period (Old Service Agreement) CDS
CDS V6-2 Type 110 - Elective Admission List - Event During Period (New Service Agreement) CDS

COMMISSIONING DATA SET BUSINESS RULES

Change to Supporting Information: Changed Dataset

The Commissioning Data Sets have notation to identify the business and/or processing rules which apply to individual Data Elements. This notation appears in the Rules column of the Commissioning Data Sets details page.

Population Validation

All Data Elements are subject to **length** validation. Some Data Elements are also subject to **format** and **content** validation against a list of permitted values defined in the NHS Data Model and Dictionary. The value lists are held on the Attribute which the Data Element is based on, plus default codes which are held on the Data Element itself.

RULE	POPULATION VALIDATION
F	The format is validated, for example the format of a DATE must comply with the XML standard.
V	The Data Element is validated against an explicit list of permitted values as defined in the NHS Data Model and Dictionary.

Business Rules

Some Data Elements are subject to additional Business Rules as indicated below:

- **Prefix H** = Healthcare Resource Group Business Rules.
- **Prefix I** = CDS-XML Schema anomalies and issues.
- **Prefix N** = NHS Data Standards and Policy Rules
- **Prefix S** = Secondary Uses Service Business Rules

PREFIX	BUSINESS RULES: H - Healthcare Resource Group Business Rules
H4	This Data Element is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4.** Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource. For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

PREFIX	BUSINESS RULES: I - CDS-XML Schema Anomalies and Issues

I1	This is a known schema anomaly and has been registered for future resolution.
I2	See the specifications in the NHS Data Model and Dictionary for the specific format characteristics of this Data Element.
I3	There is no national requirement to flow Healthcare Resource Group 4 (HRG4) through the Commissioning Data Sets, see DSCN 17/2008.

PREFIX	BUSINESS RULES: N - NHS Data Standards and Policy Rules
N1	Psychiatric PATIENTS only.
N2	Not defined or approved by the Standardisation Committee for Care Information or its predecessor the Information Standards Board for Health and Social Care.
N3	The definition and value list for this data is under review.
N4	Up to 20 codes per daily activity occurrence may be recorded.
N5	This data should only flow in Commissioning Data Set version 6-1 for PATIENTS detained under the Mental Health Act prior to the Mental Health Act 2007 (Retired June 2015).
N6	This data should only flow in Commissioning Data Set version 6-2 for PATIENTS detained under the Mental Health Act 2007.
N7	From Commissioning Data Set version 6-0 onwards, the use of the DETAINED AND (OR) LONG TERM PSYCHIATRIC CENSUS DATE in the location group is **optional** as it **must** be carried in the Episode Characteristics.

PREFIX	BUSINESS RULES: S - Secondary Uses Service Business Rules
S1	This mandatory Commissioning Data Set date is used as the originating date to determine the mandatory CDS ACTIVITY DATE.
S2	The Secondary Uses Service **DOES NOT** support the use of the CDS TEST INDICATOR. Therefore this Data Element must not be used (Retired June 2015).
S3	See Security Issues and Patient Confidentiality, for further information.
S4	Used to ensure the correct sequencing of multiple and/or subsequent Commissioning Data Set submissions.
S5	These ORGANISATION CODES must be present and registered with the Secondary Uses Service. The Commissioning Data Set Schema does not validate the content value of this data
S6	All CDS REPORT PERIOD START DATES and CDS REPORT PERIOD END DATES must be consistent in all Commissioning Data Set records contained in a BULK Interchange submission. The CDS REPORT PERIOD START DATE must be on or before the CDS REPORT PERIOD END DATE. The CDS ACTIVITY DATE is a mandatory data element and must fall within the period defined. See the Commissioning Data Set Submission Protocol.
S7	See the Commissioning Data Set Addressing Grid.
S8	These Data Elements are required for correct processing by the Secondary Uses Service. If omitted, the Secondary Uses Service will reject the Commissioning Data Set data.
S9	The CDS UNIQUE IDENTIFIER is a mandatory data item when using the Net Change Protocol. When using the Bulk Update Protocol this data item is optional but it is strongly advised that where it can be correctly generated and maintained it should be used. See the Commissioning Data Set Submission Protocol.
S10	For CDS V6-2 Type 170 - Admitted Patient Care - Detained and or Long Term Psychiatric Census Commissioning Data Set, the CDS ACTIVITY DATE contains the CDS CENSUS DATE which is also the DETAINED AND (OR) LONG TERM PSYCHIATRIC CENSUS DATE.
S11	For the following CDS Types, the CDS ACTIVITY DATE must contain the DATE OF ELECTIVE ADMISSION LIST CENSUS which is usually the end of the Period being reported: CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set CDS V6-2 Type 040 - Elective Admission List - End Of Period Census (Old) Commissioning Data Set CDS V6-2 Type 050 - Elective Admission List - End Of Period Census (New) Commissioning Data Set
S12	These PERSON BIRTH DATE Data Elements must use DATES between 01/01/1880 and 31/12/2999 in order to pass validation
S13	Data Elements reporting a DATE (which is not a PERSON BIRTH DATE Data Element) must use dates between 01/01/1900 and 31/12/2999 in order to pass validation
S14	For Data Elements reporting a TIME, the hour portion must be between 00 and 23 inclusive in order to pass validation

COMMISSIONING DATA SET MANDATED DATA FLOWS

Change to Supporting Information: Changed Description

The minimum Commissioning Data Sets information flow requirement to enable Hospital Episode Statistics, 18 Weeks ACTIVITY reporting, and the National Tariff Payment System to be supported by the Secondary Uses Service is shown in the table below.

The Secondary Uses Service supports every CDS Type but only a subset is mandated to flow.

Commissioning Data Sets may flow to the Secondary Uses Service using either Net Change or Bulk Replacement Commissioning Data Set Submission Protocols. Many Standard NHS Contracts between Health Care Providers and the commissioners of their SERVICES, now specify weekly submission of initially-coded data sets to the Secondary Uses Service. The use of Net Change Commissioning Data Set Submission Protocols is recommended for submissions of this frequency.

CDS TYPE	DESCRIPTION	MIN FREQUENCY	DIRECTIVE	DATA FLOW
CDS 010	Accident And Emergency	Monthly	Accident and Emergency Attendances were mandated to flow nationally from 1st April 2005, see DSCN 32/2004	All Accident and Emergency Attendances occurring during the time period being reported and defined by the Commissioning Data Set Submission Protocol being used.
CDS 011	Emergency Care	Weekly	Emergency Care Attendances for EMERGENCY CARE DEPARTMENT TYPE 01 and 02 were mandated to flow nationally from 1st October 2017. See ISNxxxxxxx.	Data is expected to flow on a daily basis where possible, but a weekly frequency is the minimum requirement.

			Emergency Care Attendances for EMERGENCY CARE DEPARTMENT TYPES 03 and 04 were mandated to flow from October 2018. See ISNxxxxxxx.	
CDS 020	Out-Patient	Monthly	Out-Patient Attendance Commissioning Data Sets (including Ward Attenders) were mandated to be submitted to the Secondary Uses Service from 1st October 2001, see DSCN 05/2001. Out-Patient Attendance Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009. NURSE and MIDWIFE attendances and Attendances for nursing care were enabled to be carried in the Out-Patient Attendance Commissioning Data Set from 1 April 2005, DSCN 32/2004 Other Care Professional Attendances where an appropriate Treatment Function exists may also be submitted. Out-patient records where the activity relates to the Allied Health Professional Referral To Treatment Measurement standard must be submitted to the Secondary Uses Service (in accordance with ISN ISB0092 Amd 06/2011, and must include the PATIENT PATHWAY data group data items. Note that this is only supported in Commissioning Data Set version 6-2 onwards, with the introduction of data element WAITING TIME MEASUREMENT TYPE.	Due to the high volumes involved, these are often submitted on a weekly basis.
CDS 021	Future Out-Patients	As Required for piloting	From 01/01/2008, submissions to support local activities and commissioning will be supported for piloting purposes only.	
CDS 030	Elective Admission List End of Period (Standard)	Monthly if used	All Providers should endeavour to support this data flow. Elective Admission List End of Period Census (Standard) Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	All entries where at the end of the time period being reported and defined by the Commissioning Data Set Submission Protocol, the PATIENT remains on the ELECTIVE ADMISSION LIST. Optionally and by local agreement with commissioners, entries relating to the PATIENTS that have been removed from the ELECTIVE ADMISSION LIST may be included.
CDS 040	Elective Admission List End of Period (New)	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
CDS 050	Elective Admission List End of Period (Old)	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
CDS 060	Elective Admission List Event During Period (Add)	Monthly if used	Optional Elective Admission List Event During Period (Add) Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	May be submitted where an entry has been added to the ELECTIVE ADMISSION LIST during the time period reported.
CDS 070	Elective Admission List Event During Period (Remove)	Monthly if used	Optional Elective Admission List Event During Period (Remove) Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	May be submitted where an entry has been removed from the ELECTIVE ADMISSION LIST during the time period reported.
CDS 080	Elective Admission List Event During Period (Offer)	Monthly if used	Optional Elective Admission List Event During Period (Offer) CDS records where the activity relates to a Referral To Treatment Period	May be submitted where an offer has been made during the time period reported.

			Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	
CDS 090	Elective Admission List Event During Period (Available / Unavailable)	Monthly if used	Optional	May be submitted where a patient becomes Available or Unavailable during the time period reported.
CDS 100	Elective Admission List Event During Period (Old Service Agreement)	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
CDS 110	Elective Admission List Event During Period (New Service Agreement)	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
CDS 120	Finished Birth Episode	Monthly	All finished Admitted Patient Care data must be submitted "at least monthly" (EL - Dec 1995). This includes Non-Contract Activity.	All Episodes that have finished relevant to the time period defined by the Commissioning Data Set Submission Protocol being used.
CDS 130	Finished General Episode	Monthly	All finished Admitted Patient Care data must be submitted "at least monthly" (EL - Dec 1995). This includes Non-Contract Activity. Finished General Episode Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	All Episodes that have finished relevant to the time period defined by the Commissioning Data Set Submission Protocol being used.
CDS 140	Finished Delivery Episode	Monthly	All finished Admitted Patient Care data must be submitted "at least monthly" (EL - Dec 1995). This includes Non-Contract Activity.	All Episodes that have finished relevant to the time period defined by the Commissioning Data Set Submission Protocol being used.
CDS 150	Other Birth	Monthly	This includes Home Birth.	All Episodes that have finished relevant to the time period defined by the Commissioning Data Set Submission Protocol being used.
CDS 160	Other Delivery	Monthly	This includes Home Delivery.	All Episodes that have finished relevant to the time period defined by the Commissioning Data Set Submission Protocol being used.
CDS 170	The Detained and/or Long Term Psychiatric Census	Annually	Required by the NHS Digital. May optionally be sent more regularly, usually monthly.	Reflects data as at the 31st March each year. All Episodes that are relevant to the time period defined by the Commissioning Data Set Submission Protocol being used.
CDS 180	Unfinished Birth Episode	Annually	The Annual Census / Unfinished Census. Required by the NHS Digital. May optionally be sent more regularly, usually monthly.	Data relating to episodes that were unfinished as at midnight on 31st March and have not been included in the Detained and/or Long Term Psychiatric Census, and have not been submitted to the Secondary Uses Service in either Finished or Unfinished Commissioning Data Set data, must be submitted to the Secondary Uses Service.
CDS 190	Unfinished General Episode	Annually	The Annual Census / Unfinished Census. Required by the NHS Digital May optionally be sent more regularly, usually monthly. Unfinished General Episode Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	Data relating to episodes that were unfinished as at midnight on 31st March and have not been included in the Detained and/or Long Term Psychiatric Census, and have not been submitted to the Secondary Uses Service in either Finished or Unfinished Commissioning Data Set data, must be submitted to the Secondary Uses Service.
CDS 200	Unfinished Delivery Episode	Annually	The Annual Census / Unfinished Census. Required by the NHS Digital May optionally be sent more regularly, usually monthly.	Data relating to episodes that were unfinished as at midnight on 31st March and have not been included in the Detained and/or Long Term Psychiatric Census, and have not been submitted to the Secondary Uses Service in either Finished or Unfinished Commissioning Data Set data, must be submitted to the Secondary Uses Service.

COMMISSIONING DATA SET NOTATION

Change to Supporting Information: Changed Dataset

The Commissioning Data Set is the basic structure used for the submission of commissioning data to the Secondary Uses Service and is designed to be capable of individually conveying many different Commissioning Data Set structures, encompassing Accident and Emergency Attendances, Out-Patient Attendances, Admitted Patient Care and Elective Admission List.

The Commissioning Data Sets have been defined in specific components known as a CDS Type.

Specific notation is used to indicate the requirements of the Commissioning Data Set XML Schema Design conditions for submission of data in the Commissioning Data Sets.

The structure of the Commissioning Data Set XML Schema is shown by the use of Data Groups and Sub Groups within those Data Groups. For each Data Group, Sub Group and individual Data Element, the allowed cardinality at each level is also shown in the "Status" and "Repeats" columns.

The CDS Type specifications must therefore be read in this hierarchy, using the Status and Repeat conditions within the Data Groups and Sub Groups, to determine the requirements for the individual Data Elements.

Status Column Notation

The Notation used for the **"STATUS"** column is as follows:

STATUS	MEANING	DESCRIPTION
M	**MANDATORY**	This signifies that the collection and submission of this Commissioning Data Set data is deemed **MANDATORY** and its presence is necessary for the CDS Type to be correctly validated and accepted for processing by the Secondary Uses Service. If a data item is shown as **MANDATORY**, this should also be regarded as **REQUIRED** by the Department of Health. In most instances, data marked as **MANDATORY** in a Sub Group will result in its parent Data Group also being marked as mandatory, but this is not always the case. For instance, although the Consultant Episode - Clinical Diagnosis Group (ICD) is marked as **R=REQUIRED** (and therefore need not actually be populated), if it is used then both the DIAGNOSIS SCHEME IN USE and the PRIMARY DIAGNOSIS (ICD) are marked as **M=MANDATORY** and must both be present.
R	**REQUIRED**	This signifies that the collection and submission of this Commissioning Data Set data is deemed **REQUIRED** by the Department of Health to comply with authorised NHS Standards, Policies and Directives. Therefore whenever a Commissioning Data Set is collected and subsequently submitted to the Secondary Uses Service, this data must be supported and populated into the relevant data sets if the data is available. Note that "temporal" conditions may mean that there are instances where this directive cannot be fulfilled. For instance in a CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set, ICD and OPCS data elements are marked as "Required" indicating that this data should be included. However, if at the time of submission to the Secondary Uses Service this data remains incomplete (perhaps awaiting coding in the Organisation), the remaining data in the CDS record should still be submitted. Once the Organisation has updated its systems with the data, the CDS Type relating to that ACTIVITY should then be resubmitted to the Secondary Uses Service.
O	**OPTIONAL**	This signifies that the collection and submission of this Commissioning Data Set data is **OPTIONAL**. Its inclusion in the Commissioning Data Set is therefore determined by "local agreement" between the Organisations exchanging the data. Note that even if marked **O=OPTIONAL**, any data included in a Commissioning Data Set submission to the Secondary Uses Service must comply with its specification published in the NHS Data Model and Dictionary otherwise the data may be deemed invalid and rejected.
X	**X**	This is used where the Data Element name has been included in the Commissioning Data Set design, usually for pilot use, but is not yet authorised for transmission by the wider NHS. The Data Element will be in italics and not linked to the Data Element where one exists.

Repeats Column Notation

The Notation used for the **"REPEATS"** column is as follows:

REPEATS	DESCRIPTION
0..1	This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 0 to a maximum of 1.
0..9	This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 0 to a maximum of 9.
0..*	This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 0 to an unlimited maximum.
1..1	This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 1 to a maximum of 1.
1..97	This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 1 to a maximum of 97.
1..*	

	This signifies that the permitted occurrences of the Data Group, Sub Group or individual Data Element are from a minimum of 1 to an unlimited maximum.

Rules Column Notation

An entry in the **"Rules"** column shows that a specific Rule applies to submission of an individual Data Element.

The meaning of these Rules can be found in Commissioning Data Set Business Rules.

Notation Examples

The following are examples of some common scenarios.

EXAMPLE 1:
A MANDATORY Data Group with differing Sub-Groups and component data status conditions.

The following example shows a **MANDATORY** Data Group - therefore the Data Group must be present for the CDS Type to be validated and accepted for processing by the Secondary Uses Service.

When a Data Group is used:

1. All **MANDATORY** Sub Groups and/or Data Elements must be present
2. Any **REQUIRED** Sub Groups and/or Data Elements must be present if the data is available
3. Any **OPTIONAL** Sub Groups and/or Data Elements may be omitted

The following data structure is one of three options when completing the Patient Identity Data Group:

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

EXPLANATION:

The parent Data Group has a "Status" of **M=MANDATORY** which indicates that this Data Group must be present in the Commissioning Data Set to ensure correct validation and acceptance when submitted to the Secondary Uses Service. The parent Data Group "Repeats" = 1..1 indicates that only one occurrence of this Data Group must flow in this particular Commissioning Data Set record.

The Sub Group of "Local Identifier Structure" is marked as **R=REQUIRED** and therefore must be populated if the data is available. The "Repeats" notation of 0..1 indicates that population of this Sub Group is not necessary to enable the Commissioning Data Set record to be sent to the Secondary Uses Service. If it is sent, then only one occurrence of this Sub Group may flow in this particular Commissioning Data Set record.
Both Data Elements in the Sub Group are marked **M=MANDATORY** and must both be correctly populated.

The Sub Group of "Data Element Components" is a "generic" structure and is marked as **M=MANDATORY** and therefore must be populated. The "Repeats" notation of 1..1 indicates that only one occurrence of this Data Group may flow in this particular Commissioning Data Set record. All the Data Elements marked with **M=MANDATORY** must be populated. PERSON BIRTH DATE however is marked with **R=REQUIRED**, so must also be completed if the data is available.

EXAMPLE 2:
A REQUIRED Data Group with differing component data status conditions.

The following example shows a **REQUIRED** Data Group. This data must be present in the relevant Commissioning Data Set if available. However, if submitted to the Secondary Uses Service, omission of this **REQUIRED** Data Group will not cause rejection.

When the Data Group is used:

1. All **MANDATORY** Sub Groups and/or Data Elements must be utilised
2. Any **REQUIRED** Sub Groups and/or Data Elements must be present if the data is available
3. Any **OPTIONAL** Sub Groups and/or Data Elements may be omitted

Notation	**DATA GROUP: CONSULTANT EPISODE - CLINICAL DIAGNOSIS GROUP (ICD)**				
Group Status R	**Group Repeats 0..1**	**FUNCTION:** **To carry the details of the ICD coded Clinical Diagnoses.**			
M	**1..1**	**Data Element Components**			**Rules**
		M	**1..1**	PROCEDURE SCHEME IN USE	V

M	**1..1**	**DATA GROUP: PRIMARY DIAGNOSIS**			**Rules**
		M	**1..1**	PRIMARY DIAGNOSIS (ICD)	F H4
		O	0..1	PRESENT ON ADMISSION INDICATOR	F
O	0..*	**DATA GROUP: SECONDARY DIAGNOSIS**			**Rules**
		M	**1..1**	SECONDARY DIAGNOSIS (ICD)	F H4
		O	0..1	PRESENT ON ADMISSION INDICATOR	F

EXPLANATION:

The Data Group **"Status" = R = Required** indicates that this Data Group must be populated in the relevant Commissioning Data Set if the data is available. The Data Group **"Repeats" = 0..1** indicates that population of this Data Group is not necessary to enable the Commissioning Data Set to be sent to the Secondary Uses Service. If it is sent, then only one occurrence of this Data Group may flow in this particular Commissioning Data Set record.

If the Data Group is completed then the Data Element PROCEDURE SCHEME IN USE, marked as **M=MANDATORY**, must be populated. The **"Repeats"** notation of 1..1 indicates that only one occurrence of this Data Element is valid.

If the Data Group is completed then the Data Element PRIMARY DIAGNOSIS (ICD), marked as **M=MANDATORY**, must be populated. The **"Repeats"** notation of 1..1 indicates that only one occurrence of this Data Element is valid.

If the Data Group is completed then the Sub Group "Secondary Diagnoses", marked as **O=OPTIONAL**, may be omitted, but if populated it must be in the correct format. The **"Repeats"** notation of 0..* indicates that unlimited occurrences of this Data Element are valid. Each occurrence must contain a valid SECONDARY DIAGNOSIS (ICD)**.**

COMMISSIONING DATA SETS MENU

Change to Supporting Information: Changed Description

- CDS Overview
- CDS Version 6-2 Type List
- CDS Versions

- CDS Addressing Grid
- CDS Business Rules
- CDS Data Duplication
- CDS Mandated Data Flows
- CDS Notation
- CDS Submission and Organisation Mergers
- CDS Submission Protocol
- Referral To Treatment Clock Stop Administrative Event
- Security Issues and Patient Confidentiality

- **CDS XML Schema:**
- CDS XML Schema Overview
- CDS XML Schema Design
- CDS XML Schema Version Numbering
- CDS XML Schema Documentation
- XML Schema TRUD Download

XML Schema Constraints:
- CDS Version 6-2 XML Schema Constraints
- CDS Version 6-2-1 XML Schema Constraints

COMMISSIONING DATA SET VERSION 6-2 TYPE LIST

Change to Supporting Information: Changed Description

CDS Layout with CDS XML Schema Rules	Overview
~~**Accident and Emergency:**~~	
Emergency Care:	
CDS V6-2 Type 010 - Accident and Emergency CDS	CDS V6-2 Type 010 - Accident and Emergency CDS Overview
CDS V6-2-1 Type 011 - Emergency Care CDS	CDS V6-2-1 Type 011 - Emergency Care CDS Overview
Outpatient Care:	
CDS V6-2 Type 020 - Outpatient CDS	CDS V6-2 Type 020 - Outpatient CDS Overview
CDS V6-2 Type 021 - Future Outpatient CDS	CDS V6-2 Type 021 - Future Outpatient CDS Overview
Admitted Patient Care:	
CDS V6-2 Type 120 - Admitted Patient Care - Finished Birth Episode CDS	CDS V6-2 Type 120 - Admitted Patient Care - Finished Birth Episode CDS Overview
CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode CDS	

	CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode CDS Overview
CDS V6-2 Type 140 - Admitted Patient Care - Finished Delivery Episode CDS	CDS V6-2 Type 140 - Admitted Patient Care - Finished Delivery Episode CDS Overview
CDS V6-2 Type 150 - Admitted Patient Care - Other Birth Event CDS	CDS V6-2 Type 150 - Admitted Patient Care - Other Birth Event CDS Overview
CDS V6-2 Type 160 - Admitted Patient Care - Other Delivery Event CDS	CDS V6-2 Type 160 - Admitted Patient Care - Other Delivery Event CDS Overview
CDS V6-2 Type 170 - Admitted Patient Care - Detained and/or Long Term Psychiatric Census CDS	CDS V6-2 Type 170 - Admitted Patient Care - Detained and/or Long Term Psychiatric Census CDS Overview
CDS V6-2 Type 180 - Admitted Patient Care - Unfinished Birth Episode CDS	CDS V6-2 Type 180 - Admitted Patient Care - Unfinished Birth Episode CDS Overview
CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode CDS	CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode CDS Overview
CDS V6-2 Type 200 - Admitted Patient Care - Unfinished Delivery Episode CDS	CDS V6-2 Type 200 - Admitted Patient Care - Unfinished Delivery Episode CDS Overview
Elective Admission List - End Of Period Census Types:	
CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) CDS	CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) CDS Overview
CDS V6-2 Type 040 - Elective Admission List - End Of Period Census (Old) CDS	CDS V6-2 Type 040 - Elective Admission List - End Of Period Census (Old) CDS Overview
CDS V6-2 Type 050 - Elective Admission List - End Of Period Census (New) CDS	CDS V6-2 Type 050 - Elective Admission List - End Of Period Census (New) CDS Overview
Elective Admission List - Event During Period Types:	
CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) CDS	CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) CDS Overview
CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) CDS	CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) CDS Overview
CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) CDS	CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) CDS Overview
CDS V6-2 Type 090 - Elective Admission List - Event During Period (Available or Unavailable) CDS	CDS V6-2 Type 090 - Elective Admission List - Event During Period (Available or Unavailable) CDS Overview
CDS V6-2 Type 100 - Elective Admission List - Event During Period (Old Service Agreement) CDS	CDS V6-2 Type 100 - Elective Admission List - Event During Period (Old Service Agreement) CDS Overview
CDS V6-2 Type 110 - Elective Admission List - Event During Period (New Service Agreement) CDS	CDS V6-2 Type 110 - Elective Admission List - Event During Period (New Service Agreement) CDS Overview
Commissioning Data Set Interchange and Message Controls - Mandatory for every Interchange:	
CDS V6-2 Type 001 - CDS Interchange Header	CDS V6-2 Type 001 - CDS Interchange Header Overview
CDS V6-2 Type 002 - CDS Interchange Trailer	CDS V6-2 Type 002 - CDS Interchange Trailer Overview
CDS V6-2 Type 003 - CDS Message Header	CDS V6-2 Type 003 - CDS Message Header Overview
CDS V6-2 Type 004 - CDS Message Trailer	CDS V6-2 Type 004 - CDS Message Trailer Overview
CDS V6-2-1 Type 001 - CDS Interchange Header	CDS V6-2-1 Type 001 - CDS Interchange Header Overview
CDS V6-2-1 Type 002 - CDS Interchange Trailer	CDS V6-2-1 Type 002 - CDS Interchange Trailer Overview
CDS V6-2-1 Type 003 - CDS Message Header	CDS V6-2-1 Type 003 - CDS Message Header Overview
CDS V6-2-1 Type 004 - CDS Message Trailer	CDS V6-2-1 Type 004 - CDS Message Trailer Overview
Commissioning Data Set Transaction Header Group - Mandatory for every Commissioning Data Set:	
CDS V6-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol	CDS V6-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol Overview
or	
CDS V6-2 Type 005N - CDS Transaction Header Group - Net Change Protocol	CDS V6-2 Type 005N - CDS Transaction Header Group - Net Change Protocol Overview
CDS V6-2-1 Type 005B - CDS Transaction Header Group - Bulk Update Protocol	CDS V6-2-1 Type 005B - CDS Transaction Header Group - Bulk Update Protocol Overview
or	
CDS V6-2-1 Type 005N - CDS Transaction Header Group - Net Change Protocol	CDS V6-2-1 Type 005N - CDS Transaction Header Group - Net Change Protocol Overview

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COMMISSIONING DATA SET VERSIONS

Change to Supporting Information: Changed Description

Listed below are the Commissioning Data Set versions since 2001.

Current versions:

- ~~November 2012: CDS Version 6-2 Type List~~
- November 2012: CDS Version 6-2 Type List (updated October 2017 to support CDS Version 6-2-1)

Retired versions:

- November 2008: CDS Version 6-1 Type List
- December 2007 to November 2012: CDS Version 6-0
- April 2005 to March 2008: CDS Version NHS005 Type List
- April 2001 to March 2005: CDS Version NHS003 and 4 Type List

The XML Schemas and supporting information can be downloaded from Technology Reference Data Update Distribution (TRUD) at: NHS Data Model and Dictionary: DD XML Schemas.

EMERGENCY CARE ARRIVAL DATE

Change to Supporting Information: New Supporting Information

An Emergency Care Arrival Date is an ACTIVITY DATE TIME.

An Emergency Care Arrival Date may be either:

- the Arrival Date At Accident and Emergency Department or
- the Ambulatory Emergency Care Arrival Date.

This supporting information is also known by these names:

Context	Alias
plural	Emergency Care Arrival Dates

EMERGENCY CARE ARRIVAL TIME

Change to Supporting Information: New Supporting Information

An Arrival Time At Accident and Emergency Department is an ACTIVITY DATE TIME.

The Emergency Care Arrival Time may be either:

- the Arrival Time At Accident and Emergency Department or
- the Ambulatory Emergency Care Arrival Time.

This supporting information is also known by these names:

Context	Alias
plural	Emergency Care Arrival Times

EMERGENCY CARE ATTENDANCE

Change to Supporting Information: New Supporting Information

An Emergency Care Attendance is a CARE CONTACT.

An Emergency Care Attendance may be either:

- an Accident and Emergency Attendance or
- an Ambulatory Emergency Care Attendance.

This supporting information is also known by these names:

Context	Alias
plural	Emergency Care Attendances

EMERGENCY CARE ATTENDANCE CONCLUSION DATE

Change to Supporting Information: New Supporting Information

An Emergency Care Attendance Conclusion Date is an ACTIVITY DATE TIME.

The Emergency Care Attendance Conclusion Date may be either:

- the Accident and Emergency Attendance Conclusion Date or
- the Ambulatory Emergency Care Attendance Conclusion Date.

Where the PATIENT dies in the Emergency Care Department, the Emergency Care Attendance Conclusion Date is the same as the PERSON DEATH DATE.

This supporting information is also known by these names:

Context	Alias
plural	Emergency Care Attendance Conclusion Dates

EMERGENCY CARE ATTENDANCE CONCLUSION TIME

Change to Supporting Information: New Supporting Information

An Emergency Care Attendance Conclusion Time is an ACTIVITY DATE TIME.

The Emergency Care Attendance Conclusion Time may be either:

- the Accident and Emergency Attendance Conclusion Time or
- the Ambulatory Emergency Care Attendance Conclusion Time.

Where the PATIENT dies in the Emergency Care Department, the Emergency Care Attendance Conclusion Time is the same as the PERSON DEATH TIME.

This supporting information is also known by these names:

Context	Alias
plural	Emergency Care Attendance Conclusion Times

EMERGENCY CARE DATE SEEN FOR TREATMENT

Change to Supporting Information: New Supporting Information

An Emergency Care Date Seen For Treatment is an ACTIVITY DATE TIME.

The Emergency Care Date Seen For Treatment may be:

- the Accident and Emergency Date Seen For Treatment or
- the Ambulatory Emergency Care Date Seen For Treatment.

This supporting information is also known by these names:

Context	Alias
plural	Emergency Care Dates Seen For Treatment

EMERGENCY CARE DEPARTMENT

Change to Supporting Information: New Supporting Information

An Emergency Care Department is a Department.

An Emergency Care Department may be either:

- an Accident and Emergency Department or
- an Ambulatory Emergency Care Service.

This supporting information is also known by these names:

Context	Alias
plural	Emergency Care Departments

EMERGENCY CARE DEPARTURE DATE

Change to Supporting Information: New Supporting Information

An Emergency Care Departure Date is an ACTIVITY DATE TIME.

The Emergency Care Departure Date may be either:

- the Accident and Emergency Departure Date or
- the Ambulatory Emergency Care Departure Date.

This supporting information is also known by these names:

Context	Alias
plural	Emergency Care Departure Dates

EMERGENCY CARE DEPARTURE TIME

Change to Supporting Information: New Supporting Information

An Emergency Care Departure Time is an ACTIVITY DATE TIME.

The Emergency Care Departure Time may be either:

- the Accident and Emergency Departure Time or
- the Ambulatory Emergency Care Departure Time.

This supporting information is also known by these names:

Context	Alias
plural	Emergency Care Departure Times

EMERGENCY CARE INITIAL ASSESSMENT DATE

Change to Supporting Information: New Supporting Information

An Emergency Care Initial Assessment Date is an ACTIVITY DATE TIME.

The Emergency Care Initial Assessment Date may be either:

- the Accident and Emergency Initial Assessment Date or
- the Ambulatory Emergency Care Initial Assessment Date.

This supporting information is also known by these names:

Context	Alias
plural	Emergency Care Initial Assessment Dates

EMERGENCY CARE INITIAL ASSESSMENT TIME

Change to Supporting Information: New Supporting Information

An Emergency Care Initial Assessment Time is an ACTIVITY DATE TIME.

The Emergency Care Initial Assessment Time may be either:

- the Accident and Emergency Initial Assessment Time or
- the Ambulatory Emergency Care Initial Assessment Time.

This supporting information is also known by these names:

Context	Alias
plural	Emergency Care Initial Assessment Times

EMERGENCY CARE TIME SEEN FOR TREATMENT

Change to Supporting Information: New Supporting Information

An Emergency Care Time Seen For Treatment is an ACTIVITY DATE TIME.

The Emergency Care Time Seen For Treatment may be either:

- the Accident and Emergency Time Seen For Treatment or
- the Ambulatory Emergency Care Time Seen For Treatment.

This supporting information is also known by these names:

Context	Alias
plural	Emergency Care Times Seen For Treatment

INJURY DATE

Change to Supporting Information: New Supporting Information

An Injury Date is an ACTIVITY DATE TIME.

Injury Date is the DATE the PATIENT was injured. Where this information cannot be obtained directly from the PATIENT (or Patient Proxy), the Injury Date should be estimated.

This supporting information is also known by these names:

Context	Alias
plural	Injury Dates

INJURY TIME

Change to Supporting Information: New Supporting Information

An Injury Time is an ACTIVITY DATE TIME.

Injury Time is the TIME the PATIENT was injured. Where this information cannot be obtained directly from the PATIENT (or Patient Proxy), the Injury Time should be estimated.

This supporting information is also known by these names:

Context	Alias
plural	Injury Times

PROCEDURE TIME

Change to Supporting Information: New Supporting Information

Procedure Time is an ACTIVITY DATE TIME.

Procedure Time is the TIME of the Patient Procedure.

This supporting information is also known by these names:

Context	Alias
plural	Procedure Times

REFERENCED ORGANISATIONS MENU

Change to Supporting Information: Changed Description

- NHS Business Definitions
- Organisations
- Regulatory Bodies

- ~~**Referenced Organisations:**~~
  - ~~American Joint Committee on Cancer~~
  - ~~British Association for Paediatric Nephrology~~
  - ~~British HIV Association~~
  - ~~British Psychological Society~~

    - ~~British Renal Society~~
    - ~~British Transplantation Society~~
    - ~~Burden Advice and Assessment Service~~
    - ~~Care Quality Commission~~
    - ~~Children's Cancer and Leukaemia Group~~
    - ~~Community Health Partnership (Scotland)~~
    - ~~Community Safety Partnership~~
    - ~~Department for Education~~
    - ~~Department for Work and Pensions~~
    - ~~Department for Work and Pensions Overseas Healthcare Team~~
    - ~~Department of Health~~
    - ~~European Renal Association~~
    - ~~Faculty of General Dental Practice (UK)~~
    - ~~GS1~~
    - ~~Health and Wellbeing Board~~
    - ~~Health Education England~~
    - ~~Health Research Authority~~
    - ~~Healthcare Quality Improvement Partnership~~
    - ~~Healthwatch England~~
    - ~~Human Tissue Authority~~
    - ~~Improving Access to Psychological Therapies Programme~~
    - ~~Information Standards Board for Health and Social Care~~
    - ~~International Commission on Radiation Units and Measurements~~
    - ~~International Federation of Gynecology and Obstetrics~~
    - ~~International Health Terminology Standards Development Organisation~~
    - ~~International Society of Paediatric Oncology~~
    - ~~Local Health Board (Wales)~~
    - ~~Local Healthwatch~~
    - ~~Medicines and Healthcare Products Regulatory Agency~~
    - ~~National Cancer Registration and Analysis Service~~
    - ~~National Casemix Office~~
    - ~~National Contact Point~~
    - ~~National Commissioning Group~~
    - ~~National Information Board~~
    - ~~National Institute for Health and Care Excellence~~
    - ~~National Joint Registry~~
    - ~~National Kidney Federation~~
    - ~~National Specialised Commissioning Group~~
    - ~~Neonatal Data Analysis Unit~~
    - ~~NHS Business Services Authority~~
    - ~~NHS Dental Services~~
    - ~~NHS Digital~~
    - ~~NHS England~~
    - ~~NHS Improvement~~
    - ~~NHS Prescription Services~~
    - ~~NHS Wales Informatics Service~~
    - ~~Northern Ireland Local Commissioning Group~~
    - ~~Office for National Statistics~~
    - ~~Ofsted~~
    - ~~Public Health England~~
    - ~~Royal College of General Practitioners~~
    - ~~Royal College of Psychiatrists~~
    - ~~Royal College of Pathologists~~
    - ~~Royal Pharmaceutical Society~~
    - ~~Standardisation Committee for Care Information~~
    - ~~Sustainable Development Unit~~
    - ~~The Renal Association~~
    - ~~The Royal Marsden~~
    - ~~UK National Screening Committee~~
    - ~~UK Renal Registry~~
    - ~~UK Terminology Centre~~
    - ~~Union for International Cancer Control~~
    - ~~United Kingdom and Ireland Association of Cancer Registries~~
    - ~~World Health Organisation~~
- **Referenced Organisations:**
    - American Joint Committee on Cancer
    - British Association for Paediatric Nephrology
    - British HIV Association
    - British Psychological Society
    - British Renal Society
    - British Transplantation Society
    - Burden Advice and Assessment Service
    - Care Quality Commission

- Children's Cancer and Leukaemia Group
- Community Health Partnership (Scotland)
- Community Safety Partnership
- Department for Education
- Department for Work and Pensions
- Department for Work and Pensions Overseas Healthcare Team
- Department of Health
- European Renal Association
- Faculty of General Dental Practice (UK)
- GS1
- Health and Wellbeing Board
- Health Education England
- Health Research Authority
- Healthcare Quality Improvement Partnership
- Healthwatch England
- Human Tissue Authority
- Improving Access to Psychological Therapies Programme
- Information Standards Board for Health and Social Care
- International Commission on Radiation Units and Measurements
- International Federation of Gynecology and Obstetrics
- International Health Terminology Standards Development Organisation
- International Society of Paediatric Oncology
- Local Health Board (Wales)
- Local Healthwatch
- Medicines and Healthcare Products Regulatory Agency
- National Cancer Registration and Analysis Service
- National Casemix Office
- National Contact Point
- National Commissioning Group
- National Information Board
- National Institute for Health and Care Excellence
- National Joint Registry
- National Kidney Federation
- National Specialised Commissioning Group
- Neonatal Data Analysis Unit
- NHS Business Services Authority
- NHS Dental Services
- NHS Digital
- NHS England
- NHS Improvement
- NHS Prescription Services
- NHS Wales Informatics Service
- Northern Ireland Local Commissioning Group
- Office for National Statistics
- Ofsted
- Public Health England
- Royal College of Emergency Medicine
- Royal College of General Practitioners
- Royal College of Psychiatrists
- Royal College of Pathologists
- Royal Pharmaceutical Society
- Standardisation Committee for Care Information
- Sustainable Development Unit
- The Renal Association
- The Royal Marsden
- UK National Screening Committee
- UK Renal Registry
- UK Terminology Centre
- Union for International Cancer Control
- United Kingdom and Ireland Association of Cancer Registries
- World Health Organisation

REFERRED TO SERVICE ASSESSMENT DATE

Change to Supporting Information: New Supporting Information

A Referred To Service Assessment Date is an ACTIVITY DATE TIME.

A Referred To Service Assessment Date is the date that a CARE PROFESSIONAL from a SERVICE which a PATIENT has been referred to, assesses the PATIENT.

This supporting information is also known by these names:

Context	Alias
plural	Referred To Service Assessment Dates

REFERRED TO SERVICE ASSESSMENT TIME

Change to Supporting Information: New Supporting Information

A Referred To Service Assessment Time is an ACTIVITY DATE TIME.

A Referred To Service Assessment Time is the time that a CARE PROFESSIONAL from a SERVICE which a PATIENT has been referred to, assesses the PATIENT.

This supporting information is also known by these names:

Context	Alias
plural	Referred To Service Assessment Times

ROYAL COLLEGE OF EMERGENCY MEDICINE

Change to Supporting Information: New Supporting Information

The Royal College of Emergency Medicine (RCEM) is an Organisation.

The Royal College of Emergency Medicine works to ensure high quality care for PATIENTS by setting and monitoring standards of care in Emergency Care Departments, as well as providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine.

For further information on the Royal College of Emergency Medicine, see the Royal College of Emergency Medicine website.

This supporting information is also known by these names:

Context	Alias
shortname	RCEM

SECONDARY USES SERVICE

Change to Supporting Information: Changed Dataset

The Secondary Uses Service is designed to provide anonymous PATIENT-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.

The NHS Digital Secondary Uses Service has overall responsibility for delivering the Secondary Uses Service to users, Commissioners and Providers of NHS funded care.

The Secondary Uses Service provides a consistent environment for the management and linkage of data, allowing better comparison of data across the care sector, together with associated analysis and reporting tools.

Further information about the Secondary Uses Service can be found on the Secondary Uses Service website.

XML SCHEMA TRUD DOWNLOAD

Change to Supporting Information: Changed Description, 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 Welcome to the Technology Reference data Update Distribution site (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)
- Children and Young People's Health Services Data Set (CYPHS)
- ~~Commissioning Data Set (CDS)~~
- Commissioning Data Set (CDS) V6-2
- CDS V6-2-1 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)~~
- ~~NHS Health Checks Data Set (NHSHC)~~
- ~~Systemic Anti-Cancer Therapy Data Set (SACT)~~
- 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)
- NHS Health Checks Data Set (NHSHC)
- Systemic Anti-Cancer Therapy Data Set (SACT)

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.

ACTIVITY GROUP

Change to Class: Changed Attributes

Attributes of this Class are:

A and E INCIDENT LOCATION TYPE
A and E PATIENT GROUP
ACTIVITY GROUP TYPE
ADMISSION METHOD
ASSAULT METHOD
BABY FIRST FEED BREAST MILK STATUS
BREASTFEEDING STATUS
CANCER OR SYMPTOMATIC BREAST REFERRAL PATIENT STATUS
CANCER REFERRAL TO TREATMENT PERIOD START DATE
CANCER SCREENING STATUS
CANCER TREATMENT INTENT
CANCER TREATMENT PERIOD START DATE
CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR
CARER RESIDENT INDICATION CODE FOR NATIONAL NEONATAL DATA SET
CHILDREN TEENAGERS AND YOUNG ADULTS AGE CATEGORY
COMMUNITY TREATMENT ORDER END REASON
COMPLEX SOCIAL FACTORS INDICATOR
DAUGHTER BORN AT THIS ENCOUNTER INDICATOR
DELIVERY PLACE CHANGE REASON
DISCHARGE DESTINATION
DISCHARGED TO HOSPITAL AT HOME SERVICE INDICATOR
DISCHARGE METHOD
EMERGENCY CARE ATTENDANCE CATEGORY
ESTIMATED DATE OF DELIVERY
ESTIMATED DATE OF DELIVERY METHOD
FEMALE GENITAL MUTILATION AGE CATEGORY
FIRST REGULAR DAY OR NIGHT ADMISSION
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES CARE SPELL END CODE
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES OPT IN DATE
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED CARE INTENSITY DELIVERED
IN LABOUR BEFORE CAESARIAN SECTION INDICATOR
INTENDED DELIVERY PLACE
INTRAVESICAL CHEMOTHERAPY RECEIVED INDICATOR

INTRAVESICAL IMMUNOTHERAPY RECEIVED INDICATOR
KEY WORKER SEEN INDICATOR
LENGTH OF STAY ADJUSTMENT
LENGTH OF STAY ADJUSTMENT REASON
MATERNAL CRITICAL INCIDENT TYPE
MECONIUM PRESENT IN LIQUOR INDICATOR
MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY
MENTAL HEALTH CONDITIONAL DISCHARGE END REASON
MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE
MENTAL HEALTH DELAYED DISCHARGE REASON
MONITORING INTENT
MOTHER ANTENATALLY BOOKED INDICATOR
NEONATAL CRITICAL INCIDENT TYPE
NEONATAL LEVEL OF CARE
NON SMOKING CONFIRMATION STATUS AT 4 WEEKS
ORGAN OR TISSUE UNSUITABLE ORGAN CODE RENAL TRANSPLANT
OUTCOME AT 4 WEEK FOLLOW-UP
PAEDIATRIC NEPHROLOGY REGISTRY STATUS CODE
PALLIATIVE CARE SPECIALIST SEEN INDICATOR
PALLIATIVE TREATMENT REASON CODE FOR UPPER GASTROINTESTINAL
PATIENT CLASSIFICATION
PATIENT RECEIVING ONE TO ONE NURSING CARE INDICATOR
PHARMACOTHERAPY STOP SMOKING AID RECEIVED
PREGNANCY OUTCOME CODE
PREGNANCY PREVIOUS CAESAREAN SECTIONS
PREGNANCY TOTAL LIVE BIRTHS
PREGNANCY TOTAL PREVIOUS LOSSES LESS THAN 24 WEEKS
PREGNANCY TOTAL PREVIOUS PREGNANCIES
PREGNANCY TOTAL STILL BIRTHS
PREVIOUS NEGATIVE HIV TEST INDICATOR
RADIOTHERAPY INTENT
RENAL DIALYSIS SCHEDULE TYPE
SMOKING QUIT DATE
SOURCE OF ADMISSION
TIME BETWEEN DELIVERY AND SPONTANEOUS RESPIRATION CODE
TREATMENT START DATE FOR CANCER

ADDRESS STRUCTURED

Change to Class: Changed Dataset

A subtype of ADDRESS.

An ADDRESS comprised of address elements.

Address elements correspond to the Royal Mail Postal Address File unless indicated otherwise.

ADDRESS UNSTRUCTURED

Change to Class: Changed Dataset

A subtype of ADDRESS.

A recognizable postal address comprised of up to five lines of 35 alphanumeric characters.

Note: the format relates to the physical layout, and not necessarily to the logical layout of the address.

CARE PROFESSIONAL

Change to Class: Changed Attributes

Attributes of this Class are:

K CARE PROFESSIONAL IDENTIFIER
CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR FOR EMERGENCY CARE
CARE PROFESSIONAL FIRST ASSISTANT GRADE FOR JOINT REPLACEMENT
CARE PROFESSIONAL LEAD OPERATING SURGEON GRADE FOR JOINT REPLACEMENT
CARE PROFESSIONAL OPERATING SURGEON TYPE FOR CANCER
CARE PROFESSIONAL RETRIEVING SURGEON GRADE
CARE PROFESSIONAL SENIOR OPERATING SURGEON GRADE FOR CANCER

CARE PROFESSIONAL STAFF GROUP FOR COMMUNITY CARE
CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH
CARE PROFESSIONAL TIER FOR EMERGENCY CARE
CARE PROFESSIONAL TYPE CODE
CARE PROFESSIONAL TYPE FOR HIV
JOB ROLE CLINICIAN TYPE FOR ORGAN DONATION
PRIVATE CONTROLLED DRUG PRESCRIBER CODE
REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH AND COMMUNITY CARE

CODED CLINICAL ENTRY

Change to Class: Changed Attributes

Attributes of this Class are:

CLINICAL CLASSIFICATION CODE
CLINICAL TERMINOLOGY CODE
CODED CLINICAL ENTRY SEQUENCE NUMBER
DEATH CAUSE CODE FOR EUROPEAN DIALYSIS AND TRANSPLANT ASSOCIATION
EUROPEAN RENAL ASSOCIATION CODE
SNOMED VERSION

DECISION TO ADMIT

Change to Class: Changed Attributes

Attributes of this Class are:

K	DECIDED TO ADMIT DATE
K	DECIDED TO ADMIT TIME

ORGANISATION

Change to Class: Changed Attributes

Attributes of this Class are:

K	ORGANISATION IDENTIFIER
	ACCIDENT AND EMERGENCY DEPARTMENT TYPE
	DEPARTMENT CODE
	DEPARTMENT TYPE FOR KH12
	EMERGENCY CARE DEPARTMENT TYPE
	LABORATORY CODE
	LABORATORY NAME
	ONS ORGANISATION IDENTIFIER
	ORGANISATION CODE
	ORGANISATION IDENTIFIER FOR NATIONAL BREAST SCREENING PROGRAMME
	ORGANISATION NAME
	ORGANISATION SITE CODE
	ORGANISATION SITE NAME
	ORGANISATION TYPE FOR WORKFORCE

OVERSEAS VISITOR STATUS

Change to Class: Changed Attributes

Attributes of this Class are:

K	OVERSEAS VISITOR STATUS START DATE
	OVERSEAS VISITOR CHARGING CATEGORY
	OVERSEAS VISITOR EXEMPT CATEGORY
	OVERSEAS VISITOR STATUS CLASSIFICATION
	OVERSEAS VISITOR STATUS END DATE

PERSON NAME STRUCTURED

Change to Class: Changed Dataset

A subtype of PERSON NAME.

A full name comprised of one or more separate PERSON NAMES in sequence.

The PERSON NAME must contain at least one PERSON NAME of the type 'Person Family Name'.

PERSON NAME UNSTRUCTURED

Change to Class: Changed Dataset

A subtype of PERSON NAME.

The full name of a PERSON expressed as a single textual record.

SERVICE REQUEST

Change to Class: Changed Attributes

Attributes of this Class are:

K	SERVICE REQUEST IDENTIFIER
	ACTIVITY SERVICE REQUEST DATE
	ACTIVITY SERVICE REQUEST TIME
	CLINICAL RESPONSE PRIORITY TYPE
	DIAGNOSTIC SERVICE REQUEST TYPE
	DIRECT ACCESS REFERRAL INDICATOR
	ONWARD REFERRAL REASON
	ORIGINAL REFERRAL REQUEST RECEIVED DATE
	REASON FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH
	REFERRAL REQUEST RECEIVED DATE
	~~REFERRED OUT OF AREA REASON FOR ADULT ACUTE MENTAL HEALTH~~
	SERVICE REQUEST ACCEPTANCE INDICATOR
	SERVICE REQUEST DATE
	SERVICE REQUEST RAISED REASON

ACTIVITY DATE

Change to Attribute: Changed Dataset

Any DATE that is of relevance to an ACTIVITY.

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

ACTIVITY DATE TYPE

Change to Attribute: Changed Description

The type of date that defines the usage with regard to the ACTIVITY.

An ACTIVITY may have many dates associated with it but may only have one date of a particular type.

National Codes:

001	Angiogram Date (Retired July 2012)
002	Arrival Date At Accident and Emergency Department
003	Breast Assessment Date (Retired 1 January 2013)
004	Cancer Dental Assessment Date
005	Colorectal or Stoma Nurse Seen Date (Retired 1 January 2013)
006	Coronary Angiography Date (Retired July 2012)
007	Care Programme Approach Review Date
008	Date Biopsy Taken (Retired 01 April 2014)
009	Discharge Date
010	Discharge Ready Date
011	End Date
012	Event Date (Retired July 2012)
013	Expected Delivery Date (Retired September 2012)
014	First Antenatal Assessment Date
015	Full Postnatal Examination Date (Retired September 2012)
016	Initial Patient Contact Date (Retired July 2012)
017	Investigation Transfer Date (Retired July 2012)
018	Intrauterine Device Application Date (Retired September 2012)
019	Intrauterine Device Fitted Date (Retired September 2012)
020	Last Dosage Date
021	Mental Health Care Assessment Date (Retired September 2012)
022	Miscarriage Date (Retired September 2012)
023	Pathology Result Due Date

024 Patient Informed Biopsy Result Date
025 Patient Informed Of Outcome Date (Retired September 2012)
026 Smoking Quit Date
027 Review Planned Date (Retired 01 April 2014)
028 Screening Result Date (Retired 01 April 2014)
029 Screening Result Sent Date
030 Specialist Palliative Care Date (Retired 01 April 2014)
031 Start Date
032 Cancer Symptoms First Noted Date
033 Attendance Date
034 Clinical Intervention Date
035 Immunisation Completion Date (Retired 01 September 2015)
036 Clinical Status Assessment Date
037 Dose Given Date (Retired September 2012)
038 Test Date (Retired September 2012)
039 Contact Date
040 Appointment Date
041 Primary Procedure Date
042 Second Operation Date (Retired 01 April 2014)
043 Speech and Language Assessment Date
044 Third Operation Date (Retired 01 April 2014)
045 Date First Seen
046 Statutory Assessment Date (Retired 01 January 2016)
047 Screening Test Date
048 Genitourinary Care Contact Date (Retired January 2014)
049 Consultant Upgrade Date
101 Referral Closure Date (Community Care) (Retired 01 September 2015)
102 Discharge Letter Issued Date (Community Care) (Retired 01 September 2015)
103 Systemic Anti-Cancer Therapy Administration Date
104 Procedure Date
105 Immunisation Date
106 Antenatal Appointment Date
107 Antenatal Booking Appointment Date
108 Pregnancy First Contact Date
109 Screening Test Information Given Date
110 Assessment Date For Transplant Suitability
111 Accident and Emergency Initial Assessment Date
112 Accident and Emergency Date Seen For Treatment
113 Accident and Emergency Attendance Conclusion Date
114 Accident and Emergency Departure Date
115 Clinical Assessment Date
116 Imaging or Radiodiagnostic Event Date
117 Neonatal Critical Care Daily Care Date
118 Two Year Neonatal Outcomes Assessment Date
119 Date of Pregnancy Outcome (Current Fetus)
120 Neonatal Critical Incident Date
121 American Joint Committee on Cancer Stage Date
122 Ann Arbor Stage Date
123 Barcelona Clinic Liver Cancer Stage Date
124 Binet Stage Date
125 Chang Staging System Stage Date
126 Clinical Stage Date (Pancreatic Cancer)
127 Final Figo Stage Date
128 Holistic Needs Assessment Completed Date
129 Intergroup Rhabdomyosarcoma Study Post Surgical Group Date
130 International Neuroblastoma Staging System Date (Retired 01 April 2017)
131 Myeloma International Staging System Stage Date
132 Modified Dukes Stage Date
133 Multidisciplinary Team Discussion Date (Cancer)
134 Multidisciplinary Team Meeting Date (Cancer)
135 Murphy St Jude Stage Date
136 Rai Stage Date (Retired 01 April 2017)
137 Retinoblastoma Assessment Date
138 TNM Stage Grouping Date (Final Pretreatment)
139 TNM Stage Grouping Date (Integrated)
140 Wilms Tumour Stage Date
141 Care Contact Cancellation Date
142 Care Contact Date
143 Child Protection Plan End Date
144 Child Protection Plan Start Date
145 Discharge Letter Issued Date (Mental Health and Community Care)
146 Health Visitor First Antenatal Visit Date
147 Infant Physical Examination Date
148 Onward Referral Date
149 Referral Closure Date

150 Referral Rejection Date
151 Replacement Appointment Booked Date
152 Replacement Appointment Date Offered
153 Service Discharge Date
154 Date of Restrictive Intervention
155 Indirect Activity Date
156 Mental Health Crisis Plan Creation Date (Retired 01 April 2017)
157 Mental Health Crisis Plan Last Updated Date (Retired 01 April 2017)
158 Care Plan Agreed Date
159 Care Plan Creation Date
160 Care Plan Implementation Date
161 Care Plan Last Updated Date
162 Five Forensic Pathways Assessment Date
163 International Neuroblastoma Risk Group Staging System Stage Date
164 Stage Grouping Date (Testicular Cancer)
??? Emergency Care Arrival Date
??? Emergency Care Initial Assessment Date
??? Emergency Care Date Seen For Treatment
??? Emergency Care Attendance Conclusion Date
??? Emergency Care Departure Date
??? Injury Date
??? Referred To Service Assessment Date

Note: This 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 SERVICE REQUEST DATE

Change to Attribute: New Attribute

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

This attribute is also known by these names:

Context	Alias
plural	ACTIVITY SERVICE REQUEST DATES

ACTIVITY SERVICE REQUEST DATE

Change to Attribute: New Attribute

ACTIVITY SERVICE REQUEST DATE

Data Elements:

ACTIVITY SERVICE REQUEST DATE (EMERGENCY CARE)

ACTIVITY SERVICE REQUEST TIME

Change to Attribute: New Attribute

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

This attribute is also known by these names:

Context	Alias
plural	ACTIVITY SERVICE REQUEST TIMES

ACTIVITY SERVICE REQUEST TIME

Change to Attribute: New Attribute

ACTIVITY SERVICE REQUEST TIME

Data Elements:

ACTIVITY SERVICE REQUEST TIME (EMERGENCY CARE)

ACTIVITY TIME

Change to Attribute: Changed Dataset

Any TIME that is of relevance to an ACTIVITY.

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

ACTIVITY TIME TYPE

Change to Attribute: Changed Description

The type of TIME that defines the usage with regard to the ACTIVITY.

An ACTIVITY may have many TIMES associated with it but may only have one TIME of a particular type.

National Codes:

50	Accident and Emergency Attendance Conclusion Time
51	Accident and Emergency Departure Time
52	Accident and Emergency Initial Assessment Time
53	Accident and Emergency Time Seen For Treatment
54	Arrival At Hospital Time (Retired April 2012)
55	ARRIVAL TIME (Retired April 2012)
56	End Time
57	Event Time (Retired July 2012)
58	Initial Patient Contact Time (Retired July 2012)
59	Last Dosage Time
60	Pathology Result Due Time
61	Start Time
62	Theatre Case Time In To Theatre Suite (Retired September 2012)
63	Theatre Case Time Out Of Theatre (Retired September 2012)
64	Theatre Case Time Out Of Theatre Suite (Retired September 2012)
65	Time Seen
66	Discharge Ready Time (Retired April 2012)
67	Arrival Time At Accident and Emergency Department
68	Arrival Time For Transport Requests (Retired September 2015)
69	Discharge Time
70	Clinical Intervention Time
71	Care Contact Time
72	Indirect Activity Time
73	Service Discharge Time
74	Referral Closure Time
75	Onward Referral Time
??	Emergency Care Arrival Time
??	Emergency Care Initial Assessment Time
??	Emergency Care Time Seen For Treatment
??	Emergency Care Attendance Conclusion Time
??	Emergency Care Departure Time
??	Injury Time
??	Referred To Service Assessment Time
??	Procedure Time

Note: This list is not in alphabetical order.

CARE CONTACT TYPE

Change to Attribute: Changed Description

The type of CARE CONTACT.

National Codes:

01	Accident and Emergency Attendance
02	Acute Home-Based Contact (Retired 01 January 2016)
03	Audiology Attendance (Retired 01 April 2014)
04	Cancer Clinical Status Assessment

05	Care Programme Approach Review
06	Clinic Attendance Consultant
07	Clinic Attendance Sexual and Reproductive Health Service (Retired November 2014)
08	Clinic Attendance Midwife
09	Clinic Attendance Non-Consultant
10	Clinic Attendance Nurse
11	Contact Tracing Activity (Retired 01 April 2014)
12	Dental Treatment Contact (Retired 01 April 2014)
13	Day Care Attendance (Retired 01 January 2016)
14	Domiciliary Consultation
15	Emergency Dental Attendance (Retired 01 April 2014)
16	Face To Face Contact Community Care (Retired 01 January 2016)
17	Face To Face Contact CPA Care Coordinator (Retired 01 January 2016)
18	Face To Face Contact Dental (Retired 01 April 2014)
19	Face To Face Contact Optical (Retired 01 April 2014)
20	Face To Face Contact Social Worker (Retired 01 April 2011)
21	Face To Face Contact Surveillance (Retired 01 April 2014)
22	Sexual and Reproductive Health Domiciliary Visit
23	Genitourinary Consultant Clinic Attendance
24	GMP Consultation (Retired 01 April 2014)
25	GMP Practice Consultation (Retired 01 April 2014)
26	Home Assessment Visit (Retired 01 January 2016)
27	Maternity Domiciliary Visit
28	Night Consultation Visit (Retired 01 April 2014)
29	Nurse or Midwife Contact
30	Out-Patient Attendance Consultant
31	Registration Health Check (Retired 01 April 2014)
32	Sheltered Work Attendance (Retired 01 April 2011)
33	Sight Test (Retired 01 April 2014)
34	Social Services Statutory Assessment (Retired 01 January 2016)
35	Professional Advice And Support Contact (Retired 01 April 2014)
36	Professional Staff Group Contact (Retired 01 January 2016)
37	Telephone Contact NHS Direct (Mental Health) (Retired 01 April 2011)
38	Theatre Case
39	Ward Attendance
40	Genitourinary Care Contact (Retired January 2014)
41	Improving Access to Psychological Therapies Contact
42	NHS Health Check Assessment
43	Antenatal Booking Appointment
44	Pregnancy First Contact
45	Nutritional Assessment
46	HIV Clinic Attendance
47	Multi-Disciplinary Consultation (National Tariff Payment System)
48	Multi-Professional Consultation (National Tariff Payment System)
49	Two Year Neonatal Outcomes Assessment
50	Radiotherapy Attendance
51	Holistic Needs Assessment
??	Emergency Care Attendance

Note: The list is not in alphabetical order.

CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR FOR EMERGENCY CARE

Change to Attribute: New Attribute

An indication of whether a CARE PROFESSIONAL is responsible for discharge of the PATIENT from an Emergency Care Attendance.

National Codes:

Y	Yes - the CARE PROFESSIONAL is responsible for discharge of the PATIENT
N	No - the CARE PROFESSIONAL is not responsible for discharge of the PATIENT

This attribute is also known by these names:

Context	Alias
plural	CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATORS FOR EMERGENCY CARE

CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR FOR EMERGENCY CARE

Change to Attribute: New Attribute

CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR FOR EMERGENCY CARE

Data Elements:

CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR (EMERGENCY CARE)

CARE PROFESSIONAL TIER FOR EMERGENCY CARE

Change to Attribute: New Attribute

The tier of CARE PROFESSIONAL treating the PATIENT during an Emergency Care Attendance.

The CARE PROFESSIONAL TIERS FOR EMERGENCY CARE are defined in the Royal College of Emergency Medicine Guidelines for Medical and Practitioner Staffing in Emergency Departments. See the Royal College of Emergency Medicine website at Medical and Practitioner Workforce Guidance.

National Codes:

01	Require complete supervision. All PATIENTS must be signed off by a senior CARE PROFESSIONAL before admission or discharge
02	Require access to advice or direct supervision, or practice independently but with limited scope
03	More senior/experienced CARE PROFESSIONALS, requiring less direct supervision. Fewer limitations in scope of practice
04	Senior CARE PROFESSIONALS able to supervise an Emergency Care Department alone with remote support. Possess some extended skills. Full scope of practice
05	Senior CARE PROFESSIONALS (CONSULTANTS) with accredited advanced qualifications in Emergency Medicine. Full set of extended skills. Full scope of practice

This attribute is also known by these names:

Context	Alias
plural	CARE PROFESSIONAL TIERS FOR EMERGENCY CARE

CARE PROFESSIONAL TIER FOR EMERGENCY CARE

Change to Attribute: New Attribute

CARE PROFESSIONAL TIER FOR EMERGENCY CARE

Data Elements:

CARE PROFESSIONAL TIER (EMERGENCY CARE)

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.

CLINICAL TRIAL IDENTIFIER

Change to Attribute: Changed Description, Dataset

~~A number allocated to provide a unique identifier for each CLINICAL TRIAL.~~A unique identifier assigned to a CLINICAL TRIAL.

CODED CLINICAL ENTRY SEQUENCE NUMBER

Change to Attribute: New Attribute

The sequence number of a CODED CLINICAL ENTRY, recorded to enable correct sequential processing of data.

This attribute is also known by these names:

Context	Alias
plural	CODED CLINICAL ENTRY SEQUENCE NUMBERS

CODED CLINICAL ENTRY SEQUENCE NUMBER

Change to Attribute: New Attribute

CODED CLINICAL ENTRY SEQUENCE NUMBER

Data Elements:

CODED CLINICAL ENTRY SEQUENCE NUMBER

COMMISSIONER REFERENCE NUMBER

Change to Attribute: Changed Dataset

A number (alphanumeric) allocated by the commissioner to a REFERRAL REQUEST.

DECIDED TO ADMIT DATE

Change to Attribute: Changed Dataset

The date a DECISION TO ADMIT was made.

DECIDED TO ADMIT TIME

Change to Attribute: New Attribute

The time a DECISION TO ADMIT was made.

This attribute is also known by these names:

Context	Alias
plural	DECIDED TO ADMIT TIMES

DECIDED TO ADMIT TIME

Change to Attribute: New Attribute

DECIDED TO ADMIT TIME

Data Elements:

DECIDED TO ADMIT TIME

EMERGENCY CARE ATTENDANCE CATEGORY

Change to Attribute: New Attribute

The category of Emergency Care Attendance.

National Codes:

1 Unplanned First Emergency Care Attendance for a new clinical condition (or deterioration of a chronic condition).
2 Unplanned Follow-up Emergency Care Attendance for the same or a related clinical condition and within 7 days of the First Emergency Care Attendance at **THIS** Emergency Care Department
3 Unplanned Follow-up Emergency Care Attendance for the same or a related clinical condition and within 7 days of the First Emergency Care Attendance at **ANOTHER** Emergency Care Department
4 Planned Follow-up Emergency Care Attendance within 7 days of the First Emergency Care Attendance at **THIS** Emergency Care Department

This attribute is also known by these names:

Context	Alias
plural	EMERGENCY CARE ATTENDANCE CATEGORIES

EMERGENCY CARE ATTENDANCE CATEGORY

Change to Attribute: New Attribute

EMERGENCY CARE ATTENDANCE CATEGORY

Data Elements:

EMERGENCY CARE ATTENDANCE CATEGORY

EMERGENCY CARE DEPARTMENT TYPE

Change to Attribute: New Attribute

The type of Emergency Care Department.

National Codes:

01	Emergency departments are a CONSULTANT led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency PATIENTS
02	Consultant led mono specialty accident and emergency service (e.g. ophthalmology, dental) with designated accommodation for the reception of PATIENTS
03	Other type of A&E/minor injury ACTIVITY with designated accommodation for the reception of accident and emergency PATIENTS. The department may be doctor led or NURSE led and treats at least minor injuries and illnesses and can be routinely accessed without APPOINTMENT. A SERVICE mainly or entirely APPOINTMENT based (for example a GP Practice or Out-Patient Clinic) is excluded even though it may treat a number of PATIENTS with minor illness or injury. Excludes NHS walk-in centres
04	NHS walk in centres
05	Ambulatory Emergency Care Service *

* Note that National Code 05 is only valid for piloting purposes in the CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set and must not be submitted in the CDS V6-2 Type 010 - Accident and Emergency Commissioning Data Set.

This attribute is also known by these names:

Context	Alias
plural	EMERGENCY CARE DEPARTMENT TYPES

EMERGENCY CARE DEPARTMENT TYPE

Change to Attribute: New Attribute

EMERGENCY CARE DEPARTMENT TYPE

Data Elements:

EMERGENCY CARE DEPARTMENT TYPE

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.

GENERAL MEDICAL PRACTITIONER PPD CODE

Change to Attribute: Changed Dataset

This is the NHS Prescription Services code to identify a GENERAL MEDICAL PRACTITIONER.

The DOCTOR INDEX NUMBER is passed to the NHS Prescription Services, which adds a leading character and a check digit to create the GENERAL MEDICAL PRACTITIONER PPD CODE. NHS Prescription Services use this for the issue of prescription pads etc.

For England and Wales, in addition to a GENERAL MEDICAL PRACTITIONER PPD CODE, a GENERAL MEDICAL PRACTITIONER may have one or more spurious GENERAL MEDICAL PRACTITIONER Code(s). These are allocated if a GENERAL MEDICAL PRACTITIONER works in additional General Medical Practitioner Practice. The spurious GENERAL MEDICAL PRACTITIONER Codes are not derived from the DOCTOR INDEX NUMBER, but do follow the same format as the GENERAL MEDICAL PRACTITIONER PPD CODE, and are allocated by the NHS Prescription Services. All spurious GENERAL MEDICAL PRACTITIONER Codes begin with either 'G6' or 'G7'.

England and Wales General Medical Practitioner Code format

Practitioner Code Type	Character Position								Allocated By	Allocated To	Known As	Notes
	1	2	3	4	5	6	7	8				
GENERAL MEDICAL PRACTITIONER PPD CODE	G	0-9	0-9	0-9	0-9	0-9	0-9	0-9	NHS Prescription Services	Prescribing GMPs in England & Wales	GMP	Derived from DOCTOR INDEX NUMBER - NHS Prescription Services add leading G and a check digit. Associated with practice.

Scottish General Medical Practitioner Code format

Practitioner Code Type	Character Position								Allocated By	Allocated To	Known As	Notes
	1	2	3	4	5	6	7	8				
Scottish General Medical Practitioner Code	S	0-9	0-9	0-9	0-9	0-9	0-9	0-9	Information Standards Division (Scotland)	GMPs in Scotland	GMP	

Northern Ireland General Medical Practitioner Code format

Practitioner Code Type	Character Position								Allocated By	Allocated To	Known As	Notes
	1	2	3	4	5	6	7	8				
Northern Ireland General Medical Practitioner Code	Z	E, N, S, W	0-9	0-9	0-9	0-9	0-9	0	Northern Ireland Dept of Health, Social Services and Public Safety	GMPs in Northern Ireland	GMP	

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.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE

Change to Attribute: Changed Description, Dataset

A code which identifies the MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION.

Note that the National Code '*Informal*' is used for those PATIENTS who are neither formally detained nor receiving supervised aftercare.

Where applicable, MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE is aligned with descriptors for "Mental Health Act legal status findings" in SNOMED CT® as follows:

SNOMED CT Subset Metadata:

- Subset Name: Mental Health Act legal status findings
- Subset Original Id: 75081000000134
- Refset FSN: Mental Health Act legal status findings simple reference set
- Refset Id: 999003071000000100

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Mental Health Act legal status findings.

National Codes:

01	Informal
02	Formally detained under Mental Health Act Section 2
03	Formally detained under Mental Health Act Section 3
04	Formally detained under Mental Health Act Section 4
05	Formally detained under Mental Health Act Section 5(2)
06	Formally detained under Mental Health Act Section 5(4)
07	Formally detained under Mental Health Act Section 35
08	Formally detained under Mental Health Act Section 36
09	Formally detained under Mental Health Act Section 37 with section 41 restrictions
10	Formally detained under Mental Health Act Section 37
12	Formally detained under Mental Health Act Section 38
13	Formally detained under Mental Health Act Section 44
14	Formally detained under Mental Health Act Section 46
15	Formally detained under Mental Health Act Section 47 with section 49 restrictions
16	Formally detained under Mental Health Act Section 47
17	Formally detained under Mental Health Act Section 48 with section 49 restrictions
18	Formally detained under Mental Health Act Section 48
19	Formally detained under Mental Health Act Section 135
20	Formally detained under Mental Health Act Section 136
31	Formally detained under Criminal Procedure(Insanity) Act 1964 as amended by the Criminal Procedures (Insanity and Unfitness to Plead) Act 1991
32	Formally detained under other acts
33	Supervised Discharge (Mental Health (Patients in the Community) Act 1995) (Retired 03 November 2008 - but may apply to some patients until 3 May 2009)
34	Formally detained under Mental Health Act Section 45A (Retired 01 September 2014)
35	Subject to guardianship under Mental Health Act Section 7
36	Subject to guardianship under Mental Health Act Section 37
37	Formally detained under Mental Health Act Section 45A (Limited direction in force)
38	Formally detained under Mental Health Act Section 45A (Limitation direction ended)

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 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.

NHS SERVICE AGREEMENT NUMBER

Change to Attribute: Changed Dataset

A number used to uniquely identify a NHS SERVICE AGREEMENT by an Organisation acting as commissioner of patient care services.

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 (Geography)	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		Character Position		Notes/Comments

	Frame Type									Code allocated by:	
	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 See Note 1	X	0-9	0-9						ODS	E.g. X09
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 (Geography)	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
Northern Ireland Health & Social Care Board	N/A	Z	B	0	0	1				ODS	E.g. ZB001
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.

OVERSEAS VISITOR CHARGING CATEGORY

Change to Attribute: New Attribute

The charging category relating to an OVERSEAS VISITOR STATUS.

See Overseas Visitor Chargeable Category for more information.

National Codes:

A	Standard NHS-funded PATIENT
B	Immigration Health Surcharge payee
C	Charge-exempt Overseas Visitor (European Economic Area)
D	Chargeable European Economic Area PATIENT
E	Charge-exempt Overseas Visitor (non-European Economic Area)
F	Chargeable non-European Economic Area PATIENT

This attribute is also known by these names:

Context	Alias
plural	OVERSEAS VISITOR CHARGING CATEGORIES

OVERSEAS VISITOR CHARGING CATEGORY

Change to Attribute: New Attribute

OVERSEAS VISITOR CHARGING CATEGORY

Data Elements:

OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE

PATIENT JOURNEY NUMBER

Change to Attribute: Changed Dataset

An identifier for each PATIENT TRANSPORT JOURNEY.

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 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 OBSERVATION TEXT STRING

Change to Attribute: Changed Dataset

A free text string to record a PERSON PROPERTY.

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 END TIME

Change to Attribute: Changed Dataset

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

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.

PROFESSIONAL REGISTRATION BODY CODE

Change to Attribute: Changed Dataset

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	Care Council for 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 *
12	Association for Operating Department Practitioners (Retired January 2015)
13	Association of Chartered Certified Accountants *
14	Chartered Institute of Personnel and Development *
15	Chartered Institute of Management Accountants *
16	General Pharmaceutical Council

* Note: National Codes 11, 13, 14 and 15 are not valid for use in the Children and Young People's Health Services Data Set, Community Information Data Set and Mental Health Services Data Set.

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.

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 START DATE

Change to Attribute: Changed Dataset

The start date of a REFERRAL TO TREATMENT PERIOD.

This is a specific type of the attribute ACTIVITY DATE.

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

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

- the REFERRAL REQUEST RECEIVED DATE of a SERVICE REQUEST when a decision has been made to refer the PATIENT directly to a Consultant Led Service or an NHS Allied Health Professional Service (Referral To Treatment Measurement) for a separate condition (the REFERRAL TO TREATMENT PERIOD STATUS for the first CARE ACTIVITY with the new CONSULTANT or NHS Allied Health Professional Service (Referral To Treatment Measurement) is '*National Code 12 - consultant or NHS Allied Health Professional Service (Referral To Treatment) referral*').

Referral To Treatment Consultant Led Waiting Times:

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

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

A REFERRAL TO TREATMENT PERIOD may also start from SERVICE REQUESTS to CONSULTANTS from GENERAL DENTAL PRACTITIONERS, 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 part of the gov.uk website at: Allied health professional referral to treatment revised guide.

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.

TREATMENT FUNCTION CODE

Change to Attribute: Changed Dataset

TREATMENT FUNCTION CODE is a unique identifier for a TREATMENT FUNCTION.

TREATMENT FUNCTION CODE is recorded to report the specialised service within which the PATIENT is treated.

It is based on MAIN SPECIALTY but also includes approved sub-specialties and treatment specialties used by lead CARE PROFESSIONALS including CONSULTANTS.

TREATMENT FUNCTION, rather than the Royal College or Faculty specialty, is required on most activity returns and in the Commissioning Data Sets.

TREATMENT FUNCTION CODES should be used for all aggregate Central Returns unless otherwise stated eg National Workforce Data Set uses MAIN SPECIALTY CODES.

GENERAL MEDICAL PRACTITIONER, NURSE and Allied Health Professional/ Biomedical Scientist/ Clinical Scientist ACTIVITY should be recorded against the TREATMENT FUNCTION under which the PATIENT is treated.

Joint Consultant Clinic ACTIVITY should be recorded against the TREATMENT FUNCTION which best describes the specialised service.

Assigning a Treatment Function Code:

- Assigning a TREATMENT FUNCTION CODE for a SERVICE is a decision which must be made locally. For national reporting purposes, only the TREATMENT FUNCTION CODES listed in the table below must be used.
- Recording of activity according to TREATMENT FUNCTION CODES is not on the basis of the procedure carried out, but should be allocated according to whether a specialised SERVICE exists within the Health Care Provider for that TREATMENT FUNCTION CODE, such as a CLINIC OR FACILITY.
- TREATMENT FUNCTION CODES have not been mapped to procedures or MAIN SPECIALTY.
- TREATMENT FUNCTION CODE should be assigned irrespective of the type of CARE PROFESSIONAL responsible. This is also applicable where the name of the TREATMENT FUNCTION CODE suggests it is limited for use by a particular Healthcare Profession.
- A change in TREATMENT FUNCTION CODE, but no change in responsible CARE PROFESSIONAL, does not initiate a new episode of care. For the Commissioning Data Sets, the ACTIVITY TREATMENT FUNCTION CODE reported should be that which is recorded at the CDS ACTIVITY DATE.

For further information, contact NHS Digital by email at: enquiries@nhsdigital.nhs.uk with the subject "Main Specialty and Treatment Function Codes".

National Codes:

Code	Treatment Function Title	Comments
Surgical Specialties		
100	GENERAL SURGERY	Includes sub-categories not elsewhere listed e.g. endocrine surgery
101	UROLOGY	Surgical treatment of disorders of the urinary system and male reproductive system
102	TRANSPLANTATION SURGERY	Includes pre- and post-operative care for major organ transplants except heart and lung (see Cardiothoracic Transplantation). Excludes corneal grafts
103	BREAST SURGERY	Includes treatment for cancer, suspected neoplasms, cysts and post-cancer reconstructive surgery. Excludes cosmetic surgery
104	COLORECTAL SURGERY	Surgical treatment of disorders of the lower intestine (colon, anus and rectum)
105	HEPATOBILIARY & PANCREATIC SURGERY	Includes liver surgery, but liver transplantation should be recorded in 102 Transplantation Surgery
106	UPPER GASTROINTESTINAL SURGERY	Surgical treatment of disorders of the upper parts of the gastrointestinal tract

107	VASCULAR SURGERY	Surgical treatment of diseases of the vascular system
108	SPINAL SURGERY SERVICE	Surgery concentrating on specialised and complex treatment of the back and spine. The SERVICE has a significantly different composition and profile from the SERVICE provided in TREATMENT FUNCTION CODE - 110 Trauma & Orthopaedic. Excludes Spinal Injuries - see TREATMENT FUNCTION CODE 323
110	TRAUMA & ORTHOPAEDICS	Surgery to treat injuries, congenital and acquired disorders of the bones, joints, and their associated soft tissues, including ligaments, nerves and muscles. Excludes Spinal Surgery Service - see TREATMENT FUNCTION CODE 108
120	ENT	Ear, nose and throat
130	OPHTHALMOLOGY	The surgical treatment of disorders and diseases of the eye. Excludes Medical Ophthalmology - see TREATMENT FUNCTION CODE 460
140	ORAL SURGERY	The diagnosis and surgical treatment of diseases, injuries and defects involving both the functional and aesthetic aspects of the hard and soft tissues of the head, mouth, teeth, gums, jaws and neck
141	RESTORATIVE DENTISTRY	Endodontics, Periodontics and Prosthodontics are all part of Restorative Dentistry
142	PAEDIATRIC DENTISTRY	Dentistry SERVICES dedicated to children with appropriate facilities and support staff
143	ORTHODONTICS	The treatment of malocclusions (improper bites). Orthodontic treatment can focus on dental displacement only, or can deal with the control and modification of facial growth
144	MAXILLO-FACIAL SURGERY	Mouth, jaw and face related surgery
150	NEUROSURGERY	The prevention, diagnosis, treatment, and rehabilitation of disorders which affect any portion of the nervous system including the brain, spinal cord, peripheral nerves, and extra-cranial cerebrovascular system
160	PLASTIC SURGERY	SERVICES to correct or restore form and function. In addition to cosmetic or aesthetic surgery, plastic surgery includes many types of reconstructive surgery, and the treatment of burns
161	BURNS CARE	To be used by recognised specialist units and associated outreach SERVICES only
170	CARDIOTHORACIC SURGERY	Should only be used where there are no separate SERVICES for Cardiac Surgery and Thoracic Surgery
171	PAEDIATRIC SURGERY	This is paediatric general surgery
172	CARDIAC SURGERY	Surgical treatment of the heart or great vessels
173	THORACIC SURGERY	Surgical treatment of diseases affecting organs inside the thorax (the chest). Generally treatment of conditions of the lungs, chest wall, and diaphragm
174	CARDIOTHORACIC TRANSPLANTATION	To be used by recognised specialist units and associated outreach services only. Includes pre- and post-operative services
180	ACCIDENT & EMERGENCY	SERVICES to care for PATIENTS with urgent problems delivered as part of an Accident and Emergency Attendance or admission at an Accident and Emergency Department
191	PAIN MANAGEMENT	Complex pain disorders requiring diagnosis and treatment by a specialist multi-professional team
Other Children's Specialist Services - The Paediatric TREATMENT FUNCTION CODES represent CLINICS OR FACILITIES intended to provide dedicated SERVICES to children with appropriate facilities and support staff, i.e. they are designed for children only. If a CLINIC OR FACILITY provides this but also treats adult PATIENTS as part of the SERVICE then a Paediatric TREATMENT FUNCTION CODE may not be appropriate. The age of the PATIENT attending does not initiate a change to the TREATMENT FUNCTION CODE for the ACTIVITY.		
211	PAEDIATRIC UROLOGY	Surgical treatment of disorders of the urinary system and male reproductive system
212	PAEDIATRIC TRANSPLANTATION SURGERY	Includes pre- and post-operative care for major organ transplants except heart and lung (see Cardiothoracic Transplantation). Excludes corneal grafts
213	PAEDIATRIC GASTROINTESTINAL SURGERY	Surgical treatment of disorders of the gastrointestinal tract
214	PAEDIATRIC TRAUMA AND ORTHOPAEDICS	Surgery to treat injuries, congenital and acquired disorders of the bones, joints, and their associated soft tissues, including ligaments, nerves and muscles. Excludes Spinal Surgery Service - see TREATMENT FUNCTION CODE 108
215	PAEDIATRIC EAR NOSE AND THROAT	Ear, nose and throat
216	PAEDIATRIC OPHTHALMOLOGY	The surgical treatment of disorders and diseases of the eye.
217	PAEDIATRIC MAXILLO-FACIAL SURGERY	Mouth, jaw and face related surgery
218	PAEDIATRIC NEUROSURGERY	The prevention, diagnosis, treatment, and rehabilitation of disorders which affect any portion of the nervous system including the brain, spinal cord, peripheral nerves, and extra-cranial cerebrovascular system
219	PAEDIATRIC PLASTIC SURGERY	SERVICES to correct or restore form and function. In addition to cosmetic or aesthetic surgery, plastic surgery includes many types of reconstructive surgery, and the treatment of burns
220	PAEDIATRIC BURNS CARE	To be used by recognised specialist units and associated outreach SERVICES only
221	PAEDIATRIC CARDIAC SURGERY	Surgical treatment of the heart or great vessels
222	PAEDIATRIC THORACIC SURGERY	Surgical treatment of diseases affecting organs inside the thorax (the chest). Generally treatment of conditions of the lungs, chest wall, and diaphragm
223	PAEDIATRIC EPILEPSY	Designated clinic which provides SERVICES to children led by CONSULTANT paediatrician with expertise in epilepsy supported by specialist staff
241	PAEDIATRIC PAIN MANAGEMENT	Complex pain disorders requiring diagnosis and treatment by a specialist multi-professional team
242	PAEDIATRIC INTENSIVE CARE	Only to be used by designated Paediatric Intensive Care Units
251	PAEDIATRIC GASTROENTEROLOGY	The treatment of disorders of the digestive system
252	PAEDIATRIC ENDOCRINOLOGY	The treatment of disorders of the endocrine system
253	PAEDIATRIC CLINICAL HAEMATOLOGY	Excludes Anticoagulant Service - see TREATMENT FUNCTION CODE 324

254	PAEDIATRIC AUDIOLOGICAL MEDICINE	The medical specialty concerned with the investigation, diagnosis and management of patients with disorders of balance, hearing, tinnitus and auditory communication. Excludes audiology and hearing tests
255	PAEDIATRIC CLINICAL IMMUNOLOGY AND ALLERGY SERVICE	Clinical Immunology is the treatment of disorders of the immune system. Allergy Service is the diagnosis and management of allergic disease
256	PAEDIATRIC INFECTIOUS DISEASES	SERVICES to diagnose and treat contagious or communicable diseases
257	PAEDIATRIC DERMATOLOGY	SERVICES for the treatment of diseases of the skin
258	PAEDIATRIC RESPIRATORY MEDICINE	Also known as Thoracic Medicine
259	PAEDIATRIC NEPHROLOGY	SERVICES to treat kidney conditions and abnormalities
260	PAEDIATRIC MEDICAL ONCOLOGY	The diagnosis and treatment, typically with Chemotherapy of PATIENTS with cancer
261	PAEDIATRIC METABOLIC DISEASE	The diagnosis and management of inherited metabolic conditions
262	PAEDIATRIC RHEUMATOLOGY	SERVICES to treat rheumatism, arthritis, and other disorders of the joints, muscles and ligaments
263	PAEDIATRIC DIABETIC MEDICINE	SERVICES to diagnose, treat and support PATIENTS with diabetes
264	PAEDIATRIC CYSTIC FIBROSIS	Specialised, multidisciplinary SERVICE concerned with the diagnosis, assessment and management of PATIENTS with cystic fibrosis. This TREATMENT FUNCTION CODE should be used by recognised specialist centres only
280	PAEDIATRIC INTERVENTIONAL RADIOLOGY	Diagnosis and treatment of diseases utilising minimally-invasive image-guided procedures. Not to be used for Diagnostic Imaging - see TREATMENT FUNCTION CODE 812
290	COMMUNITY PAEDIATRICS	Includes routine health surveillance, health promotion, behavioural paediatrics and Looked After Children. Excludes Paediatric Neuro-Disability
291	PAEDIATRIC NEURO-DISABILITY	Dedicated SERVICES for children with Cerebral Palsy and non-progressive handicapping neurological conditions, with or without Learning Disability
Medical Specialties		
190	ANAESTHETICS	This can be used in out-patients only. Pain Management should be recorded in 191
192	CRITICAL CARE MEDICINE	also known as Intensive Care Medicine
300	GENERAL MEDICINE	Includes sub-categories not elsewhere listed e.g. Metabolic Medicine.
301	GASTROENTEROLOGY	The treatment of disorders of the digestive system
302	ENDOCRINOLOGY	The treatment of disorders of the endocrine system
303	CLINICAL HAEMATOLOGY	Excludes Anticoagulant Service - see TREATMENT FUNCTION CODE 324
304	CLINICAL PHYSIOLOGY	Physiological measurement including ECG (e.g. exercise testing, stress testing), gastrointestinal physiology, cardiac physiology, vascular technology, urodynamics, and ophthalmic and vision science. Excludes Clinical Neurophysiology - see TREATMENT FUNCTION CODE 401, Audiology - see TREATMENT FUNCTION CODE 840 or Respiratory Physiology - see TREATMENT FUNCTION CODE 341
305	CLINICAL PHARMACOLOGY	SERVICES providing drug information, medication safety and other aspects of pharmacy practice
306	HEPATOLOGY	Also known as liver medicine
307	DIABETIC MEDICINE	SERVICES to diagnose, treat and support PATIENTS with diabetes
308	BLOOD AND MARROW TRANSPLANTATION	Previously coded within Clinical Haematology (TREATMENT FUNCTION CODE 303). Includes haemopoietic stem cell transplantation
309	HAEMOPHILIA SERVICE	Previously coded within Clinical Haematology (TREATMENT FUNCTION CODE 303).
310	AUDIOLOGICAL MEDICINE	The medical specialty concerned with the investigation, diagnosis and management of patients with disorders of balance, hearing, tinnitus and auditory communication. Excludes audiology and hearing tests
311	CLINICAL GENETICS	Diagnosis of disorders caused by genetic mechanisms and counselling SERVICE to PATIENTS and affected family members. To be used by recognised specialist units and associated outreach SERVICES only
312	not a Treatment Function	
313	CLINICAL IMMUNOLOGY and ALLERGY SERVICE	Should only be used where there are no separate SERVICES for Clinical Immunology and Allergy
314	REHABILITATION SERVICE	SERVICES to enhance and restore functional ability and quality of life to those with physical impairments or disabilities. Excludes Mental Health Recovery and Rehabilitation Service - see TREATMENT FUNCTION CODE 725
315	PALLIATIVE MEDICINE	The treatment for curable illnesses and those living with chronic diseases, as well as PATIENTS who are nearing the end of life
316	CLINICAL IMMUNOLOGY	The treatment of disorders of the immune system
317	ALLERGY SERVICE	The diagnosis and management of allergic disease (abnormal immune responses to external substances) and the exclusion of allergic causes in other conditions
318	INTERMEDIATE CARE	Intermediate care encompasses a range of multi-disciplinary SERVICES designed to safeguard independence by maximising rehabilitation and recovery after illness or injury
319	RESPITE CARE	SERVICES providing temporary care of a dependant person, providing relief for their usual caregivers
320	CARDIOLOGY	SERVICES treating diseases and abnormalities of the heart
321	PAEDIATRIC CARDIOLOGY	Dedicated SERVICES to children with diseases and abnormalities of the heart, with appropriate facilities and support staff
322	CLINICAL MICROBIOLOGY	SERVICES to treat diseases caused by bacteria, viruses, fungi and parasites
323	SPINAL INJURIES	

		To be used by recognised specialist units and associated outreach SERVICES only, Excludes Spinal Surgery Service - see TREATMENT FUNCTION CODE 108
324	ANTICOAGULANT SERVICE	The monitoring and control of anticoagulant therapy including the initiation and/or supervision of oral anticoagulant therapy and the determination of anticoagulant dosage. This can be used in out-patients only
325	SPORT AND EXERCISE MEDICINE	The diagnosis and management of medical problems caused by physical activity, the prevention of related injury and disease and the role of exercise in disease treatment
327	CARDIAC REHABILITATION	Rehabilitation SERVICE for PATIENTS with or recovering from heart related conditions such as heart attacks or from procedures such as coronary artery bypass surgery to ensure that they achieve their full potential in terms of physical and psychological health
328	STROKE MEDICINE	For stroke services excluding Transient Ischaemic Attack - see TREATMENT FUNCTION CODE 329
329	TRANSIENT ISCHAEMIC ATTACK	A multidisciplinary SERVICE for rapid diagnosis and treatment of PATIENTS presenting with suspected Transient Ischaemic Attack and mini-strokes to minimise the chance of a full stroke occurring and maximise the chances of independent living after a stroke
330	DERMATOLOGY	SERVICES for the treatment of diseases of the skin
331	CONGENITAL HEART DISEASE SERVICE	The management and treatment of congenital heart disease, this includes the ongoing care of children in to adulthood
340	RESPIRATORY MEDICINE	Also known as Thoracic Medicine
341	RESPIRATORY PHYSIOLOGY	Physiological measurement of the function of the respiratory system. Includes Sleep Studies (the diagnosis and treatment of sleep disordered breathing, including upper airway resistance syndrome and sleep apnoea)
342	PROGRAMMED PULMONARY REHABILITATION	A multidisciplinary programme of care for PATIENTS with chronic respiratory impairment that is individually tailored and designed to optimise the individual's physical and social performance and autonomy
343	ADULT CYSTIC FIBROSIS SERVICE	Specialised, multidisciplinary SERVICE concerned with the diagnosis, assessment and management of PATIENTS with cystic fibrosis. This TREATMENT FUNCTION CODE should be used by recognised specialist centres only
344	COMPLEX SPECIALISED REHABILITATION SERVICE	Complex specialised rehabilitation SERVICE which meets the NHS Specialised Services Rehabilitation Services' criteria and is registered as a Level 1 service. For further information see the NHS Specialised Services website
345	SPECIALIST REHABILITATION SERVICE	Specialist rehabilitation SERVICE which meets the NHS Specialised Services Rehabilitation Services' criteria and is registered as a Level 2a service. For further information see the NHS Specialised Services website
346	LOCAL SPECIALIST REHABILITATION SERVICE	Local specialist rehabilitation SERVICE which meets the NHS Specialised Services Rehabilitation Services' criteria and is registered as a Level 2b service. For further information see the NHS Specialised Services website
350	INFECTIOUS DISEASES	SERVICES to diagnose and treat contagious or communicable diseases
352	TROPICAL MEDICINE	SERVICES to diagnose and treat diseases that are found most often in tropical or sub-tropical regions
360	GENITOURINARY MEDICINE	Primarily related to medicine dealing with sexually transmitted diseases
361	NEPHROLOGY	SERVICES to treat kidney conditions and abnormalities
370	MEDICAL ONCOLOGY	The diagnosis and treatment, typically with Chemotherapy, of PATIENTS with cancer
371	NUCLEAR MEDICINE	The treatment of PATIENTS through the use of radioactive substances
400	NEUROLOGY	SERVICES to diagnose and treat conditions and diseases of the central nervous system
401	CLINICAL NEUROPHYSIOLOGY	The study of the central and peripheral nervous systems through the recording of bioelectrical activity. Includes Electroencephalogram (EEG)
410	RHEUMATOLOGY	SERVICES to treat rheumatism, arthritis, and other disorders of the joints, muscles and ligaments
420	PAEDIATRICS	SERVICES to treat infants, children, and adolescents
421	PAEDIATRIC NEUROLOGY	Dedicated SERVICES to children to diagnose and treat conditions and diseases of the central nervous system, with appropriate facilities and support staff
422	NEONATOLOGY	Special Care, High Dependency and Intensive Care
424	WELL BABIES	**Use when NEONATAL LEVEL OF CARE = 0 - Normal Care:** Care given by the mother/substitute with medical and neonatal nursing advice if needed. See Well Baby
430	GERIATRIC MEDICINE	SERVICES to treat diseases and disabilities in older adults. There is no set age at which PATIENTS may be under the care of Geriatric Medicine, this decision should be determined by the individual PATIENT's needs
450	DENTAL MEDICINE SPECIALTIES	Includes Oral Medicine.
460	MEDICAL OPHTHALMOLOGY	SERVICES to diagnose and treat medical conditions affecting the eye, orbits, and visual pathways
500	not a Treatment Function	
501	OBSTETRICS	The management of pregnancy and childbirth including miscarriages and still births but excluding planned terminations. Excludes Midwifery Service see TREATMENT FUNCTION CODE 560
502	GYNAECOLOGY	Disorders of the female reproductive system. Includes planned terminations
503	GYNAECOLOGICAL ONCOLOGY	SERVICES to treat cancers of the female reproductive system
510	Retired	Record as Obstetrics, antenatal clinic can be used as a local sub-specialty if required

520	Retired	Record as Obstetrics, postnatal clinic can be used as a local sub-specialty if required
560	MIDWIFERY SERVICE	SERVICES provided under the direct care of a MIDWIFE. Excludes Obstetrics see TREATMENT FUNCTION CODE 501
600	not a Treatment Function	
610	Retired	Record as Obstetrics
620	Retired	Use the appropriate function under which the patient is treated
Therapies		
650	PHYSIOTHERAPY	The treatment of human function and movement to help people to achieve their full physical potential. The use of physical approaches to promote, maintain and restore wellbeing
651	OCCUPATIONAL THERAPY	The use of specific activities to limit the effects of disability and promote independence in all aspects of daily life
652	SPEECH AND LANGUAGE THERAPY	The assessment, treatment and help to prevent speech, language and swallowing difficulties
653	PODIATRY	Also known as Chiropody. The diagnosis and treatment of disorders, diseases and deformities of the feet. Excludes Podiatric Surgery see TREATMENT FUNCTION CODE 663
654	DIETETICS	The application of the science of nutrition to devise eating plans for PATIENTS to treat medical conditions. The promotion of good health by helping to facilitate a positive change in food choices amongst individuals, groups and communities
655	ORTHOPTICS	The diagnosis and treatment of visual problems involving eye movement and alignment
656	CLINICAL PSYCHOLOGY	The diagnosis and treatment of emotional and behavioural disorders
657	PROSTHETICS	The supply of prosthetics for PATIENTS
658	ORTHOTICS	The supply of orthoses for PATIENTS
659	DRAMA THERAPY	The use of drama and theatre techniques including role play, voice work and storytelling for therapeutic purposes
660	ART THERAPY	The use of art techniques including clay, paint and paper for therapeutic purposes and as a means of communication
661	MUSIC THERAPY	The use of music and all of its facets to help clients to improve or maintain their health
662	OPTOMETRY	The diagnosis and non-surgical treatment of disorders of the eye and vision care
663	PODIATRIC SURGERY	The treatment of foot problems, including soft tissue, bone and joint surgery of the foot, ankle and associated structures, excludes Podiatry see TREATMENT FUNCTION CODE - 653
Psychiatry		
700	LEARNING DISABILITY	SERVICES provided to PATIENTS with a Learning Disability
710	ADULT MENTAL ILLNESS	SERVICES provided to adult PATIENTS for the assessment, diagnosis and treatment of mental illness
711	CHILD and ADOLESCENT PSYCHIATRY	SERVICES providing diagnosis, treatment, and prevention of psychopathological disorders of children and adolescents
712	FORENSIC PSYCHIATRY	SERVICES to assess PATIENTS who have committed an offence and are receiving treatment in high, medium and low secure units or prisons
713	PSYCHOTHERAPY	SERVICES providing therapy used to treat emotional problems and mental health conditions
715	OLD AGE PSYCHIATRY	SERVICES providing the diagnosis, treatment, and prevention of mental and emotional disorders in older adult PATIENTS
720	EATING DISORDERS	A specialist SERVICE for the diagnosis and treatment of eating disorders including anorexia, bulimia and compulsive overeating
721	ADDICTION SERVICES	The prevention and treatment of substance misuse including drugs and alcohol. If PATIENTS have both severe mental illness and problematic substance misuse, see TREATMENT FUNCTION CODE 726 Dual Diagnosis Service
722	LIAISON PSYCHIATRY	The provision of psychiatric treatment to PATIENTS attending general hospitals including out-patient clinics, Accident and Emergency Departments and admission to wards. Deals with the interface between physical and psychological health.
723	PSYCHIATRIC INTENSIVE CARE	The provision of psychiatric SERVICES to vulnerable individuals who are admitted to Psychiatric Intensive Care Units from open acute wards and forensic settings
724	PERINATAL PSYCHIATRY	A specialist psychiatric SERVICE for the diagnosis and treatment of ante-natal and post-natal psychiatric problems
725	MENTAL HEALTH RECOVERY AND REHABILITATION SERVICE	SERVICES provided to support recovery from mental illness that maximises the PATIENT's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy
726	MENTAL HEALTH DUAL DIAGNOSIS SERVICE	SERVICES to provide support to PATIENTS with both severe mental illness and substance misuse problems. Personality disorder may coexist with psychiatric illness and/or substance misuse
727	DEMENTIA ASSESSMENT SERVICE	SERVICES for the assessment of PATIENTS with dementia, which may complicate care giving and can occur at any stage of the illness. In addition to memory impairment, dementia may include behavioural and psychological problems
Radiology		
800	CLINICAL ONCOLOGY (previously RADIOTHERAPY)	The diagnosis and treatment, typically with Radiotherapy, of PATIENTS with cancer.
810	not a Treatment Function	
811	INTERVENTIONAL RADIOLOGY	

		Diagnosis and treatment of diseases utilising minimally-invasive image-guided procedures. Not to be used for Diagnostic Imaging - see TREATMENT FUNCTION CODE 812
812	DIAGNOSTIC IMAGING	The production and interpretation of high quality images of the body to diagnose injuries and disease, e.g. x-rays, Ultrasound Scan, MRI Scan, PET Scan or CT Scan.
Pathology		
820	not a Treatment Function	
821	not a Treatment Function	
822	CHEMICAL PATHOLOGY	To be used for clinical management only
823	not a Treatment Function	See Clinical Haematology
824	not a Treatment Function	
830	not a Treatment Function	See Clinical Immunology
831	not a Treatment Function	See Clinical Microbiology
832	Retired	
834	MEDICAL VIROLOGY	The diagnosis and management and prevention of virus and related infections, in hospital and in the community including HIV/AIDS, other blood-borne infections like hepatitis B and C and viruses such as SARS and avian flu
Other		
840	AUDIOLOGY	Physiological measurement and diagnosis of hearing disorders, and the rehabilitation of PATIENTS with hearing loss
900	not a Treatment Function	
901	not a Treatment Function	
920	DIABETIC EDUCATION SERVICE	SERVICES providing dedicated small group education courses regarding self management for diabetic PATIENTS
950	not a Treatment Function	Use the appropriate function under which the patient is treated
960	not a Treatment Function	Use the appropriate function under which the patient is treated
990	Retired	

Notes:

†	Code 500 is not acceptable for Central Returns including Hospital Episode Statistics

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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

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

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

National Codes:

01 Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement
02 Allied Health Professional Referral To Treatment Measurement
03 Improving Access to Psychological Therapies Referral To Treatment Measurement *
04 Early Intervention in Psychosis Waiting Time Measurement *
09 Other Referral To Treatment Measurement Type

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.

ACCESSIBLE INFORMATION PROFESSIONAL REQUIRED CODE (SNOMED CT)

Change to Data Element: Changed Dataset

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

Notes:
ACCESSIBLE INFORMATION PROFESSIONAL REQUIRED CODE (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

ACCESSIBLE INFORMATION PROFESSIONAL REQUIRED CODE (SNOMED CT) is the SNOMED CT® concept ID which is used to identify that the PATIENT requires support from a communication professional.

SNOMED CT Subset Metadata:

- Subset Name: Accessible Information - requires communication professional
- Subset Original Id: 58951000000133
- Refset FSN: Accessible information - requires communication professional simple reference set (foundation metadata concept)
- Refset Id: 999002151000000104

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Accessible Information - requires communication professional.

ACCOMMODATION STATUS (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
ACCOMMODATION STATUS (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

ACCOMMODATION STATUS (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the details of the ACCOMMODATION of the PERSON.

SNOMED CT Subset Metadata:

- Subset Name: Emergency care usual residence type
- Subset Original Id: 72091000000139
- Refset FSN: Emergency care usual residence type simple reference set (foundation metadata concept)
- Refset Id: 999003051000000109

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Accommodation Status.

This data element is also known by these names:

Context	Alias
snomedctsubsetoriginalid	72091000000139
snomedctrefsetname	Emergency care usual residence type simple reference set
snomedctsubsetname	Emergency care usual residence type
plural	ACCOMMODATION STATUSES (SNOMED CT)
snomedctrefsetid	999003051000000109

ACCOMMODATION STATUS (SNOMED CT)

Change to Data Element: New Data Element

ACCOMMODATION STATUS (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

ACTIVITY SERVICE REQUEST DATE (EMERGENCY CARE)

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
ACTIVITY SERVICE REQUEST DATE (EMERGENCY CARE) is the same as attribute ACTIVITY SERVICE REQUEST DATE.

ACTIVITY SERVICE REQUEST DATE (EMERGENCY CARE) is the DATE that a PATIENT was referred to another SERVICE during an Emergency Care Attendance.

This data element is also known by these names:

Context	Alias
plural	ACTIVITY SERVICE REQUEST DATES (EMERGENCY CARE)

ACTIVITY SERVICE REQUEST DATE (EMERGENCY CARE)

Change to Data Element: New Data Element

ACTIVITY SERVICE REQUEST DATE (EMERGENCY CARE)

Attribute:

ACTIVITY SERVICE REQUEST DATE

ACTIVITY SERVICE REQUEST TIME (EMERGENCY CARE)

Change to Data Element: New Data Element

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
ACTIVITY SERVICE REQUEST TIME (EMERGENCY CARE) is the same as attribute ACTIVITY SERVICE REQUEST TIME.

ACTIVITY SERVICE REQUEST TIME (EMERGENCY CARE) is the TIME that a PATIENT was referred to another SERVICE during an Emergency Care Attendance.

This data element is also known by these names:

Context	Alias
plural	ACTIVITY SERVICE REQUEST TIMES (EMERGENCY CARE)

ACTIVITY SERVICE REQUEST TIME (EMERGENCY CARE)

Change to Data Element: New Data Element

ACTIVITY SERVICE REQUEST TIME (EMERGENCY CARE)

Attribute:

ACTIVITY SERVICE REQUEST TIME

ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT)

Change to Data Element: New Data Element

Format/Length:	an3
National Codes:	See TREATMENT FUNCTION CODE
Default codes:	

Notes:
ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT) is the same as attribute TREATMENT FUNCTION CODE.

ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT) is the TREATMENT FUNCTION CODE of the SERVICE to which a PATIENT is to be admitted.

This data element is also known by these names:

Context	Alias
plural	ACTIVITY TREATMENT FUNCTION CODES (DECISION TO ADMIT)

ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT)

Change to Data Element: New Data Element

ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT)

Attribute:

TREATMENT FUNCTION CODE

AGE AT CDS ACTIVITY DATE

Change to Data Element: Changed Dataset

Format/Length:	n3
National Codes:	
Default Codes:	999 - Not known i.e. date of birth not known and age cannot be estimated

Notes:
AGE AT CDS ACTIVITY DATE is derived as the number of completed years between the PERSON BIRTH DATE of the PATIENT and the CDS ACTIVITY DATE.

AGE AT CDS ACTIVITY DATE is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

AMBULANCE INCIDENT NUMBER

Change to Data Element: Changed Dataset

Format/Length:	max an20
National Codes:	See PATIENT JOURNEY NUMBER
Default Codes:	

Notes:
AMBULANCE INCIDENT NUMBER is the same as attribute PATIENT JOURNEY NUMBER.

From Commissioning Data Set version 6-2, this data element may be submitted where the PATIENT arrived at hospital by Ambulance, and an Accident and Emergency Attendance or Hospital Provider Spell related to this PATIENT TRANSPORT JOURNEY was recorded.

CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR (EMERGENCY CARE)

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR FOR EMERGENCY CARE
Default Codes:	

Notes:
CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR (EMERGENCY CARE) is the same as attribute CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR FOR EMERGENCY CARE.

This data element is also known by these names:

Context	Alias
plural	CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATORS (EMERGENCY CARE)

CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR (EMERGENCY CARE)

Change to Data Element: New Data Element

CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR (EMERGENCY CARE)

Attribute:

CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR FOR EMERGENCY CARE

CARE PROFESSIONAL TIER (EMERGENCY CARE)

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See CARE PROFESSIONAL TIER FOR EMERGENCY CARE
Default Codes:	

Notes:
CARE PROFESSIONAL TIER (EMERGENCY CARE) is the same as attribute CARE PROFESSIONAL TIER FOR EMERGENCY CARE.

This data element is also known by these names:

Context	Alias
plural	CARE PROFESSIONAL TIERS (EMERGENCY CARE)

CARE PROFESSIONAL TIER (EMERGENCY CARE)

Change to Data Element: New Data Element

CARE PROFESSIONAL TIER (EMERGENCY CARE)

Attribute:

CARE PROFESSIONAL TIER FOR EMERGENCY CARE

CDS ACTIVITY DATE

Change to Data Element: Changed Description, Dataset

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
For Commissioning data, every CDS Type has a "CDS Originating Date" contained within the Commissioning Data Set data that must be used to populate the CDS ACTIVITY DATE.

The CDS ACTIVITY DATE is held in the Commissioning Data Set Transaction Header Group and is a mandatory data element for all uses of the Commissioning Data Set for both Bulk Update and Net Change Protocols, see the Commissioning Data Set Submission Protocol supporting information.

~~For Bulk Update use, see: CDS V6-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol~~ For Bulk Update use, see: CDS V6-2 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol / CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol
~~For Net Change Use, see: CDS V6-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol~~ For Net Change Use, see: CDS V6-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol / CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol

The CDS ACTIVITY DATE has an associated "CDS Originating Date" specifically identified for each CDS Type as follows:

CDS TYPE	DESCRIPTION	CDS ORIGINATING DATE (used to populate the CDS ACTIVITY DATE)
010	Accident and Emergency Attendance	ARRIVAL DATE, ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT
011	Emergency Care Attendance	EMERGENCY CARE ARRIVAL DATE, EMERGENCY CARE ARRIVAL TIME
020	Outpatient (known in the Schema as Care Activity)	APPOINTMENT DATE
021	Future Outpatient (known in the Schema as Future Care Activity)	APPOINTMENT DATE
030	EAL End Of Period Census - STANDARD	DECIDED TO ADMIT DATE
040	EAL End Of Period Census - OLD	NHS SERVICE AGREEMENT CHANGE DATE
050	EAL End Of Period Census - NEW	NHS SERVICE AGREEMENT CHANGE DATE
060	EAL Event During Period - ADD	DECIDED TO ADMIT DATE
070	EAL Event During Period - REMOVE	ELECTIVE ADMISSION LIST REMOVAL DATE
080	EAL Event During Period - OFFER	OFFERED FOR ADMISSION DATE
090	EAL Event During Period - AVAILABLE / UNAVAILABLE	SUSPENSION START DATE
100	EAL Event During Period - OLD SERVICE AGREEMENT	NHS SERVICE AGREEMENT CHANGE DATE
110	EAL Event During Period - NEW SERVICE AGREEMENT	NHS SERVICE AGREEMENT CHANGE DATE
120	Finished Birth Episode	END DATE (EPISODE)
130	Finished General Episode	END DATE (EPISODE)
140	Finished Delivery Episode	END DATE (EPISODE)
150	Other Birth	DELIVERY DATE
160	Other Delivery	DELIVERY DATE
170	Detained and/or Long-Term Psychiatric Census	DETAINED AND (OR) LONG TERM PSYCHIATRIC CENSUS DATE
180	Unfinished Birth Episode	START DATE (EPISODE)
190	Unfinished General Episode	START DATE (EPISODE)

200	Unfinished Delivery Episode	START DATE (EPISODE)

Usage:
The CDS ACTIVITY DATE is validated by the Secondary Uses Service and Commissioning Data Set Interchanges are rejected if the date is not present, invalid or not compatible with the Commissioning Data Set Submission Protocol controls being used.

In particular, when using the Commissioning Data Set Bulk Replacement Update Mechanism, the CDS ACTIVITY DATE and its "CDS Originating Date" are used by the Secondary Uses Service to validate that the CDS Type date applicability falls within the CDS REPORT PERIOD START DATE and the CDS REPORT PERIOD END DATE.

CDS APPLICABLE DATE

Change to Data Element: Changed Dataset

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
CDS APPLICABLE DATE is the date (with an associated CDS APPLICABLE TIME) of the update event (or the nearest equivalent) that resulted in the need to exchange this Commissioning Data Set.

Usage:
CDS APPLICABLE DATE is mandatory when used with the Commissioning Data Set Net Change Update Mechanism. It is not required when the Commissioning Data Set Bulk Replacement Update Mechanism is used. See the Commissioning Data Set Submission Protocol.

The CDS APPLICABLE DATE (and the CDS APPLICABLE TIME if supplied) is stored in the Secondary Uses Service database and in the event of multiple submissions of the same uniquely identified Commissioning data (even in separate interchanges).

The Secondary Uses Service database update process is then able to use this date and time to ensure correct updating of the Commissioning data in the correct relative date/time sequence.

CDS APPLICABLE TIME

Change to Data Element: Changed Dataset

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
CDS APPLICABLE TIME is the time (with an associated CDS APPLICABLE DATE) of the update event (or the nearest equivalent) that resulted in the need to exchange this Commissioning data.

Usage:
CDS APPLICABLE TIME is mandatory when used with the Commissioning Data Set Net Change Update Mechanism. It is not required when the CDS Bulk Replacement Update Mechanism is used. See the Commissioning Data Set Submission Protocol.

The CDS APPLICABLE TIME (and CDS APPLICABLE DATE if supplied) is stored in the Secondary Uses Service database and in the event of multiple submissions of the same uniquely identified Commissioning data (even in separate interchanges), the Secondary Uses Service database update process is then able to use the date and time to ensure correct updating of the Commissioning data in the correct relative date/time sequence.

CDS BULK REPLACEMENT GROUP CODE

Change to Data Element: Changed Description, Dataset

Format/Length:	an3
National Codes:	
Default Codes:	

Notes:
CDS BULK REPLACEMENT GROUP CODE is the Commissioning Data Set Group into which CDS Types must be grouped when using the Commissioning Data Set Bulk Replacement Update Mechanism.

CDS BULK REPLACEMENT GROUP CODE is not required when the Commissioning Data Set Net Change Update Mechanism is used.

The Commissioning Data Set Bulk Replacement Update Mechanism process identifies previously transferred CDS Types that are to be replaced by the submitted Commissioning Data Set interchange. To do this the CDS BULK REPLACEMENT GROUP CODE must be used together with the following data items:

- CDS REPORT PERIOD START DATE
- CDS REPORT PERIOD END DATE
- CDS INTERCHANGE SENDER IDENTITY
- CDS PRIME RECIPIENT IDENTITY

It is particularly important when using the Commissioning Data Set Bulk Replacement Update Mechanism for a CDS BULK REPLACEMENT GROUP CODE to contain all the relevant CDS Types for the extracted time period in a single Commissioning Data Set Interchange, e.g. the Finished General Episodes, Finished Delivery Episodes and Finished Birth Episodes in a Finished Episode Group.

Permitted National Codes:

010	Finished General, Delivery and Birth Episodes
020	Unfinished General, Delivery and Birth Episodes
030	Other Delivery
040	Other Birth
050	Detained and/or Long Term Psychiatric Census
060	Outpatient
070	Standard variation of Elective Admission List End Of Period Census
080	New and Old variations of Elective Admission List End Of Period Census
090	Add variation of Elective Admission List Event During Period
100	Remove variation of Elective Admission List Event During Period
110	Offer variation of Elective Admission List Event During Period
120	Available/Unavailable variation of Elective Admission List Event During Period
130	New and Old variations of Elective Admission List Event During Period
140	Accident and Emergency Attendance
150	Future Outpatient
160	Emergency Care Attendance

* Note - National Code '*Emergency Care Attendance*' is only valid for the CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol and CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol

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CDS COPY RECIPIENT IDENTITY

Change to Data Element: Changed Dataset

Format/Length:	an3 or an5
National Codes:	
ODS Default Codes:	VPP00 - Private PATIENTS / Overseas Visitor liable for charges YDD82 - Episodes funded directly by the National Commissioning Group for England

Notes:
CDS COPY RECIPIENT IDENTITY is the same as attribute ORGANISATION CODE.

CDS COPY RECIPIENT IDENTITY is the NHS ORGANISATION CODE (or valid Organisation Data Service Default Code) for an Organisation indicated as a CDS COPY RECIPIENT IDENTITY of the Commissioning data.

Usage:
A Recipient may be an agency or service provider that carries out the receiving (and perhaps other) processes on behalf of the NHS Organisation that ultimately uses the data. There may be multiple recipients for Commissioning data.

Organisation Data Service Default Codes for CDS COPY RECIPIENT IDENTITIES are detailed in the Commissioning Data Set Addressing Grid.

CDS EXTRACT DATE

Change to Data Element: Changed Dataset

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
CDS EXTRACT DATE is the DATE (with an associated CDS EXTRACT TIME) of the update event (or the nearest equivalent) that resulted in the need to exchange this Commissioning Data Set.

Usage:
CDS EXTRACT DATE is mandatory when used with the Commissioning Data Set Bulk Replacement Update Mechanism. It is not required when the Commissioning Data Set Net Change Update Mechanism is used, see the Commissioning Data Set Submission Protocol.

The CDS EXTRACT DATE (and CDS EXTRACT TIME if supplied) is used by the Secondary Uses Service to detect duplicate Interchanges of a similarly defined Bulk Update submission of Commissioning Data Sets.

The Secondary Uses Service processes and stores the date and time information to ensure correct updating of the Commissioning Data Set data in the correct relative date/time sequence.

CDS EXTRACT TIME

Change to Data Element: Changed Dataset

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
CDS EXTRACT TIME is the TIME (with an associated CDS EXTRACT DATE) at which the Commissioning data extract was undertaken.

Usage:
CDS EXTRACT TIME is mandatory when using the Commissioning Data Set Bulk Replacement Update Mechanism and is used to ensure that submissions are processed in the correct relative sequence. See the Commissioning Data Set Submission Protocol.

The sender of Commissioning Data Set data should determine the most useful point of the system's processes to generate this time value to provide a useful reference/audit control point.

CDS INTERCHANGE APPLICATION REFERENCE

Change to Data Element: Changed Dataset

Format/Length:	an14
National Codes:	
Default Codes:	

Notes:
CDS INTERCHANGE APPLICATION REFERENCE identifies the application content of the Interchange where the Interchange contains only one type of Message.

Usage:
This facility enables submitted interchanges to be marked to enable interchange content to be identified and recorded.
All CDS Interchanges must contain this data element.

CODE	CLASSIFICATION
NHSCDS	CDS Interchange

CDS XML Schema Interchanges:
CDS XML Schema interchanges submitted may contain the optional CDS INTERCHANGE APPLICATION REFERENCE.

CDS INTERCHANGE CONTROL COUNT

Change to Data Element: Changed Dataset

Format/Length:	n7
National Codes:	
Default Codes:	

Notes:
CDS INTERCHANGE CONTROL COUNT is a mandatory data element and is a count of CDS Messages contained in the CDS Interchange.

Usage:
Senders of CDS Interchanges must generate this data. Recipients of CDS Interchanges are advised to recount the received CDS messages and match this control count to ensure all CDS data submitted has been correctly received.

CDS INTERCHANGE CONTROL REFERENCE

Change to Data Element: Changed Dataset

Format/Length:	an14
National Codes:	
Default Codes:	

Notes:
CDS INTERCHANGE CONTROL REFERENCE provides a unique number (per sender identity) to identify every Commissioning Data Set Interchange submission.

For each Interchange submitted, the CDS INTERCHANGE CONTROL REFERENCE must be incremented by 1. The maximum value supported is n7 and wrap around from 9999999 to 1 must be supported.

Usage:
CDS INTERCHANGE CONTROL REFERENCE is a mandatory data element when submitting Commissioning Data Set Interchanges and is used to uniquely identify and if required, to sequence check Commissioning Data Set submissions.

Although (for historical reasons) contained in a 14 alpha-numeric format, a maximum value of 9999999 is permitted in the format of n7.

This control reference data may also be presented on Secondary Uses Service (SUS) service messages and audit logs, etc.

CDS XML Schema Interchanges:
All CDS XML Schema interchanges submitted must contain a CDS INTERCHANGE CONTROL REFERENCE.

CDS INTERCHANGE DATE OF PREPARATION

Change to Data Element: Changed Dataset

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
CDS INTERCHANGE DATE OF PREPARATION is the DATE when the Commissioning Data Set Interchange data was created.

Usage:
CDS INTERCHANGE DATE OF PREPARATION is a mandatory data element when submitting Commissioning data.

CDS XML Schema Interchanges:
All CDS XML Schema interchanges submitted must contain a CDS INTERCHANGE DATE OF PREPARATION.

CDS INTERCHANGE RECEIVER IDENTITY

Change to Data Element: Changed Dataset

Format/Length:	an15
National Codes:	
Default Codes:	

Notes:
CDS INTERCHANGE RECEIVER IDENTITY is the address of the physical site receiving a Commissioning Data Set interchange.

Usage:
The collection facility for Commissioning data is the Secondary Uses Service.

CDS XML Schema Interchanges:
All CDS XML Schema interchanges submitted must contain the CDS INTERCHANGE RECEIVER IDENTITY of the Secondary Uses Service.

CDS INTERCHANGE SENDER IDENTITY

Change to Data Element: Changed Dataset

Format/Length:	an15
National Codes:	
Default Codes:	

Notes:
CDS INTERCHANGE SENDER IDENTITY is the assigned EDI Address of the physical Organisation or site responsible for sending Commissioning data.

Usage:
CDS INTERCHANGE SENDER IDENTITY is a mandatory data element when submitting Commissioning Data Set interchanges.
Every Organisation must register its CDS INTERCHANGE SENDER IDENTITY for use with the Secondary Uses Service.

Where an Organisation acts on behalf of another NHS Organisation, care must be taken to ensure the correct use of the identity. For data submitted to the service, the CDS INTERCHANGE SENDER IDENTITY is the EDI Address of the sending site.

CDS XML Schema Interchanges:
All CDS XML Schema interchanges submitted must contain a CDS INTERCHANGE SENDER IDENTITY.

CDS INTERCHANGE TEST INDICATOR

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	
Default Codes:	

Notes:
CDS INTERCHANGE TEST INDICATOR indicates whether the Interchange is a production or test Interchange.

Permitted National Codes:

1	The whole Interchange contains Test data

0 (zero)	The whole Interchange contains Production data
Other Blank Null	The whole Interchange contains Production data

Usage:
This optional test facility enables interchanges submitted to be marked and therefore processed as Test or Production data.

Whilst the data element is optional it is highly recommended that correct values be completed in the data.

On receipt of a Test Interchange, the processes are as follows:
a) All normal validation processes will be carried out
b) The Interchange data will not be entered into the Secondary Uses Service database

CDS XML Schema Interchanges:
All CDS XML Schema interchanges submitted may contain a CDS INTERCHANGE TEST INDICATOR.

CDS INTERCHANGE TIME OF PREPARATION

Change to Data Element: Changed Dataset

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
CDS INTERCHANGE TIME OF PREPARATION is the time when the Commissioning Data Set Interchange data was created.

Usage:
CDS INTERCHANGE TIME OF PREPARATION is a mandatory data element when submitting Commissioning Data Set Interchanges.

CDS XML Schema Interchanges:
All CDS XML Schema interchanges submitted to the service must contain a CDS INTERCHANGE TIME OF PREPARATION.

CDS MESSAGE REFERENCE

Change to Data Element: Changed Dataset

Format/Length:	an14
National Codes:	
Default Codes:	

Notes:
CDS MESSAGE REFERENCE is a mandatory data element and is a sequentially incremented number for each message within an interchange.

Usage:
For each message within an interchange the CDS MESSAGE REFERENCE is assigned to provide a unique identity (within an interchange). Although the data is configured in a 14 alpha-numeric format, a maximum value of 9999999 is permitted in the format of n7. Wrap around from 9999999 to 1 must be supported.

CDS MESSAGE TYPE

Change to Data Element: Changed Dataset

Format/Length:	an6
National Codes:	
Default Codes:	

Notes:
CDS MESSAGE TYPE is a recommended data element and should be used to indicate the type of message within a Commissioning Data Set Interchange.

Permitted National Codes:

NHSCDS	CDS Message

Usage:
Commissioning Data Set XML Schema interchanges should only contain multiple message of the same CDS MESSAGE TYPE.

CDS MESSAGE VERSION NUMBER

Change to Data Element: Changed Description, Dataset

Format/Length:	an8
National Codes:	
Default Codes:	

Notes:
CDS MESSAGE VERSION NUMBER is a mandatory data element in the Commissioning Data Set Message Header and reflects the version number of the CDS XML Schema in use. Message version numbers are updated as required during the on-going message development processes.

Permitted National Codes:

NHS003	The 2000 / 2001 Specification	
NHS004	The 2004 / 2005 CDS XML Specification	
NHS005	The 2005 / 2006 CDS XML Specification	For implementation of XML messaging in the Secondary Uses Service
CDS006	The 2007 CDS-XML Specification (CDS V6-0/6-1/6-1-1)	Note the change to the prefix **CDS**
~~CDS062~~	~~The 2012 CDS XML Specification (CDS V6-2)~~	~~Note the change to the format which represents the sub-version identifier (version 6-2)~~
CDS062	The 2012 CDS XML Specification (CDS V6-2/6-2-1)	Note the change to the format which represents the sub-version identifier (version 6-2)

Usage:
Interchanges must only contain CDS Messages of the same CDS MESSAGE VERSION NUMBER and each and every CDS Type must contain a CDS MESSAGE VERSION NUMBER.

CDS PRIME RECIPIENT IDENTITY

Change to Data Element: Changed Dataset

Format/Length:	an3 or an5
National Codes:	
ODS Default Codes:	TDH00 - Overseas Visitor exempt from charges

Notes:
CDS PRIME RECIPIENT IDENTITY is the same as attribute ORGANISATION CODE.

CDS PRIME RECIPIENT IDENTITY is the mandatory NHS ORGANISATION CODE (or valid Organisation Data Service Default Code) representing the Organisation determined to be the Commissioning Data Set Prime Recipient of the Commissioning Data Set Message as indicated in the Commissioning Data Set Addressing Grid.

Usage:
The CDS PRIME RECIPIENT IDENTITY must be allocated on the first creation and submission of a CDS Type for a PATIENT and **must not change even if the ADDRESS or ORGANISATION CODE (RESIDENCE RESPONSIBILITY) of the PATIENT changes during the lifetime of the Commissioning Data Set record** otherwise duplicate Commissioning Data Set data may be lodged in the Secondary Uses Service database.

CDS PRIME RECIPIENT IDENTITY is a mandatory data item crucial for the correct indexing of the database and must not be changed during the life of the associated Commissioning Data Set. It does not identify the first or most important recipient of data, i.e. there is no inference of primacy of one recipient over another.

Organisation Data Service Default Codes for CDS PRIME RECIPIENT IDENTITIES are detailed in the Commissioning Data Set Addressing Grid.

Please note that the following Organisation Data Service Default Codes must not be used in the Commissioning Data Set (CDS) header because they are not default Commissioner codes:

- Q99 - High Level Health Geography/Primary Care Organisation of Residence Not Known
  - for the CDS PRIME RECIPIENT IDENTITY, a valid ORGANISATION CODE (RESIDENCE RESPONSIBILITY) must be reported
- X98 - Primary Care Organisation Not Applicable (Overseas Visitors)
  - for the CDS PRIME RECIPIENT IDENTITY, the Commissioning Data Set Addressing Grid confirms the correct code that should be reported for Overseas Visitors who are exempt from charges.

CDS PROTOCOL IDENTIFIER CODE

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	
Default Codes:	

Notes:
CDS PROTOCOL IDENTIFIER CODE is a code to identify the Commissioning Data Set Submission Protocol associated with the transaction.

Permitted National Codes:

010 Net Change Update Mechanism
(This is the recommended Protocol for Commissioning Data Set submissions)
020 Bulk Replacement Update Mechanism

CDS RECORD IDENTIFIER

Change to Data Element: Changed Dataset

Format/Length:	an35
National Codes:	
Default Codes:	

Notes:
CDS RECORD IDENTIFIER may also be referred to as the **CDS-RID**.

When exchanging Commissioning Data Set data, this is an optional data element and when used is a unique number generated by the sender and inserted into the Commissioning Data Set data to enable senders and recipients to be able to cross-match and uniquely identify each and every Commissioning Data Set record.

The CDS RECORD IDENTIFIER consists of the following components:

REF	RID COMPONENT	FORMAT	CODES / VALUES
1	CDS SENDER IDENTITY	an5	As generated in the CDS V6-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol or the CDS V6-2 Type 005N - CDS Transaction Header Group - Net Change Protocol
2	Not Used	an2	Set = Blank
3	CDS INTERCHANGE CONTROL REFERENCE	an14 (n7) *	As generated in the CDS V6-2 Type 001 - CDS Interchange Header
4	CDS MESSAGE REFERENCE	an14 (n7) *	As generated in the CDS V6-2 Type 003 - CDS Message Header

* This data item is configured as an14 format element, but a maximum value of 9999999 is permitted in the format of n7.

Usage:

The CDS-RID is an optional reference assigned to each record by the Commissioning Data Set sender to aid the identification and cross-referencing of data between the sender and the receiver(s) of the Commissioning Data Set data.

CDS XML Schema Interchanges:

The CDS-RID data element is carried in the CDS Message Header (CDS V6-2 Type 003 - CDS Message Header).

CDS REPORT PERIOD END DATE

Change to Data Element: Changed Dataset

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
CDS REPORT PERIOD END DATE defines the End Date (for the date range of the data being exchanged) for the Commissioning Data Set Bulk Replacement Update time period.

Usage:
CDS REPORT PERIOD END DATE is a mandatory data item when the Commissioning Data Set Bulk Replacement Update Mechanism is used. It is not required when the Commissioning Data Set Net Change Update Mechanism is used.
The CDS REPORT PERIOD END DATE must be a valid date and must not be before the CDS REPORT PERIOD START DATE.

See the supporting information in the Commissioning Data Set Submission Protocol for further details.

CDS REPORT PERIOD START DATE

Change to Data Element: Changed Dataset

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
CDS REPORT PERIOD START DATE defines the Start Date (for the date range of the data being exchanged) for the Bulk Replacement Update time period.

Usage:
CDS REPORT PERIOD START DATE is a mandatory data item when the Commissioning Data Set Bulk Replacement Update Mechanism is used. It is not required when the Commissioning Data Set Net Change Update Mechanism is used.
The CDS REPORT PERIOD START DATE must be a valid date and cannot be after the CDS REPORT PERIOD END DATE.

See the supporting information in the Commissioning Data Set Submission Protocol for further details.

CDS SENDER IDENTITY

Change to Data Element: Changed Dataset

Format/Length:	an3 or an5
National Codes:	
Default Codes:	

Notes:
CDS SENDER IDENTITY is the mandatory NHS ORGANISATION CODE of the Organisation acting as the physical Sender of Commissioning Data Set submissions.

Usage:
The Commissioning Data Set sender must make sure that the Commissioning Data Set extraction and submission facilities and processes differentiate correctly between:

- The ORGANISATION CODE (CDS SENDER IDENTITY) as carried in the CDS Transaction Header Group for every Commissioning Data Set, and
- The ORGANISATION CODE (CODE OF PROVIDER) as carried in the Service Agreement details which are part of the Episode/Attendance details.

Once associated with the a Commissioning Data Set record and submitted to the Secondary Uses Service, the CDS SENDER IDENTITY should not be changed unless great care is taken to delete the original Commissioning Data Set records before any resubmission is undertaken.

Usually, the CDS SENDER IDENTITY is never altered once assigned.

CDS TYPE CODE

Change to Data Element: Changed Description, Dataset

Format/Length:	an3
National Codes:	
Default Codes:	

Notes:
CDS TYPE CODE is a code to identify the specific type of Commissioning Data Set data.

Permitted National Codes:

010	Accident and Emergency Attendance
011	Emergency Care Attendance *
020	Outpatient May also be used to submit a Referral To Treatment Clock Stop Administrative Event
021	Future Outpatient
030	Elective Admission List End of Period Census (Standard)
040	Elective Admission List End of Period Census (Old)
050	Elective Admission List End of Period Census (New)
060	Elective Admission List Event During Period (Add)
070	Elective Admission List Event During Period (Remove)
080	Elective Admission List Event During Period (Offer)
090	Elective Admission List Event During Period (Available/Unavailable)
100	Elective Admission List Event During Period (Old Service Agreement)
110	Elective Admission List Event During Period (New Service Agreement)
120	Finished Birth Episode
130	Finished General Episode
140	Finished Delivery Episode
150	Other Birth
160	Other Delivery
170	Detained and/or Long-Term Psychiatric Census
180	Unfinished Birth Episode
190	Unfinished General Episode
200	Unfinished Delivery Episode

* Note - National Code '*Emergency Care Attendance*' is only valid for the CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol and CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol

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CDS UNIQUE IDENTIFIER

Change to Data Element: Changed Dataset

Format/Length:	an35
National Codes:	
Default Codes:	

Notes:
See the supporting information in the Commissioning Data Set Submission Protocol.

A Commissioning Data Set data element providing a unique identity for the life-time of an episode carried in a Commissioning Data Set message.

Once assigned, a Commissioning Data Set record must retain its CDS UNIQUE IDENTIFIER otherwise duplicate Commissioning Data Set records may be generated and stored in the Secondary Uses Service database.

The CDS UNIQUE IDENTIFIER has three components. The recommended constructs are given below.

For All CDS Types EXCEPT the EAL CDS Types:

REF	UID	FORMAT	CODES / VALUES	COMMENT
1	**NHS Organisation Code Type**	an1	A = Pre 1996 Organisation Code B = Post 1996 NHS Organisation Code	Mandatory For all CDS Types
2	**Provider Code**	an5	The NHS Organisation Code of the Provider at the time of, or at the start of, the period covered by the activity reported by the CDS Message.	Mandatory for all CDS Types
3a	**Application Specific CDS Identity**	an29	A code of up to **29 alpha-numeric characters** generated by the Sender's application to uniquely identify the CDS within its CDS Type or family of CDS Types	Mandatory for all CDS Types **Except for EAL CDS Types**

For EAL End Of Period (EOP) CDS Types only:

REF	UID	FORMAT	CODES / VALUES	COMMENT
1	**NHS Organisation Code Type**	an1	A = Pre 1996 Organisation Code B = Post 1996 NHS Organisation Code	Mandatory For all CDS Types
2	**Provider Code**	an5	The NHS Organisation Code of the Provider at the time of, or at the start of, the period covered by the activity reported by the CDS Message.	Mandatory for all CDS Types
3b	**Application Specific CDS Identity**	an9	A code of up to **9 alpha-numeric characters** generated by the Sender's application to uniquely identify the EAL End Of period census CDS Types with the same Admission List Entry. Additional data positions must be left blank.	**Mandatory for all EAL EOP CDS Types**
3c	**Filler**	an20	Additional data positions must be left blank.	

For EAL Event During Period (EDP) CDS Types only:

REF	UID	FORMAT	CODES / VALUES	COMMENT
1	**NHS Organisation Code Type**	an1	A = Pre 1996 Organisation Code B = Post 1996 NHS Organisation Code	**Mandatory For all CDS Types**
2	**Provider Code**	an5	The NHS Organisation Code of the Provider at the time of, or at the start of, the period covered by the activity reported by the CDS Message.	**Mandatory for all CDS Types**
3d	**Application Specific CDS Identity**	an9	A code of up to **5 alpha-numeric characters padded with 4 trailing spaces to 9 characters**. Generated by the Sender's application to uniquely identify the EAL Event During Period Census CDS Types with the same Admission List Entry.	**Mandatory for all EAL EDP CDS Types**
3e	**Filler**	an3	A code of **3 alpha-numeric characters** generated by the Sender's application to identify **the event** within the EAL Entry. Even if the events are of different types, they must have different identifiers. .	**Mandatory for all EAL EDP CDS Types**
3f	**Filler**	an17	Additional data positions must be left blank.	

Usage:
See the supporting information in the Commissioning Data Set Submission Protocol for detailed information.

This is a mandatory data item when the Net Change Update Mechanism is used and strongly recommended for use with the Bulk Replacement Update Mechanism.

However it is strongly advised that users of the Bulk Replacement Mechanism maintain a correctly generated CDS UNIQUE IDENTIFIER within the Commissioning data. This will establish a migration path towards the use of the Net Change Mechanism and will also then minimise the risk of creating duplicate Commissioning Data Set data in the Secondary Uses Service database.

1. Note that senders of Commissioning Data Set data remain directly responsible for the integrity of the CDS UNIQUE IDENTIFIER.
2. The first two components, the ORGANISATION CODE TYPE and the ORGANISATION CODE (CODE OF PROVIDER), are required for all CDS Types.
3. It is a mandatory requirement for all submissions using the Net Change Update Mechanism that these two components are constructed correctly to ensure uniqueness of CDS UNIQUE IDENTIFIERS across the NHS.
4. The structure of 3b and 3c allows the EAL End of Period Census and the EAL Event During Period Census for the same EAL Entry to be linked.

There are circumstances in patient care application systems where the control of the UID key integrity may be suspect. These issues include:

a) Episode deletion (not resulting in a Commissioning Data Set deletion of previously submitted data sent to the original Commissioner);
b) Episode re-sequencing (not resulting in a corresponding Commissioning Data Set records being sent);
c) Service agreement alterations not resulting in correct adjustments - Old Service Agreement deletion / New Service Agreement addition
d) Re-admissions causing duplicate keys on the Secondary Uses Service database.

CDS UPDATE TYPE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	
Default Codes:	

Notes:
CDS UPDATE TYPE is a code to indicate the required database update process for the submitted CDS Message.

Permitted National Codes:

1	To indicate a CDS Deletion or Cancellation
9	To indicate a CDS Original or Replacement

Usage:
CDS UPDATE TYPE is a mandatory data item when using the Net Change Update Mechanism. It is not required when using the Bulk Replacement Update Mechanism.

CLINICAL TRIAL IDENTIFIER

Change to Data Element: New Data Element

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

Notes:
CLINICAL TRIAL IDENTIFIER is the same as attribute CLINICAL TRIAL IDENTIFIER.

Use in the CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set:

- The CLINICAL TRIAL IDENTIFIER must be recognised and registered with an ORGANISATION which is a Primary Registry in the World Health Organisation International Clinical Trials Registry Platform.
- CLINICAL TRIAL IDENTIFIER is collected for a specified purpose at national level only and will not be available from the Secondary Uses Service for use by unauthorised ORGANISATIONS or individuals.

This data element is also known by these names:

Context	Alias
plural	CLINICAL TRIAL IDENTIFIERS

CLINICAL TRIAL IDENTIFIER

Change to Data Element: New Data Element

CLINICAL TRIAL IDENTIFIER

Attribute:

CLINICAL TRIAL IDENTIFIER

CODED CLINICAL ENTRY SEQUENCE NUMBER

Change to Data Element: New Data Element

Format/Length:	max n5
National Codes:	
Default Codes:	

Notes:
CODED CLINICAL ENTRY SEQUENCE NUMBER is the same as attribute CODED CLINICAL ENTRY SEQUENCE NUMBER.

This data element is also known by these names:

Context	Alias
plural	CODED CLINICAL ENTRY SEQUENCE NUMBERS

CODED CLINICAL ENTRY SEQUENCE NUMBER

Change to Data Element: New Data Element

CODED CLINICAL ENTRY SEQUENCE NUMBER

Attribute:

CODED CLINICAL ENTRY SEQUENCE NUMBER

COMMISSIONER REFERENCE NUMBER

Change to Data Element: Changed Dataset

Format/Length:	an17
National Codes:	
Default Codes:	8 (left justified padded with spaces) - Not applicable 9 (left justified padded with spaces) - Not known

Notes:
COMMISSIONER REFERENCE NUMBER is the same as attribute COMMISSIONER REFERENCE NUMBER.

COMMISSIONING SERIAL NUMBER

Change to Data Element: Changed Dataset

Format/Length:	an6
National Codes:	
Default Codes:	

Notes:
COMMISSIONING SERIAL NUMBER is the same as attribute NHS SERVICE AGREEMENT NUMBER.

From 01/04/2001 this data item will be used to identify PATIENTS treated under Non-Contract Activities. NHS Trusts and NHS Foundation Trusts are required to insert the letters 'OAT' (mandated input as capitals) in the first three characters of the COMMISSIONING SERIAL NUMBER field of the Admitted Patient Care Commissioning Data Set. The remaining three characters will continue to be defined locally, see DSCN 17/2000.

From 01/04/2005 an '=' (equals) as the last significant character in this six character field will indicate an episode that should be excluded from the National Tariff Payment System tariff.

The position of the last character depends on any preceding characters eg 1st character if field is otherwise blank, 4th character if following 'OAT', up to a maximum of 6th position. This provides a general exclusion facility for unusual circumstances or where more specific rules regarding coding in other fields cannot be implemented due to local software restrictions.

COMORBIDITY (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
COMORBIDITY (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

COMORBIDITY (SNOMED CT) is the SNOMED CT® concept ID which is used to identify comorbid conditions.

SNOMED CT Subset Metadata:

- Subset Name: Comorbid conditions for selection
- Subset 61071000000137
- Refset FSN: Comorbid conditions for selection simple reference set (foundation metadata concept)
- Refset Id: 991381000000107

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Comorbid conditions for selection.

This data element is also known by these names:

Context	Alias
snomedctsubsetoriginalid	61071000000137
snomedctrefsetname	Comorbid conditions for selection simple reference set (foundation metadata concept)
snomedctsubsetname	Comorbid conditions for selection
plural	COMORBIDITIES (SNOMED CT)
snomedctrefsetid	991381000000107

COMORBIDITY (SNOMED CT)

Change to Data Element: New Data Element

COMORBIDITY (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

DECIDED TO ADMIT DATE

Change to Data Element: Changed Dataset

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
DECIDED TO ADMIT DATE is the same as attribute DECIDED TO ADMIT DATE.

DECIDED TO ADMIT DATE may be the same as the date of admission (e.g. most emergency admissions). Alternatively, a decision can be made to admit at a future date. This decision denotes that the PATIENT is intended to be admitted to a Hospital Bed, either immediately or subsequently in the future. It records the event that a clinical DECISION TO ADMIT a PATIENT to a Hospital Bed has been made by or on behalf of someone, who has the right of admission to a Hospital Provider.

The date will be different from the ORIGINAL DECIDED TO ADMIT DATE when the PATIENT has been transferred from another provider's list, or when the PATIENT has been admitted to hospital, discharged but not treated and is again placed on an ELECTIVE ADMISSION LIST with a new DECISION TO ADMIT.

DECIDED TO ADMIT TIME

Change to Data Element: New Data Element

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
DECIDED TO ADMIT TIME is the same as attribute DECIDED TO ADMIT TIME.

This data element is also known by these names:

Context	Alias
plural	DECIDED TO ADMIT TIMES

DECIDED TO ADMIT TIME

Change to Data Element: New Data Element

DECIDED TO ADMIT TIME

Attribute:

DECIDED TO ADMIT TIME

DISEASE OUTBREAK NOTIFICATION

Change to Data Element: New Data Element

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

Notes:
DISEASE OUTBREAK NOTIFICATION is the same as attribute PERSON OBSERVATION TEXT STRING.

DISEASE OUTBREAK NOTIFICATION is used in the CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set to support collection of nationally-notifiable data relating to outbreaks of disease which are identified in Emergency Care Departments. Where a SNOMED CT CODE is available, the DISEASE OUTBREAK NOTIFICATION field should contain this. If a SNOMED CT CODE is NOT available, then it is permissible to submit free-text detail of the disease.

DISEASE OUTBREAK NOTIFICATION is collected for a specified purpose at national level only and will not be available from the Secondary Uses Service for use by unauthorised ORGANISATIONS or individuals.

DISEASE OUTBREAK NOTIFICATION

Change to Data Element: New Data Element

DISEASE OUTBREAK NOTIFICATION

Attribute:

PERSON OBSERVATION TEXT STRING

EMERGENCY CARE ACUITY (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
EMERGENCY CARE ACUITY (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

EMERGENCY CARE ACUITY (SNOMED CT) is the SNOMED CT® concept ID which is used to indicate the acuity of the PATIENT's condition on the Emergency Care Initial Assessment Date and Emergency Care Initial Assessment Time.

The EMERGENCY CARE ACUITY (SNOMED CT) may be determined by a formal triage process, or by the physical allocation of the PATIENT to a specific clinical area such as Resuscitation.

SNOMED CT Subset Metadata:

- Subset Name: Emergency care acuity
- Subset Original Id: 75071000000132
- Refset FSN: Emergency care acuity simple reference set (foundation metadata concept)
- Refset Id: 999003061000000107

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Emergency care acuity.

This data element is also known by these names:

Context	Alias
plural	EMERGENCY CARE ACUITIES (SNOMED CT)

EMERGENCY CARE ACUITY (SNOMED CT)

Change to Data Element: New Data Element

EMERGENCY CARE ACUITY (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

EMERGENCY CARE ARRIVAL DATE

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
EMERGENCY CARE ARRIVAL DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Emergency Care Arrival Date*'.

This data element is also known by these names:

Context	Alias
plural	EMERGENCY CARE ARRIVAL DATES

EMERGENCY CARE ARRIVAL DATE

Change to Data Element: New Data Element

EMERGENCY CARE ARRIVAL DATE

Attribute:

ACTIVITY DATE

EMERGENCY CARE ARRIVAL MODE (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
EMERGENCY CARE ARRIVAL MODE (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

EMERGENCY CARE ARRIVAL MODE (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the transport mode by which the PATIENT arrived at the Emergency Care Department.

SNOMED CT Subset Metadata:

- Subset Name: Emergency care arrival mode
- Subset Original Id: 72101000000133
- Refset FSN: Emergency care arrival mode simple reference set (foundation metadata concept)
- Refset Id: 999002981000000107

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Emergency care arrival mode.

This data element is also known by these names:

Context	Alias
snomedctsubsetoriginalid	72101000000133
snomedctrefsetname	Emergency care arrival mode simple reference set
snomedctsubsetname	Emergency care arrival mode
plural	EMERGENCY CARE ARRIVAL MODES (SNOMED CT)
snomedctrefsetid	999002981000000107

EMERGENCY CARE ARRIVAL MODE (SNOMED CT)

Change to Data Element: New Data Element

EMERGENCY CARE ARRIVAL MODE (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

EMERGENCY CARE ARRIVAL TIME

Change to Data Element: New Data Element

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
EMERGENCY CARE ARRIVAL TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Emergency Care Arrival Time*'.

This data element is also known by these names:

Context	Alias
plural	EMERGENCY CARE ARRIVAL TIMES

EMERGENCY CARE ARRIVAL TIME

Change to Data Element: New Data Element

EMERGENCY CARE ARRIVAL TIME

Attribute:

ACTIVITY TIME

EMERGENCY CARE ATTENDANCE CATEGORY

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See EMERGENCY CARE ATTENDANCE CATEGORY
Default Codes:	X - Not Applicable (PATIENT dead on arrival in Emergency Care Department)

Notes:
EMERGENCY CARE ATTENDANCE CATEGORY is the same as attribute EMERGENCY CARE ATTENDANCE CATEGORY.

This data element is also known by these names:

Context	Alias
plural	EMERGENCY CARE ATTENDANCE CATEGORIES

EMERGENCY CARE ATTENDANCE CATEGORY

Change to Data Element: New Data Element

EMERGENCY CARE ATTENDANCE CATEGORY

Attribute:

EMERGENCY CARE ATTENDANCE CATEGORY

EMERGENCY CARE ATTENDANCE CONCLUSION DATE

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
EMERGENCY CARE ATTENDANCE CONCLUSION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Emergency Care Attendance Conclusion Date*'.

This data element is also known by these names:

Context	Alias
plural	EMERGENCY CARE ATTENDANCE CONCLUSION DATES

EMERGENCY CARE ATTENDANCE CONCLUSION DATE

Change to Data Element: New Data Element

EMERGENCY CARE ATTENDANCE CONCLUSION DATE

Attribute:

ACTIVITY DATE

EMERGENCY CARE ATTENDANCE CONCLUSION TIME

Change to Data Element: New Data Element

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
EMERGENCY CARE ATTENDANCE CONCLUSION TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Emergency Care Attendance Conclusion Time*'.

This data element is also known by these names:

Context	Alias
plural	EMERGENCY CARE ATTENDANCE CONCLUSION TIMES

EMERGENCY CARE ATTENDANCE CONCLUSION TIME

Change to Data Element: New Data Element

EMERGENCY CARE ATTENDANCE CONCLUSION TIME

Attribute:

ACTIVITY TIME

EMERGENCY CARE ATTENDANCE IDENTIFIER

Change to Data Element: New Data Element

Format/Length:	max an12
National Codes:	
Default Codes:	

Notes:
EMERGENCY CARE ATTENDANCE IDENTIFIER is same as attribute ACTIVITY IDENTIFIER.

EMERGENCY CARE ATTENDANCE IDENTIFIER is an identifier allocated by an Emergency Care Department to provide a unique identifier for each Emergency Care Attendance.

This data element is also known by these names:

Context	Alias
plural	EMERGENCY CARE ATTENDANCE IDENTIFIERS

EMERGENCY CARE ATTENDANCE IDENTIFIER

Change to Data Element: New Data Element

EMERGENCY CARE ATTENDANCE IDENTIFIER

Attribute:

ACTIVITY IDENTIFIER

EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT) is the SNOMED CT® concept ID which is used to indicate the source of an Emergency Care Attendance.

SNOMED CT Subset Metadata:

- Subset Name: Emergency care attendance source
- Subset Original Id: 75011000000136
- Refset FSN: Emergency care source of attendance findings simple reference set (foundation metadata concept)
- Refset Id: 999003041000000106

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Emergency care attendance source.

This data element is also known by these names:

Context	Alias
snomedctsubsetoriginalid	75011000000136
snomedctrefsetname	Emergency care source of attendance findings simple reference set
snomedctsubsetname	Emergency care attendance source
plural	EMERGENCY CARE ATTENDANCE SOURCES (SNOMED CT)
snomedctrefsetid	999003041000000106

EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT)

Change to Data Element: New Data Element

EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT) is the SNOMED CT® concept ID which is used to indicate the nature of the PATIENT's chief complaint as assessed by the CARE PROFESSIONAL first assessing the PATIENT.

SNOMED CT Subset Metadata:

- Subset Name: Emergency care presenting complaints or issues
- Subset Original Id: 63491000000132
- Refset FSN: Emergency care presenting complaints or issues simple reference set (foundation metadata concept)
- Refset Id: 991401000000107

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Emergency care presenting complaints or issues.

This data element is also known by these names:

Context	Alias
snomedctsubsetoriginalid	63491000000132
snomedctrefsetname	Emergency care presenting complaints or issues simple reference set (foundation metadata concept)
snomedctsubsetname	Emergency care presenting complaints or issues
plural	EMERGENCY CARE CHIEF COMPLAINTS (SNOMED CT)
snomedctrefsetid	991401000000107

EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT)

Change to Data Element: New Data Element

EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

EMERGENCY CARE CLINICAL INVESTIGATION (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
EMERGENCY CARE CLINICAL INVESTIGATION (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

EMERGENCY CARE CLINICAL INVESTIGATION (SNOMED CT) is the SNOMED CT® concept ID which is used to identify a Clinical Investigation performed while a PATIENT is under the care of an Emergency Care Department.

SNOMED CT Subset Metadata:

- Subset Name: Emergency care investigations
- Subset Original Id: 63541000000137
- Refset FSN: Emergency care investigations simple reference set (foundation metadata concept)
- Refset Id: 991261000000107

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Emergency care investigations.

This data element is also known by these names:

Context	Alias
snomedctsubsetoriginalid	63541000000137
snomedctrefsetname	Emergency care investigations simple reference set (foundation metadata concept)
snomedctsubsetname	Emergency care investigations
plural	EMERGENCY CARE CLINICAL INVESTIGATIONS (SNOMED CT)
snomedctrefsetid	991261000000107

EMERGENCY CARE CLINICAL INVESTIGATION (SNOMED CT)

Change to Data Element: New Data Element

EMERGENCY CARE CLINICAL INVESTIGATION (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

EMERGENCY CARE DATE SEEN FOR TREATMENT

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
EMERGENCY CARE DATE SEEN FOR TREATMENT is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Emergency Care Date Seen For Treatment*'.

This data element is also known by these names:

Context	Alias
plural	EMERGENCY CARE DATES SEEN FOR TREATMENT

EMERGENCY CARE DATE SEEN FOR TREATMENT

Change to Data Element: New Data Element

EMERGENCY CARE DATE SEEN FOR TREATMENT

Attribute:

ACTIVITY DATE

EMERGENCY CARE DEPARTMENT TYPE

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See EMERGENCY CARE DEPARTMENT TYPE
Default Codes:	

Notes:
EMERGENCY CARE DEPARTMENT TYPE is the same as attribute EMERGENCY CARE DEPARTMENT TYPE.

This data element is also known by these names:

Context	Alias
plural	EMERGENCY CARE DEPARTMENT TYPES

EMERGENCY CARE DEPARTMENT TYPE

Change to Data Element: New Data Element

EMERGENCY CARE DEPARTMENT TYPE

Attribute:

EMERGENCY CARE DEPARTMENT TYPE

EMERGENCY CARE DEPARTURE DATE

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
EMERGENCY CARE DEPARTURE DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Emergency Care Departure Date*'.

This data element is also known by these names:

Context	Alias
plural	EMERGENCY CARE DEPARTURE DATES

EMERGENCY CARE DEPARTURE DATE

Change to Data Element: New Data Element

EMERGENCY CARE DEPARTURE DATE

Attribute:

ACTIVITY DATE

EMERGENCY CARE DEPARTURE TIME

Change to Data Element: New Data Element

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
EMERGENCY CARE DEPARTURE TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Emergency Care Departure Time*'.

This data element is also known by these names:

Context	Alias
plural	EMERGENCY CARE DEPARTURE TIMES

EMERGENCY CARE DEPARTURE TIME

Change to Data Element: New Data Element

EMERGENCY CARE DEPARTURE TIME

Attribute:

ACTIVITY TIME

EMERGENCY CARE DIAGNOSIS (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
EMERGENCY CARE DIAGNOSIS (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

EMERGENCY CARE DIAGNOSIS (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the PATIENT DIAGNOSIS.

SNOMED CT Subset Metadata:

- Subset Name: Emergency care diagnosis
- Subset 63481000000130
- Refset FSN: Emergency care diagnosis simple reference set (foundation metadata concept)
- Refset Id: 991411000000109

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Emergency care diagnosis.

This data element is also known by these names:

Context	Alias
snomedctsubsetoriginalid	63481000000130
snomedctrefsetname	Emergency care diagnosis simple reference set (foundation metadata concept)
snomedctsubsetname	Emergency care diagnosis
plural	EMERGENCY CARE DIAGNOSES (SNOMED CT)
snomedctrefsetid	991411000000109

EMERGENCY CARE DIAGNOSIS (SNOMED CT)

Change to Data Element: New Data Element

EMERGENCY CARE DIAGNOSIS (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

EMERGENCY CARE DIAGNOSIS QUALIFIER (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
EMERGENCY CARE DIAGNOSIS QUALIFIER (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

EMERGENCY CARE DIAGNOSIS QUALIFIER (SNOMED CT) is the SNOMED CT® concept ID which is used to express the level of certainty of a PATIENT DIAGNOSIS.

SNOMED CT Subset Metadata:

- Subset Name: Emergency care diagnosis qualifier
- Subset Original Id: 75021000000133
- Refset FSN: Emergency care diagnosis qualifier simple reference set (foundation metadata concept)
- Refset Id: 999003001000000108

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Emergency care diagnosis qualifier.

This data element is also known by these names:

Context	Alias
snomedctsubsetoriginalid	75021000000133
snomedctrefsetname	Emergency care diagnosis qualifier simple reference set
snomedctsubsetname	Emergency care diagnosis qualifier
plural	EMERGENCY CARE DIAGNOSIS QUALIFIERS (SNOMED CT)
snomedctrefsetid	999003001000000108

EMERGENCY CARE DIAGNOSIS QUALIFIER (SNOMED CT)

Change to Data Element: New Data Element

EMERGENCY CARE DIAGNOSIS QUALIFIER (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the intended destination of the PATIENT following discharge from the Emergency Care Department.

SNOMED CT Subset Metadata:

- Subset Name: Emergency care discharge destination
- Subset Original Id: 75031000000130
- Refset FSN: Emergency care discharge destination simple reference set (foundation metadata concept)
- Refset Id: 999003011000000105

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Emergency care discharge destination.

This data element is also known by these names:

Context	Alias
snomedctsubsetoriginalid	75031000000130
snomedctrefsetname	Emergency care discharge destination simple reference set
snomedctsubsetname	Emergency care discharge destination
plural	EMERGENCY CARE DISCHARGE DESTINATIONS (SNOMED CT)
snomedctrefsetid	999003011000000105

EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT)

Change to Data Element: New Data Element

EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the SERVICE to which a PATIENT was referred for continuing care following an Emergency Care Attendance.

SNOMED CT Subset Metadata:

- Subset Name: Emergency care follow-up procedures
- Subset Original Id: 63571000000134
- Refset FSN: Emergency care follow-up procedures simple reference set (foundation metadata concept)
- Refset Id: 991441000000105

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Emergency care follow-up procedures.

This data element is also known by these names:

Context	Alias
snomedctsubsetoriginalid	63571000000134
snomedctrefsetname	Emergency care follow-up procedures simple reference set (foundation metadata concept)
snomedctsubsetname	Emergency care follow-up procedures
plural	EMERGENCY CARE DISCHARGE FOLLOW UPS (SNOMED CT)
snomedctrefsetid	991441000000105

EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT)

Change to Data Element: New Data Element

EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

EMERGENCY CARE DISCHARGE INFORMATION GIVEN (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
EMERGENCY CARE DISCHARGE INFORMATION GIVEN (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

EMERGENCY CARE DISCHARGE INFORMATION GIVEN (SNOMED CT) is the SNOMED CT® concept ID which is used to identify whether a copy of a letter to their GENERAL PRACTITIONER has been printed and given to the PATIENT on discharge from an Emergency Care Department.

SNOMED CT Subset Metadata:

- Subset Name: Emergency care notification to general practitioner
- Subset Original Id: 63611000000139
- Refset FSN: Emergency care notification to general practitioner simple reference set (foundation metadata concept)
- Refset Id: 991241000000106

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Emergency care notification to general practitioner.

This data element is also known by these names:

Context	Alias
snomedctsubsetoriginalid	63611000000139

snomedctrefsetname	Emergency care notification to general practitioner simple reference set (foundation metadata concept)
snomedctsubsetname	Emergency care notification to general practitioner
snomedctrefsetid	991241000000106

EMERGENCY CARE DISCHARGE INFORMATION GIVEN (SNOMED CT)

Change to Data Element: New Data Element

EMERGENCY CARE DISCHARGE INFORMATION GIVEN (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

EMERGENCY CARE DISCHARGE STATUS (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
EMERGENCY CARE DISCHARGE STATUS (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

EMERGENCY CARE DISCHARGE STATUS (SNOMED CT) is the SNOMED CT® concept ID which is used indicate the status of the PATIENT on discharge from an Emergency Care Department.

SNOMED CT Subset Metadata:

- Subset Name: Emergency care discharge status
- Subset Original Id: 75041000000135
- Refset FSN: Emergency care discharge status simple reference set (foundation metadata concept)
- Refset Id: 999003021000000104

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Emergency care discharge status.

This data element is also known by these names:

Context	Alias
snomedctsubsetoriginalid	75041000000135
snomedctrefsetname	Emergency care discharge status simple reference set
snomedctsubsetname	Emergency care discharge status
plural	EMERGENCY CARE DISCHARGE STATUSES (SNOMED CT)
snomedctrefsetid	999003021000000104

EMERGENCY CARE DISCHARGE STATUS (SNOMED CT)

Change to Data Element: New Data Element

EMERGENCY CARE DISCHARGE STATUS (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

EMERGENCY CARE INITIAL ASSESSMENT DATE

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
EMERGENCY CARE INITIAL ASSESSMENT DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Emergency Care Initial Assessment Date*'.

This data element is also known by these names:

Context	Alias
plural	EMERGENCY CARE INITIAL ASSESSMENT DATES

EMERGENCY CARE INITIAL ASSESSMENT DATE

Change to Data Element: New Data Element

EMERGENCY CARE INITIAL ASSESSMENT DATE

Attribute:

ACTIVITY DATE

EMERGENCY CARE INITIAL ASSESSMENT TIME

Change to Data Element: New Data Element

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
EMERGENCY CARE INITIAL ASSESSMENT TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Emergency Care Initial Assessment Time*'.

This data element is also known by these names:

Context	Alias
plural	EMERGENCY CARE INITIAL ASSESSMENT TIMES

EMERGENCY CARE INITIAL ASSESSMENT TIME

Change to Data Element: New Data Element

EMERGENCY CARE INITIAL ASSESSMENT TIME

Attribute:

ACTIVITY TIME

EMERGENCY CARE INJURY ACTIVITY STATUS (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
EMERGENCY CARE INJURY ACTIVITY STATUS (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

EMERGENCY CARE INJURY ACTIVITY STATUS (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the status of activity being undertaken by the PATIENT when the injury occurred.

SNOMED CT Subset Metadata:

- Subset Name: Emergency care injury activity status
- Subset Original Id: 75051000000137
- Refset FSN: Emergency care injury activity status simple reference set (foundation metadata concept)
- Refset Id: 999003031000000102

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Emergency care injury activity status.

This data element is also known by these names:

Context	Alias
snomedctsubsetoriginalid	75051000000137
snomedctrefsetname	Emergency care injury activity status simple reference set
snomedctsubsetname	Emergency care injury activity status

plural	EMERGENCY CARE INJURY ACTIVITY STATUSES (SNOMED CT)
snomedctrefsetid	999003031000000102

EMERGENCY CARE INJURY ACTIVITY STATUS (SNOMED CT)

Change to Data Element: New Data Element

EMERGENCY CARE INJURY ACTIVITY STATUS (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

EMERGENCY CARE INJURY ACTIVITY TYPE (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
EMERGENCY CARE INJURY ACTIVITY TYPE (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

EMERGENCY CARE INJURY ACTIVITY TYPE (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the type of activity being undertaken by the PERSON at the moment the injury occurred.

SNOMED CT Subset Metadata:

- Subset Name: Emergency care injury activity type
- Subset Original Id: 63511000000138
- Refset FSN: Emergency care injury activity type simple reference set (foundation metadata concept)
- Refset Id: 1024501000000108

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Emergency care injury activity type.

This data element is also known by these names:

Context	Alias
snomedctsubsetoriginalid	63511000000138
snomedctrefsetname	Emergency care injury activity type simple reference set (foundation metadata concept)
snomedctsubsetname	Emergency care injury activity type
plural	EMERGENCY CARE INJURY ACTIVITY TYPES (SNOMED CT)
snomedctrefsetid	1024501000000108

EMERGENCY CARE INJURY ACTIVITY TYPE (SNOMED CT)

Change to Data Element: New Data Element

EMERGENCY CARE INJURY ACTIVITY TYPE (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

EMERGENCY CARE INJURY ALCOHOL OR DRUG INVOLVEMENT (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
EMERGENCY CARE INJURY ALCOHOL OR DRUG INVOLVEMENT (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

EMERGENCY CARE INJURY ALCOHOL OR DRUG INVOLVEMENT (SNOMED CT) is the SNOMED CT® concept ID which is used to identify any drugs or alcohol used by the PATIENT, which are thought likely to have contributed to the need to attend the Emergency Care Department.

SNOMED CT Subset Metadata:

- Subset Name: Emergency care drug or alcohol use related to injury
- Subset Original Id: 63781000000138
- Refset FSN: Emergency care drug or alcohol use related to injury simple reference set (foundation metadata concept)
- Refset Id: 991421000000103

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Emergency care drug or alcohol use related to injury.

This data element is also known by these names:

Context	Alias
snomedctsubsetoriginalid	63781000000138
snomedctrefsetname	Emergency care drug or alcohol use related to injury simple reference set (foundation metadata concept)
snomedctsubsetname	Emergency care drug or alcohol use related to injury
plural	EMERGENCY CARE INJURY ALCOHOL OR DRUG INVOLVEMENTS (SNOMED CT)
snomedctrefsetid	991421000000103

EMERGENCY CARE INJURY ALCOHOL OR DRUG INVOLVEMENT (SNOMED CT)

Change to Data Element: New Data Element

EMERGENCY CARE INJURY ALCOHOL OR DRUG INVOLVEMENT (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

EMERGENCY CARE INJURY INTENT (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
EMERGENCY CARE INJURY INTENT (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

EMERGENCY CARE INJURY INTENT (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the most likely human intent in the occurrence of the injury or poisoning as assessed by the CARE PROFESSIONAL.

SNOMED CT Subset Metadata:

- Subset Name: Emergency care injury intent type
- Subset Original Id: 63531000000132
- Refset FSN: Emergency care injury intent type simple reference set (foundation metadata concept)
- Refset Id: 991431000000101

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Emergency care injury intent type.

This data element is also known by these names:

Context	Alias
snomedctsubsetoriginalid	63531000000132
snomedctrefsetname	Emergency care injury intent type simple reference set (foundation metadata concept)
snomedctsubsetname	Emergency care injury intent type
plural	EMERGENCY CARE INJURY INTENTS (SNOMED CT)
snomedctrefsetid	991431000000101

EMERGENCY CARE INJURY INTENT (SNOMED CT)

Change to Data Element: New Data Element

EMERGENCY CARE INJURY INTENT (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

EMERGENCY CARE INJURY MECHANISM (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
EMERGENCY CARE INJURY MECHANISM (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

EMERGENCY CARE INJURY MECHANISM (SNOMED CT) is the SNOMED CT® concept ID which is used to identify how an injury was caused.

SNOMED CT Subset Metadata:

- Subset Name: Emergency care mechanism of injury
- Subset Original Id: 63521000000130
- Refset FSN: Emergency care mechanism of injury simple reference set (foundation metadata concept)
- Refset Id: 991281000000103

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Emergency care mechanism of injury.

This data element is also known by these names:

Context	Alias
snomedctsubsetoriginalid	63521000000130
snomedctrefsetname	Emergency care mechanism of injury simple reference set (foundation metadata concept)
snomedctsubsetname	Emergency care mechanism of injury
plural	EMERGENCY CARE INJURY MECHANISMS (SNOMED CT)
snomedctrefsetid	991281000000103

EMERGENCY CARE INJURY MECHANISM (SNOMED CT)

Change to Data Element: New Data Element

EMERGENCY CARE INJURY MECHANISM (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

EMERGENCY CARE PLACE OF INJURY (LATITUDE)

Change to Data Element: New Data Element

Format/Length:	max n2.n6
National Codes:	
Default Codes:	

Notes:
EMERGENCY CARE PLACE OF INJURY (LATITUDE) is the latitude of the EMERGENCY CARE PLACE OF INJURY (SNOMED CT), expressed in decimal degrees.

This data element is also known by these names:

Context	Alias
plural	EMERGENCY CARE PLACES OF INJURY (LATITUDE)

EMERGENCY CARE PLACE OF INJURY (LONGITUDE)

Change to Data Element: New Data Element

Format/Length:	max n3.n6
National Codes:	

Default Codes:

Notes:
EMERGENCY CARE PLACE OF INJURY (LONGITUDE) is the longitude of the EMERGENCY CARE PLACE OF INJURY (SNOMED CT), expressed in decimal degrees.

This data element is also known by these names:

Context	Alias
plural	EMERGENCY CARE PLACES OF INJURY (LONGITUDE)

EMERGENCY CARE PLACE OF INJURY (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
EMERGENCY CARE PLACE OF INJURY (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

EMERGENCY CARE PLACE OF INJURY (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the type of LOCATION at which the PATIENT was present when the injury occurred.

SNOMED CT Subset Metadata:

- Subset Name: Emergency care place of injury type
- Subset Original Id: 63731000000137
- Refset FSN: Emergency care place of injury type simple reference set (foundation metadata concept)
- Refset Id: 991291000000101

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Emergency care place of injury type.

This data element is also known by these names:

Context	Alias
snomedctsubsetoriginalid	63731000000137
snomedctrefsetname	Emergency care place of injury type simple reference set (foundation metadata concept)
snomedctsubsetname	Emergency care place of injury type
plural	EMERGENCY CARE PLACES OF INJURY (SNOMED CT)
snomedctrefsetid	991291000000101

EMERGENCY CARE PLACE OF INJURY (SNOMED CT)

Change to Data Element: New Data Element

EMERGENCY CARE PLACE OF INJURY (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

EMERGENCY CARE PROCEDURE (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
EMERGENCY CARE PROCEDURE (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

EMERGENCY CARE PROCEDURE (SNOMED CT) is the SNOMED CT® concept ID which is used to identify a Patient Procedure performed while a PATIENT is under the care of an Emergency Care Department.

SNOMED CT Subset Metadata:

- Subset Name: Emergency care treatments
- Subset Original Id: 611000000135
- Refset FSN: Emergency care treatments simple reference set (foundation metadata concept)
- Refset Id: 991271000000100

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Emergency care treatments.

This data element is also known by these names:

Context	Alias
snomedctsubsetoriginalid	63551000000139
snomedctrefsetname	Emergency care treatments simple reference set (foundation metadata concept)
snomedctsubsetname	Emergency care treatments
plural	EMERGENCY CARE PROCEDURES (SNOMED CT)
snomedctrefsetid	991271000000100

EMERGENCY CARE PROCEDURE (SNOMED CT)

Change to Data Element: New Data Element

EMERGENCY CARE PROCEDURE (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

EMERGENCY CARE TIME SEEN FOR TREATMENT

Change to Data Element: New Data Element

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
EMERGENCY CARE TIME SEEN FOR TREATMENT is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Emergency Care Time Seen For Treatment*'.

This data element is also known by these names:

Context	Alias
plural	EMERGENCY CARE TIMES SEEN FOR TREATMENT

EMERGENCY CARE TIME SEEN FOR TREATMENT

Change to Data Element: New Data Element

EMERGENCY CARE TIME SEEN FOR TREATMENT

Attribute:

ACTIVITY TIME

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.

EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Dataset

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION) is the same as attribute PERSON PROPERTY EFFECTIVE END DATE.

EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION) is the DATE when a MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION for a PATIENT expires.

EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Dataset

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) is the same as attribute PERSON PROPERTY EFFECTIVE END TIME.

END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) is the TIME when a MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION for a PATIENT expires.

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).

GENERAL MEDICAL PRACTITIONER (SPECIFIED)

Change to Data Element: Changed Dataset

Format/Length:	an8
National Codes:	
ODS Default Codes:	G9999998 - GENERAL MEDICAL PRACTITIONER PPD CODE not known

G9999981 - GENERAL MEDICAL PRACTITIONER PPD CODE not applicable

Notes:
GENERAL MEDICAL PRACTITIONER (SPECIFIED) is the GENERAL MEDICAL PRACTITIONER PPD CODE of the GENERAL MEDICAL PRACTITIONER specified by the PATIENT.

This GENERAL MEDICAL PRACTITIONER works within the General Medical Practitioner Practice with which the PATIENT is registered.

A GENERAL MEDICAL PRACTITIONER will have at least one of the following:

- GENERAL MEDICAL COUNCIL REFERENCE NUMBER
- DOCTOR INDEX NUMBER
- GENERAL MEDICAL PRACTITIONER PPD CODE.

Ministry of Defence Doctors:

- If a Ministry of Defence Doctor **has** a GENERAL MEDICAL PRACTITIONER PPD CODE, the GENERAL MEDICAL PRACTITIONER PPD CODE should be used
- If a Ministry of Defence Doctor **does not have** a GENERAL MEDICAL PRACTITIONER PPD CODE, Organisation Data Service Default Code G9999981 '*GENERAL MEDICAL PRACTITIONER PPD CODE not applicable*' should be used.

INJURY DATE

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
INJURY DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Injury Date*'.

This data element is also known by these names:

Context	Alias
plural	INJURY DATES

INJURY DATE

Change to Data Element: New Data Element

INJURY DATE

Attribute:

ACTIVITY DATE

INJURY TIME

Change to Data Element: New Data Element

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
INJURY TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Injury Time*'.

This data element is also known by these names:

Context	Alias
plural	INJURY TIMES

INJURY TIME

Change to Data Element: New Data Element

INJURY TIME

Attribute:

ACTIVITY TIME

INTERPRETER LANGUAGE (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
INTERPRETER LANGUAGE (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

INTERPRETER LANGUAGE (SNOMED CT) is the SNOMED CT® concept ID which is used to record the LANGUAGE of the interpreter required by the PERSON.

SNOMED CT Subset Metadata:

- Subset Name: Interpreter type findings
- Subset Original Id: 63651000000135
- Refset FSN: Interpreter type findings simple reference set
- Refset Id: 991231000000102

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Interpreter type findings.

This data element is also known by these names:

Context	Alias
snomedctsubsetoriginalid	63651000000135
snomedctrefsetname	Interpreter type findings simple reference set
snomedctsubsetname	Interpreter language findings
plural	INTERPRETER LANGUAGES (SNOMED CT)
snomedctrefsetid	991231000000102

INTERPRETER LANGUAGE (SNOMED CT)

Change to Data Element: New Data Element

INTERPRETER LANGUAGE (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

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.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE
Default Codes:	98 - Not Applicable
	99 - Not Known

Notes:
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE is the same as attribute MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE is required for all PATIENTS who have a Hospital Provider Spell which includes the care of a CONSULTANT in the psychiatric specialties or have been discharged from such a Hospital Provider Spell and are required to receive supervised aftercare under the provisions of the Mental Health (Patients in the Community) Act 1995.

NHS NUMBER

Change to Data Element: Changed Dataset

Format/Length:	n10
National Codes:	See NHS NUMBER
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 STATUS INDICATOR CODE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:
NHS NUMBER STATUS INDICATOR CODE is the trace status of the NHS NUMBER.

Permitted National Codes:

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

NHS SERVICE AGREEMENT 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.

ORGANISATION CODE (CONVEYING AMBULANCE TRUST)

Change to Data Element: Changed Description

Format/Length:	an3
National Codes:	
Default Codes:	

Notes:
ORGANISATION CODE (CONVEYING AMBULANCE TRUST) is the same as attribute ORGANISATION CODE.

ORGANISATION CODE (CONVEYING AMBULANCE TRUST) is the code of an Ambulance Service which conveys a PATIENT on a PATIENT TRANSPORT JOURNEY. A PATIENT JOURNEY NUMBER and AMBULANCE INCIDENT NUMBER may be recorded for the PATIENT TRANSPORT JOURNEY.

ORGANISATION CODE (CONVEYING AMBULANCE TRUST) will be replaced with ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST), 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

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 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".

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 (CONVEYING AMBULANCE TRUST)

Change to Data Element: New Data Element

Format/Length:	min an3 max an5
National Codes:	
Default Codes:	

Notes:
ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST) is the same as attribute ORGANISATION IDENTIFIER.

ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST) is the ORGANISATION IDENTIFIER of an Ambulance Service which conveys a PATIENT on a PATIENT TRANSPORT JOURNEY. A PATIENT JOURNEY NUMBER and AMBULANCE INCIDENT NUMBER may be recorded for the PATIENT TRANSPORT JOURNEY.

ORGANISATION CODE (CONVEYING AMBULANCE TRUST) will be replaced with ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST), when it has been approved for use in national information standards.

This data element is also known by these names:

Context	Alias
plural	ORGANISATION IDENTIFIERS (CONVEYING AMBULANCE TRUST)

ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST)

Change to Data Element: New Data Element

ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST)

Attribute:

ORGANISATION IDENTIFIER

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 (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 (DISCHARGE FROM EMERGENCY CARE)

Change to Data Element: New Data Element

Format/Length:	min an5 max an9
National Codes:	
ODS Default Codes:	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 (DISCHARGE FROM EMERGENCY CARE) is the same as attribute ORGANISATION IDENTIFIER.

ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE) is the ORGANISATION IDENTIFIER of the Organisation Site to which a PATIENT is discharged following an Emergency Care Attendance.

This data element is also known by these names:

Context	Alias
plural	ORGANISATION SITE IDENTIFIERS (DISCHARGE FROM EMERGENCY CARE)

ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE)

Change to Data Element: New Data Element

ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE)

Attribute:

ORGANISATION IDENTIFIER

ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE)

Change to Data Element: New Data Element

Format/Length:	min an5 max an9
National Codes:	
ODS Default Codes:	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 (EMERGENCY CARE ATTENDANCE SOURCE) is the same as attribute ORGANISATION IDENTIFIER.

ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE) is the ORGANISATION IDENTIFIER of the Organisation Site from which a PATIENT arrived at an Emergency Care Department.

This data element is also known by these names:

Context	Alias
plural	ORGANISATION SITE IDENTIFIERS (EMERGENCY CARE ATTENDANCE SOURCE)

ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE)

Change to Data Element: New Data Element

ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE)

Attribute:

ORGANISATION IDENTIFIER

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 (for use on Out-Patient CDS) 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 (for use on Out-Patient CDS)'* 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.

OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See OVERSEAS VISITOR CHARGING CATEGORY
Default Codes:	X - Not Known (Decision pending on OVERSEAS VISITOR CHARGING CATEGORY)

Notes:
OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE is the same as attribute OVERSEAS VISITOR CHARGING CATEGORY, recorded at the CDS ACTIVITY DATE.

This data element is also known by these names:

Context	Alias
plural	OVERSEAS VISITOR CHARGING CATEGORIES AT CDS ACTIVITY DATE

OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE

Change to Data Element: New Data Element

OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE

Attribute:

OVERSEAS VISITOR CHARGING CATEGORY

PATIENT NAME

Change to Data Element: Changed Dataset

Format/length:	max an70
National Codes:	
Default Codes:	

Notes:
PATIENT NAME is the PERSON NAME where the PERSON NAME CLASSIFICATION is '*Preferred Name*' of the PATIENT.

NAME FORMAT CODE indicates whether it is a PERSON NAME STRUCTURED or PERSON NAME UNSTRUCTURED.

The PATIENT's name and address should be withheld from any commissioning data that contains a valid NHS NUMBER. See Security Issues and Patient Confidentiality for more details.

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.

PATIENT USUAL ADDRESS

Change to Data Element: Changed Dataset

Format/Length:	an175 (5 lines each an35)
National Codes:	
Default Codes:	

Notes:
PATIENT USUAL ADDRESS is the usual ADDRESS nominated by the PATIENT, where the ADDRESS ASSOCIATION TYPE is *'Main Permanent Residence'* or *'Other Permanent Residence'*.

For Commissioning Data Set functionality see ADDRESS FORMAT CODE.

If PATIENTS usually resident elsewhere are staying in hotels, hostels or other residential establishments for a short term, say a week, they should be recorded as staying at their usual place of residence. However if long term, such as at boarding school, the school ADDRESS must be recorded. University students may nominate either their home ADDRESS or the ADDRESS of their university accommodation.

Where PATIENTS are not capable of supplying this information, because of age or mental illness, for example, then the PERSON responsible for the PATIENT, such as a parent or guardian, should nominate the usual address.

PATIENTS not able to provide an ADDRESS should be asked for their most recent ADDRESS. If this cannot be established, record the ADDRESS as *'No fixed abode'* or *'Address unknown'*. These PATIENTS are regarded as resident in the local geographical district for commissioning purposes.

For birth episodes this should refer to the mother's usual place of residence.

The format of 5 lines of an35 conforms to ADDRESS FORMAT TYPE *'Unstructured Format'*. The format refers to the physical layout of the address, not the logical layout, and does not require intelligent intervention when splitting the text string into lines. For example:

Flat 1, 21 Arbuthnott Avenue, Pollo (35 chars)
k Estate, Lesser Hinkley, Staffords (35 chars)
hire (4 chars)

The PATIENT's name and ADDRESS should be withheld from any commissioning record which contains a valid NHS NUMBER.

PERSON BIRTH DATE

Change to Data Element: Changed Dataset

Format/Length:	See DATE
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 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 CURRENT and 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.

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'.*

PREFERRED SPOKEN LANGUAGE (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
PREFERRED SPOKEN LANGUAGE (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

PREFERRED SPOKEN LANGUAGE (SNOMED CT) is the SNOMED CT® concept ID which is used to capture the preferred spoken LANGUAGE of the PERSON.

SNOMED CT Subset Metadata:

- Subset Name: Preferred spoken language findings
- Subset Original Id: 58761000000134
- Refset FSN: Preferred spoken language findings simple reference set
- Refset Id: 991181000000109

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Preferred spoken language findings.

This data element is also known by these names:

Context	Alias
snomedctsubsetoriginalid	58761000000134
snomedctrefsetname	Preferred spoken language findings simple reference set
snomedctsubsetname	Preferred spoken language findings
plural	PREFERRED SPOKEN LANGUAGES (SNOMED CT)
snomedctrefsetid	991181000000109

PREFERRED SPOKEN LANGUAGE (SNOMED CT)

Change to Data Element: New Data Element

PREFERRED SPOKEN LANGUAGE (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

PROCEDURE DATE (EMERGENCY CARE CLINICAL INVESTIGATION)

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
PROCEDURE DATE (EMERGENCY CARE CLINICAL INVESTIGATION) is the same as data element PROCEDURE DATE.

PROCEDURE DATE (EMERGENCY CARE CLINICAL INVESTIGATION) is the DATE a Clinical Investigation was performed during an Emergency Care Attendance.

This data element is also known by these names:

Context	Alias

plural	PROCEDURE DATES (EMERGENCY CARE CLINICAL INVESTIGATION)

PROCEDURE DATE (EMERGENCY CARE CLINICAL INVESTIGATION)

Change to Data Element: New Data Element

PROCEDURE DATE (EMERGENCY CARE CLINICAL INVESTIGATION)

Attribute:

ACTIVITY DATE

PROCEDURE DATE (EMERGENCY CARE PROCEDURE)

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
PROCEDURE DATE (EMERGENCY CARE PROCEDURE) is the same as data element PROCEDURE DATE.

PROCEDURE DATE (EMERGENCY CARE PROCEDURE) is the DATE a Patient Procedure was performed during an Emergency Care Attendance.

This data element is also known by these names:

Context	Alias
plural	PROCEDURE DATES (EMERGENCY CARE PROCEDURE)

PROCEDURE DATE (EMERGENCY CARE PROCEDURE)

Change to Data Element: New Data Element

PROCEDURE DATE (EMERGENCY CARE PROCEDURE)

Attribute:

ACTIVITY DATE

PROCEDURE TIME

Change to Data Element: New Data Element

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
PROCEDURE TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Procedure Time*'.

This data element is also known by these names:

Context	Alias
plural	PROCEDURE TIMES

PROCEDURE TIME

Change to Data Element: New Data Element

PROCEDURE TIME

Attribute:

ACTIVITY TIME

PROCEDURE TIME (EMERGENCY CARE CLINICAL INVESTIGATION)

Change to Data Element: New Data Element

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
PROCEDURE TIME (EMERGENCY CARE CLINICAL INVESTIGATION) is the same as data element PROCEDURE TIME.

PROCEDURE TIME (EMERGENCY CARE CLINICAL INVESTIGATION) is the TIME a Clinical Investigation was performed during an Emergency Care Attendance.

This data element is also known by these names:

Context	Alias
plural	PROCEDURE TIMES (EMERGENCY CARE CLINICAL INVESTIGATION)

PROCEDURE TIME (EMERGENCY CARE CLINICAL INVESTIGATION)

Change to Data Element: New Data Element

PROCEDURE TIME (EMERGENCY CARE CLINICAL INVESTIGATION)

Attribute:

ACTIVITY TIME

PROCEDURE TIME (EMERGENCY CARE PROCEDURE)

Change to Data Element: New Data Element

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
PROCEDURE TIME (EMERGENCY CARE PROCEDURE) is the same as data element PROCEDURE TIME.

PROCEDURE TIME (EMERGENCY CARE PROCEDURE) is the TIME a Patient Procedure was performed during an Emergency Care Attendance.

This data element is also known by these names:

Context	Alias
plural	PROCEDURE DATES (EMERGENCY CARE PROCEDURE)

PROCEDURE TIME (EMERGENCY CARE PROCEDURE)

Change to Data Element: New Data Element

PROCEDURE TIME (EMERGENCY CARE PROCEDURE)

Attribute:

ACTIVITY TIME

PROFESSIONAL REGISTRATION ENTRY IDENTIFIER

Change to Data Element: Changed Dataset

Format/Length:	max an32
NWDS ID:	EPRN
NWDS Field Name:	Professional Registration Number
National Codes:	
Default Codes:	

Notes:
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER is the same as attribute PROFESSIONAL REGISTRATION ENTRY IDENTIFIER.

PROFESSIONAL REGISTRATION ISSUER CODE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:

PROFESSIONAL REGISTRATION ISSUER CODE is the same as attribute PROFESSIONAL REGISTRATION BODY CODE but only the following National Codes are permitted:

Permitted National Codes:

02	General Dental Council
03	General Medical Council
08	Health and Care Professions Council
09	Nursing and Midwifery Council

PROVIDER REFERENCE NUMBER

Change to Data Element: Changed Dataset

Format/Length:	an17
National Codes:	
Default Codes:	

Notes:
PROVIDER REFERENCE NUMBER is a number convention agreed locally between a provider and Commissioner for use within a Commissioning Data Set message.

REFERRAL TO TREATMENT PERIOD END DATE

Change to Data Element: Changed Dataset

Format/Length:	See DATE
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 START DATE

Change to Data Element: Changed Dataset

Format/Length:	See DATE
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 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.

REFERRED TO SERVICE (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
REFERRED TO SERVICE (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

REFERRED TO SERVICE (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the SERVICE to which a PATIENT was referred for admission or opinion by the treating CARE PROFESSIONAL.

SNOMED CT Subset Metadata:

- Subset Name: Emergency care referral procedures
- Subset Original Id: 63501000000135
- Refset FSN: Emergency care referral procedures simple reference set (foundation metadata concept)
- Refset Id: 991451000000108

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Emergency care referral procedures.

This data element is also known by these names:

Context	Alias
snomedctsubsetoriginalid	63501000000135
snomedctrefsetname	Emergency care referral procedures simple reference set (foundation metadata concept)
snomedctsubsetname	Emergency care referral procedures
plural	REFERRED TO SERVICES (SNOMED CT)
snomedctrefsetid	991451000000108

REFERRED TO SERVICE (SNOMED CT)

Change to Data Element: New Data Element

REFERRED TO SERVICE (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

REFERRED TO SERVICE ASSESSMENT DATE

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
REFERRED TO SERVICE ASSESSMENT DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Referred To Service Assessment Date*'.

This data element is also known by these names:

Context	Alias
plural	REFERRED TO SERVICE ASSESSMENT DATES

REFERRED TO SERVICE ASSESSMENT DATE

Change to Data Element: New Data Element

REFERRED TO SERVICE ASSESSMENT DATE

Attribute:

ACTIVITY DATE

REFERRED TO SERVICE ASSESSMENT TIME

Change to Data Element: New Data Element

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
REFERRED TO SERVICE ASSESSMENT TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Referred To Service Assessment Time*'.

This data element is also known by these names:

Context	Alias
plural	REFERRED TO SERVICE ASSESSMENT TIMES

REFERRED TO SERVICE ASSESSMENT TIME

Change to Data Element: New Data Element

REFERRED TO SERVICE ASSESSMENT TIME

Attribute:

ACTIVITY TIME

SAFEGUARDING CONCERN (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
SAFEGUARDING CONCERN (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

SAFEGUARDING CONCERN (SNOMED CT) is the SNOMED CT® concept ID which is used to identify an unresolved issue or concern regarding adult and child safeguarding that requires communication to another ORGANISATION or care agency.

SNOMED CT Subset Metadata:

- Subset Name: Safeguarding issues

- Subset Original Id: 69241000000138
- Refset FSN: Safeguarding issues simple reference set (foundation metadata concept)
- Refset Id: 999002381000000108

For further details relating to the SNOMED CT Subset Metadata, see the Data Dictionary for Care (DD4C) website at: Safeguarding issues.

This data element is also known by these names:

Context	Alias
snomedctsubsetoriginalid	69241000000138
snomedctrefsetname	Safeguarding issues simple reference set (foundation metadata concept)
snomedctsubsetname	Safeguarding issues
plural	SAFEGUARDING CONCERNS (SNOMED CT)
snomedctrefsetid	999002381000000108

SAFEGUARDING CONCERN (SNOMED CT)

Change to Data Element: New Data Element

SAFEGUARDING CONCERN (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Mental Health Act Legal Status Classification Assignment Period.

START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Start Time*' of the Mental Health Act Legal Status Classification Assignment Period.

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.

WITHHELD IDENTITY REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	
Default Codes:	99 - Identity withheld but reason not known

Notes:
WITHHELD IDENTITY REASON is used in Data Group 'Withheld Identity Structure' in the Commissioning Data Sets (version 6-2 onwards). It allows suppliers of Commissioning Data Set records to indicate to recipients of the record (for example, the Commissioner of the activity) that the record has been purposely anonymised for a valid reason.

Permitted National Codes:

01	Record anonymised for legal/statutory reasons
02	Record anonymised at request of Caldicott Guardian
03	Record anonymised at request of PATIENT
97	Record anonymised for other reason

COMMISSIONING DATA SET VERSION 6-2-1 XML SCHEMA CONSTRAINTS

Change to XML Schema Constraint: New XML Schema Constraint

XML Schema constraints applied to the:

- CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set
- CDS V6-2-1 Type 001 - Commissioning Data Set Interchange Header
- CDS V6-2-1 Type 002 - Commissioning Data Set Interchange Trailer
- CDS V6-2-1 Type 003 - Commissioning Data Set Message Header
- CDS V6-2-1 Type 004 - Commissioning Data Set Message Trailer
- CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol
- CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol

The "Allowed Values" column indicates the NHS Data Model and Dictionary National Codes and Default Codes present in the XML Schema:

- None = The National Codes and Default Codes are included in the XML Schema
- Removed = The National Codes and Default Codes are not included in the XML Schema.

Data Element	XML Schema Format/Length	Allowed Values	Range	Pattern Match	Reason / Comment / XML Choice
ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT)	None	Removed	None	None	National Codes not enumerated in the XML Schema
AGE AT CDS ACTIVITY DATE	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
CDS COPY RECIPIENT IDENTITY	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
CDS INTERCHANGE APPLICATION REFERENCE	min an1 max an14	None	None	None	Existing Format/Length states an14 - XML Schema allows min an1 max an14
CDS INTERCHANGE CONTROL COUNT	max n7	None	None	None	Existing Format/Length states n7 - XML Schema allows max n7
CDS INTERCHANGE CONTROL REFERENCE	min an1 max an14	None	None	None	Existing Format/Length states an14 - XML Schema allows min an1 max an14
	min an1 max n15	None	None	None	

CDS INTERCHANGE SENDER IDENTITY					Existing Format/Length states an15 - XML Schema allows min an1 max an15
CDS INTERCHANGE RECEIVER IDENTITY	min an1 max n15	None	None	None	Existing Format/Length states an15 - XML Schema allows min an1 max an15
CDS INTERCHANGE TEST INDICATOR	None	0,1	None	None	Null value not allowed in XML Schema
CDS MESSAGE REFERENCE	max n7	None	None	None	Existing Format/Length states an14 - XML Schema allows max n7 to support SUS requirements
CDS MESSAGE VERSION NUMBER	an6	CDS062	None	None	Message version is hard coded in the XML Schema
CDS PRIME RECIPIENT IDENTITY	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
CDS RECORD IDENTIFIER	min an1 max an35	None	None	None	Existing Format/Length states an35 - XML Schema allows max an35
CDS SENDER IDENTITY	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
CDS UNIQUE IDENTIFIER	min an1 max an35	None	None	None	Existing Format/Length states an35 - XML Schema allows min an1 max an35
COMMISSIONER REFERENCE NUMBER	max an17	None	None	None	Existing Format/Length states an17 - XML Schema allows max an17
COMMISSIONING SERIAL NUMBER	max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows max an6
EMERGENCY CARE DEPARTMENT TYPE	None	Removed	None	None	National Codes not enumerated in the XML Schema
EMERGENCY CARE PLACE OF INJURY (LATITUDE)	None	None	-90.000000-90.000000	None	Range applied to allow correct reporting of EMERGENCY CARE PLACE OF INJURY (LATITUDE)
EMERGENCY CARE PLACE OF INJURY (LONGITUDE)	None	None	-180.000000-180.000000	None	Range applied to allow correct reporting of EMERGENCY CARE PLACE OF INJURY (LONGITUDE)
ETHNIC CATEGORY	max an2	None	None	None	Existing Format/Length means fixed length which is incorrect. Unable to change this as it is used in other data sets. Second character can be for local use. Format/Length amended to max an2
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	None	Removed	None	None	Default codes not enumerated in the XML Schema
GENERAL MEDICAL PRACTITIONER (SPECIFIED)	None	Removed	None	None	National Codes and default codes not enumerated in the XML Schema
NHS SERVICE AGREEMENT LINE NUMBER	max an10	None	None	None	Existing Format/Length states an10 - XML Schema allows max an10
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION IDENTIFIER (CODE OF PROVIDER)	min an3 max an5	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE)	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE)	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION SITE IDENTIFIER (OF TREATMENT)	None	Removed	None	None	Default codes not enumerated in the XML Schema
PROVIDER REFERENCE NUMBER	max an17	None	None	None	Existing Format/Length states an17 - XML Schema allows max an17
WAITING TIME MEASUREMENT TYPE	None	01,02,09	None	None	National Codes 03 and 04 not valid in Commissioning Data Sets

COMMISSIONING DATA SET VERSION 6-2 XML SCHEMA CONSTRAINTS

Change to XML Schema Constraint: Changed Description

~~XML Schema constraints applied to the Commissioning Data Sets.~~XML Schema constraints applied to the Commissioning Data Sets V6-2.

The "Allowed Values" column indicates the NHS Data Model and Dictionary National Codes and Default Codes present in the XML Schema:

- None = The National Codes and Default Codes are included in the XML Schema
- Removed = The National Codes and Default Codes are not included in the XML Schema.

Data Element	XML Schema Format/Length	Allowed Values	Range	Pattern Match	Reason / Comment / XML Choice
A and E ATTENDANCE NUMBER	max an12	None	None	None	Existing Format/Length states an12 - XML Schema allows max an12
ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST	min an2 max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows min an2 max an6
ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND	min an2 max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows min an2 max an6
ACCIDENT AND EMERGENCY INVESTIGATION - FIRST	min an2 max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows min an2 max an6
ACCIDENT AND EMERGENCY INVESTIGATION - SECOND	min an2 max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows min an2 max an6
ACCIDENT AND EMERGENCY TREATMENT - FIRST	min an2 max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows min an2 max an6
ACCIDENT AND EMERGENCY TREATMENT - SECOND	min an2 max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows min an2 max an6
ACTIVITY LOCATION TYPE CODE	None	A01,A02,A03,A04,B01,B02,C01,C02,C03,D01,D02,D03, E01,E02,E03,E04,E99,F01,G01,G02,G03,H01,J01,K01,K02, L01,L02,L03,L04,L05,L06,L99,M01,M02,M03,M04,M05, N01,N02,N03,N04,N05,X01	None	None	National Code G04 removed (not allowed in XML Schema)
ADVANCED CARDIOVASCULAR SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
ADVANCED RESPIRATORY SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
AGE AT CDS ACTIVITY DATE	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
AGE AT CENSUS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
AGE ON ADMISSION	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
ATTENDANCE IDENTIFIER	max an12	None	None	None	Existing Format/Length states an12 - XML Schema allows max an12
BASIC CARDIOVASCULAR SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
BASIC RESPIRATORY SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
BIRTH WEIGHT	max n4	None	None	None	Existing Format/Length states n4 - XML Schema allows max n4
CARE PROFESSIONAL MAIN SPECIALTY CODE	None	100,101,110,120,130,140,141,142,143,145,146,147,148,149, 150,160,170,171,180,190,192,300,301,302,303,304,305,310, 311,312,313,314,315,320,321,325,326,330,340,350,352,360, 361,370,371,400,401,410,420,421,430,450,451,460,501,502, 504,560,600,601,700,710,711,712,713,715,800,810,820,821, 822,823,824,830,831,833,834,900,901,902,903,904,950,960, 199,499	None	None	National Code 500 removed (not allowed in XML Schema)
CDS COPY RECIPIENT IDENTITY	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
CDS MESSAGE REFERENCE	max n7	None	None	None	Existing Format/Length states n7 - XML Schema allows max n14 but SUS accepts max n7
CDS MESSAGE VERSION NUMBER	None	CDS062	None	None	Message version is hard coded in the XML Schema
CDS PRIME RECIPIENT IDENTITY	min an3 max an12	Removed	None	None	Field size extended to future proof for

					ODS ORGANISATION CODE changes
CDS SENDER IDENTITY	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
CDS UNIQUE IDENTIFIER	max an35	None	None	None	Existing Format/Length states an35 - XML Schema allows max an35
COMMISSIONER REFERENCE NUMBER	max an17	None	None	None	Existing Format/Length states an17 - XML Schema allows max an17
COMMISSIONING SERIAL NUMBER	max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows max an6
CONSULTATION MEDIUM USED	None	01,02,03,04	None	None	National Codes 05, 06 and 98 are not used in CDS version 6-2
COUNT OF DAYS SUSPENDED	max n4	None	None	None	Existing Format/Length states n4 - XML Schema allows max n4
CRITICAL CARE ACTIVITY CODE	None	01,02,03,04,05,06,07,08,09,10,11,12,13,14, 15,16,21,22,23,24,25,26,27,28,29,50,51,52, 53,55,56,57,58,59,60,61,62,63,64,65,66,67, 68,69,70,71,72,73,74,99	None	None	National Codes 80, 81, 82, 83, 84, 85, 94, 95, 96 and 97 removed (not allowed in the XML Schema)
CRITICAL CARE LEVEL 2 DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
CRITICAL CARE LEVEL 3 DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
CRITICAL CARE LOCAL IDENTIFIER	max an8	None	None	None	Existing Format/Length states an8 - XML Schema allows max an8
DERMATOLOGICAL SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL)	None	1,2,3,4,5,8,9	None	None	National Codes 6 and 7 are not used in CDS version 6-2
DURATION OF CARE TO PSYCHIATRIC CENSUS DATE	max n5	None	None	None	Existing Format/Length states n5 - XML Schema allows max n5
DURATION OF DETENTION	max n5	None	None	None	Existing Format/Length states n5 - XML Schema allows max n5
DURATION OF ELECTIVE WAIT	max n4	None	None	None	Existing Format/Length states n4 - XML Schema allows max n4
ELECTIVE ADMISSION LIST ENTRY NUMBER	max an12	None	None	None	Existing Format/Length states an12 - XML Schema allows max an12
EPISODE NUMBER	max an2	None	None	None	Existing Format/Length states an2 - XML Schema allows max an2
ETHNIC CATEGORY	max an2	None	None	None	Existing Format/Length means fixed length which is incorrect. Unable to change this as it is used in other data sets. Second character can be for local use. Format/Length amended to max an2
GASTRO-INTESTINAL SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
GENERAL MEDICAL PRACTITIONER PRACTICE (ANTENATAL CARE)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
GENERAL MEDICAL	None	Removed	None	None	National Codes and default codes not

PRACTITIONER (ANTENATAL CARE)					enumerated in the XML Schema
GENERAL MEDICAL PRACTITIONER (SPECIFIED)	None	Removed	None	None	National Codes and default codes not enumerated in the XML Schema
HOSPITAL PROVIDER SPELL NUMBER	max an12	None	None	None	Existing Format/Length states an12 - XML Schema allows max an12
INTENDED SITE CODE (OF TREATMENT)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
LIVER SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
LOCAL PATIENT IDENTIFIER	max an10	None	None	None	Existing Format/Length states an10 - XML Schema allows max an10
LOCAL PATIENT IDENTIFIER (BABY)	max an10	None	None	None	Existing Format/Length states an10 - XML Schema allows max an10
LOCAL PATIENT IDENTIFIER (MOTHER)	max an10	None	None	None	Existing Format/Length states an10 - XML Schema allows max an10
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (AT CENSUS DATE)	None	01,02,03,04,05,06,07,08,09,10,11,12,13,14, 15,16,17,18,19,20,31,32,34,35,36,37,38	None	None	Additional National Codes 37 and 38 added
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)	None	01,02,03,04,05,06,07,08,09,10,11,12,13,14, 15,16,17,18,19,20,31,32,34,35,36,37,38	None	None	Additional National Codes 37 and 38 added
NEUROLOGICAL SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
NHS SERVICE AGREEMENT LINE NUMBER	max an10	None	None	None	Existing Format/Length states an10 - XML Schema allows max an10
ORGAN SUPPORT MAXIMUM	None	None	00-06	None	Range 00-06 allowed
ORGANISATION CODE (CODE OF COMMISSIONER)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
ORGANISATION CODE (CODE OF PROVIDER)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION SITE CODE changes
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (BABY))	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION SITE CODE changes
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (MOTHER))	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION SITE CODE changes
ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
PERSON WEIGHT	n3.n3	None	None	None	Existing Format/Length states max n3.max n3 - XML Schema enforces 3 digits before and after the decimal point - max removed
	max an5	None	None	None	

PRIMARY DIAGNOSIS (READ)					Existing Format/Length allows for all clinical classifications -XML Schema allows max an5
PROVIDER REFERENCE NUMBER	max an17	None	None	None	Existing Format/Length states an17 - XML Schema allows max an17
REFERRER CODE	None	Removed	None	None	National Codes and default codes not enumerated in the XML Schema
REFERRING ORGANISATION CODE	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
RENAL SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
SECONDARY DIAGNOSIS (READ)	max an5	None	None	None	Existing Format/Length allows for all clinical classifications -XML Schema allows max an5
SITE CODE (OF TREATMENT)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION SITE CODE changes

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For enquiries about this Change Request, please email information.standards@nhs.net