

# NHS Data Model and Dictionary



<b>Type:</b>	Change Request
<b>Reference:</b>	1869
<b>Version No:</b>	1.0
<b>Subject:</b>	Introduction of Emergency Care Data Set Version 4
<b>Effective Date:</b>	1 July 2023
<b>Reason for Change:</b>	Change to Information Standards
<b>Publication Date:</b>	9 January 2023

## Background:

Commissioning Data Set V6-2-3 Type 011 Emergency Care was approved by the Data Coordination Board as [DCB0092-2062 : Commissioning Data Sets: Emergency Care Data Set](#).

Updates to Commissioning Data Set Type 011 have been identified, requiring the introduction of a new version. The new version has also enabled a change of name to Emergency Care Data Set to be made, although the data set remains a type of Commissioning Data Set, and continues to share the submission headers and trailers, with no change to process for submitters of data required. In the NHS Data Model and Dictionary, the Emergency Care Data Set now appears as a Clinical Data Set type. Previous live versions of Commissioning Data Set V6-2-2/V6-2-3 Type 011 Emergency Care remain listed under the Commissioning Data Sets area.

A number of changes have been included in Emergency Care Data Set Version 4, including:

- Recording of Virtual Care (non-face to face consultations)
- Recording of Same Day Emergency Care (SDEC) attendances
- Recording of Urgent and Emergency Care Extended Care Episodes
- Deprecation of Emergency Care Department Type 04 - 'NHS walk-in centre'
- Renaming of data items to reflect the extended data set scope into Same Day Emergency Care
- Alignment with Commissioning Data Set version 6-3, and inclusion of generic SNOMED CT data structures where appropriate
- Addition of EMED3 Fit Note Data Group, in preparation for the requirement to submit data on Fit Notes issued in secondary care
- Other minor data item updates to give additional clarification, or to conform to the most recent standards.

Recording of Hot Clinic activity is limited to Pilot sites only and should not be submitted unless this is as part of recognised pilot activity. Following pilot, the requirement to submit Hot Clinic data would be introduced at a future release of the Emergency Care Data Set.

A new Emergency Care Data Set (ECDS) XML schema pack, containing only XML schemas for CDS Type 011 and the Header and Trailer CDS types, will be made available via the Technology Reference data Update Distribution (TRUD). The existing CDS-XML Schema release versions 6-2-2 and 6-2-3 remain valid until future notification.

This Change Request adds Emergency Care Data Set Version 4 to the NHS Data Model and Dictionary to support the Information Standard.

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

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

## Summary of changes:

### **Data Set**

<a href="#">ECDS V4 TYPE 001 - CDS INTERCHANGE HEADER</a>	New Data Set
<a href="#">ECDS V4 TYPE 002 - CDS INTERCHANGE TRAILER</a>	New Data Set
<a href="#">ECDS V4 TYPE 003 - CDS MESSAGE HEADER</a>	New Data Set
<a href="#">ECDS V4 TYPE 004 - CDS MESSAGE TRAILER</a>	New Data Set
<a href="#">ECDS V4 TYPE 005B - CDS TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL</a>	New Data Set
<a href="#">ECDS V4 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL</a>	New Data Set
<a href="#">EMERGENCY CARE DATA SET VERSION 4</a>	New Data Set

### **Supporting Information**

<a href="#">CDS TYPE</a>	Changed Description
<a href="#">CLINICAL DATA SETS MENU</a>	Changed Description
<a href="#">CLINICAL DATA SETS MESSAGE DOCUMENTATION</a>	Changed Description
<a href="#">CLINICAL DATA SETS MESSAGE DOCUMENTATION MENU</a>	Changed Description
<a href="#">COMMISSIONING DATA SET BUSINESS RULES</a>	Changed Dataset, Description
<a href="#">COMMISSIONING DATA SET MANDATED DATA FLOWS</a>	Changed Description
<a href="#">COMMISSIONING DATA SET NOTATION</a>	Changed Dataset, Description
<a href="#">COMMISSIONING DATA SETS OVERVIEW</a>	Changed Description
<a href="#">COMMISSIONING DATA SET SUBMISSION PROTOCOL</a>	Changed Description
<a href="#">ECDS V4 TYPE 001 - CDS INTERCHANGE HEADER OVERVIEW</a>	New Supporting Information
<a href="#">ECDS V4 TYPE 002 - CDS INTERCHANGE TRAILER OVERVIEW</a>	New Supporting Information
<a href="#">ECDS V4 TYPE 003 - CDS MESSAGE HEADER OVERVIEW</a>	New Supporting Information
<a href="#">ECDS V4 TYPE 004 - CDS MESSAGE TRAILER OVERVIEW</a>	New Supporting Information
<a href="#">ECDS V4 TYPE 005B - CDS TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL OVERVIEW</a>	New Supporting Information
<a href="#">ECDS V4 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL OVERVIEW</a>	New Supporting Information
<a href="#">EMERGENCY CARE ARRIVAL DATE</a>	Changed Description
<a href="#">EMERGENCY CARE ARRIVAL TIME</a>	Changed Description
<a href="#">EMERGENCY CARE ATTENDANCE</a>	Changed Description

<a href="#">EMERGENCY CARE ATTENDANCE CONCLUSION DATE</a>	Changed Description
<a href="#">EMERGENCY CARE ATTENDANCE CONCLUSION TIME</a>	Changed Description
<a href="#">EMERGENCY CARE DATA SET VERSION 4 OVERVIEW</a>	New Supporting Information
<a href="#">EMERGENCY CARE DATE SEEN FOR TREATMENT</a>	Changed Description
<a href="#">EMERGENCY CARE DEPARTMENT</a>	Changed Description
<a href="#">EMERGENCY CARE DEPARTURE DATE</a>	Changed Description
<a href="#">EMERGENCY CARE DEPARTURE TIME</a>	Changed Description
<a href="#">EMERGENCY CARE EPISODE (RETIRED)</a> renamed from <a href="#">EMERGENCY CARE EPISODE</a>	Changed status to Retired, Name, Description
<a href="#">EMERGENCY CARE INITIAL ASSESSMENT DATE</a>	Changed Description
<a href="#">EMERGENCY CARE INITIAL ASSESSMENT TIME</a>	Changed Description
<a href="#">EMERGENCY CARE TIME SEEN FOR TREATMENT</a>	Changed Description
<a href="#">HES DATA DICTIONARY</a>	Changed Description
<a href="#">HOSPITAL EPISODE STATISTICS</a>	Changed Description
<a href="#">SAME DAY EMERGENCY CARE</a>	New Supporting Information
<a href="#">SAME DAY EMERGENCY CARE ATTENDANCE</a>	New Supporting Information
<a href="#">SECONDARY USES SERVICE</a>	Changed Dataset
<a href="#">URGENT AND EMERGENCY CARE ACTIVITY</a>	New Supporting Information
<a href="#">URGENT AND EMERGENCY CARE ACTIVITY END TIMESTAMP</a>	New Supporting Information
<a href="#">URGENT AND EMERGENCY CARE ACTIVITY START DATE AND TIME</a>	New Supporting Information
<a href="#">URGENT AND EMERGENCY CARE CLINICALLY READY TO PROCEED TIMESTAMP</a>	New Supporting Information
<a href="#">URGENT AND EMERGENCY CARE EXTENDED CARE EPISODE</a>	New Supporting Information
<a href="#">URGENT AND EMERGENCY CARE INITIAL ASSESSMENT TIMESTAMP</a>	New Supporting Information
<a href="#">URGENT AND EMERGENCY CARE SERVICE</a>	New Supporting Information
<a href="#">URGENT AND EMERGENCY CARE TIMESTAMP SEEN FOR TREATMENT</a>	New Supporting Information
<a href="#">URGENT TREATMENT CENTRE</a>	Changed Description

### **Class Definitions**

<a href="#">ACTIVITY</a>	Changed Attributes
<a href="#">ACTIVITY GROUP</a>	Changed Attributes
<a href="#">CARE CONTACT</a>	Changed Attributes
<a href="#">CARE PROFESSIONAL</a>	Changed Attributes
<a href="#">ORGANISATION</a>	Changed Attributes

### **Attribute Definitions**

<a href="#">ACTIVITY DATE</a>	Changed Dataset
<a href="#">ACTIVITY IDENTIFIER</a>	Changed Dataset
<a href="#">ACTIVITY SERVICE REQUEST DATE</a>	Changed Dataset
<a href="#">ACTIVITY SERVICE REQUEST TIME</a>	Changed Dataset
<a href="#">ACTIVITY TIME</a>	Changed Dataset
<a href="#">ADDRESS</a>	Changed Dataset

<a href="#"><u>AMBULANCE CALL IDENTIFIER</u></a>	Changed Dataset
<a href="#"><u>CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR FOR URGENT AND EMERGENCY CARE</u></a>	New Attribute
<a href="#"><u>CARE PROFESSIONAL TIER FOR URGENT AND EMERGENCY CARE</u></a>	New Attribute
<a href="#"><u>CDS BULK REPLACEMENT GROUP CODE</u></a>	Changed Dataset, Description
<a href="#"><u>CDS INTERCHANGE APPLICATION REFERENCE</u></a>	Changed Dataset
<a href="#"><u>CDS INTERCHANGE CONTROL COUNT</u></a>	Changed Dataset
<a href="#"><u>CDS INTERCHANGE CONTROL REFERENCE</u></a>	Changed Dataset
<a href="#"><u>CDS INTERCHANGE RECEIVER IDENTITY</u></a>	Changed Dataset
<a href="#"><u>CDS INTERCHANGE SENDER IDENTITY</u></a>	Changed Dataset
<a href="#"><u>CDS INTERCHANGE TEST INDICATOR</u></a>	Changed Dataset
<a href="#"><u>CDS MESSAGE REFERENCE</u></a>	Changed Dataset
<a href="#"><u>CDS MESSAGE TYPE</u></a>	Changed Dataset
<a href="#"><u>CDS MESSAGE VERSION NUMBER</u></a>	Changed Dataset, Description
<a href="#"><u>CDS PROTOCOL IDENTIFIER CODE</u></a>	Changed Dataset
<a href="#"><u>CDS TYPE CODE</u></a>	Changed Dataset, Description
<a href="#"><u>CDS UPDATE TYPE</u></a>	Changed Dataset
<a href="#"><u>CLINICAL CLASSIFICATION CODE</u></a>	Changed Dataset
<a href="#"><u>CLINICAL TERMINOLOGY CODE</u></a>	Changed Dataset
<a href="#"><u>CLINICAL TRIAL IDENTIFIER</u></a>	Changed Dataset
<a href="#"><u>CODED CLINICAL ENTRY SEQUENCE NUMBER</u></a>	Changed Dataset
<a href="#"><u>COMMISSIONER REFERENCE IDENTIFIER</u></a>	Changed Dataset
<a href="#"><u>CONSULTATION MECHANISM</u></a>	Changed Dataset, Description
<a href="#"><u>DECIDED TO ADMIT DATE</u></a>	Changed Dataset
<a href="#"><u>DECIDED TO ADMIT TIME</u></a>	Changed Dataset
<a href="#"><u>EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR</u></a>	Changed Dataset
<a href="#"><u>EMED3 FIT NOTE ISSUER</u></a>	Changed Dataset
<a href="#"><u>EMERGENCY CARE DEPARTMENT TYPE</u></a>	Changed Description
<a href="#"><u>EMERGENCY CARE DEPARTMENT TYPE FOR PATIENT LEVEL INFORMATION COSTING</u></a>	New Attribute
<a href="#"><u>ETHNIC CATEGORY 2021</u></a>	Changed Dataset
<a href="#"><u>ETHNIC CATEGORY CODE 2001</u></a>	Changed Dataset
<a href="#"><u>EVENT DATE</u></a>	Changed Dataset
<a href="#"><u>EVENT TIME</u></a>	Changed Dataset
<a href="#"><u>GENERAL MEDICAL PRACTITIONER PPD CODE</u></a>	Changed Dataset
<a href="#"><u>GEOGRAPHIC CO-ORDINATE</u></a>	Changed Dataset
<a href="#"><u>LOCAL PATIENT IDENTIFIER</u></a>	Changed Dataset
<a href="#"><u>MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE</u></a>	Changed Dataset
<a href="#"><u>NHS NUMBER</u></a>	Changed Dataset
<a href="#"><u>NHS NUMBER STATUS INDICATOR CODE</u></a>	Changed Dataset

<a href="#"><u>NHS SERVICE AGREEMENT IDENTIFIER</u></a>	Changed Dataset
<a href="#"><u>NHS SERVICE AGREEMENT LINE IDENTIFIER</u></a>	Changed Dataset
<a href="#"><u>OBSERVATION VALUE</u></a>	Changed Dataset
<a href="#"><u>ORGANISATION CODE</u></a>	Changed Dataset
<a href="#"><u>ORGANISATION IDENTIFIER</u></a>	Changed Dataset
<a href="#"><u>ORGANISATION SITE IDENTIFIER</u></a>	Changed Dataset
<a href="#"><u>OVERSEAS VISITOR CHARGING CATEGORY</u></a>	Changed Dataset
<a href="#"><u>PERSON AGE</u></a>	Changed Dataset
<a href="#"><u>PERSON BIRTH DATE</u></a>	Changed Dataset
<a href="#"><u>PERSON NAME WORD TEXT</u></a>	Changed Dataset
<a href="#"><u>PERSON OBSERVATION TEXT STRING</u></a>	Changed Dataset
<a href="#"><u>PERSON PROPERTY ASSIGNMENT PERIOD DURATION</u></a>	Changed Dataset
<a href="#"><u>PERSON PROPERTY EFFECTIVE END DATE</u></a>	Changed Dataset
<a href="#"><u>PERSON PROPERTY EFFECTIVE END TIME</u></a>	Changed Dataset
<a href="#"><u>PERSON PROPERTY EFFECTIVE START DATE</u></a>	Changed Dataset
<a href="#"><u>PERSON PROPERTY EFFECTIVE START TIME</u></a>	Changed Dataset
<a href="#"><u>PERSON PROPERTY RECORDED DATE</u></a>	Changed Dataset
<a href="#"><u>PERSON PROPERTY RECORDED TIME</u></a>	Changed Dataset
<a href="#"><u>PERSON SCORE</u></a>	Changed Dataset
<a href="#"><u>PERSON STATED GENDER CODE</u></a>	Changed Dataset
<a href="#"><u>PLANNED ACTIVITY DATE</u></a>	Changed Dataset
<a href="#"><u>PLANNED ACTIVITY TIME</u></a>	Changed Dataset
<a href="#"><u>POSTCODE</u></a>	Changed Dataset
<a href="#"><u>PROFESSIONAL REGISTRATION BODY CODE</u></a>	Changed Dataset
<a href="#"><u>PROFESSIONAL REGISTRATION ENTRY IDENTIFIER</u></a>	Changed Dataset
<a href="#"><u>PROVIDER REFERENCE IDENTIFIER</u></a>	Changed Dataset
<a href="#"><u>RECORD IDENTIFIER</u></a>	Changed Dataset
<a href="#"><u>SERVICE CODE</u></a>	Changed Dataset
<a href="#"><u>TREATMENT FUNCTION CODE</u></a>	Changed Dataset
<a href="#"><u>UCUM UNIT OF MEASUREMENT</u></a>	Changed Dataset
<a href="#"><u>URGENT AND EMERGENCY CARE ACTIVITY TYPE</u></a>	New Attribute
<a href="#"><u>URGENT AND EMERGENCY CARE ATTENDANCE CATEGORY</u></a>	New Attribute
<a href="#"><u>URGENT AND EMERGENCY CARE DISCHARGE INFORMATION GIVEN INDICATOR</u></a>	New Attribute
<a href="#"><u>WITHHELD IDENTITY REASON</u></a>	Changed Dataset

### **Data Elements**

<a href="#"><u>ACCESSIBLE INFORMATION PROFESSIONAL REQUIRED CODE (SNOMED CT)</u></a>	Changed Dataset
<a href="#"><u>ACCOMMODATION STATUS (SNOMED CT)</u></a>	Changed Dataset
<a href="#"><u>ACTIVITY SERVICE REQUEST TIMESTAMP (URGENT AND EMERGENCY CARE)</u></a>	New Data Element
<a href="#"><u>ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT)</u></a>	Changed Dataset
<a href="#"><u>AGE AT CDS ACTIVITY DATE</u></a>	Changed Dataset

<a href="#"><u>AMBULANCE CALL IDENTIFIER</u></a>	Changed Dataset
<a href="#"><u>ASSAULT LOCATION DESCRIPTION</u></a>	Changed Dataset, Description
<a href="#"><u>ASSESSMENT TOOL VALIDATION TIMESTAMP</u></a>	Changed Dataset
<a href="#"><u>CARE CONTACT IDENTIFIER (AMBULANCE SERVICE)</u></a>	Changed Dataset
<a href="#"><u>CARE PROFESSIONAL CLINICAL RESPONSIBILITY TIMESTAMP</u></a>	Changed Dataset, Description
<a href="#"><u>CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR (URGENT AND EMERGENCY CARE)</u></a>	New Data Element
<a href="#"><u>CARE PROFESSIONAL TIER (URGENT AND EMERGENCY CARE)</u></a>	New Data Element
<a href="#"><u>CDS ACTIVITY DATE</u></a>	Changed Dataset, Description
<a href="#"><u>CDS APPLICABLE DATE</u></a>	Changed Dataset
<a href="#"><u>CDS APPLICABLE TIME</u></a>	Changed Dataset
<a href="#"><u>CDS BULK REPLACEMENT GROUP CODE</u></a>	Changed Dataset
<a href="#"><u>CDS EXTRACT DATE</u></a>	Changed Dataset
<a href="#"><u>CDS EXTRACT TIME</u></a>	Changed Dataset
<a href="#"><u>CDS INTERCHANGE APPLICATION REFERENCE</u></a>	Changed Dataset
<a href="#"><u>CDS INTERCHANGE CONTROL COUNT</u></a>	Changed Dataset
<a href="#"><u>CDS INTERCHANGE CONTROL REFERENCE</u></a>	Changed Dataset, Description
<a href="#"><u>CDS INTERCHANGE DATE OF PREPARATION</u></a>	Changed Dataset
<a href="#"><u>CDS INTERCHANGE RECEIVER IDENTITY</u></a>	Changed Dataset
<a href="#"><u>CDS INTERCHANGE SENDER IDENTITY</u></a>	Changed Dataset
<a href="#"><u>CDS INTERCHANGE TEST INDICATOR</u></a>	Changed Dataset
<a href="#"><u>CDS INTERCHANGE TIME OF PREPARATION</u></a>	Changed Dataset
<a href="#"><u>CDS MESSAGE REFERENCE</u></a>	Changed Dataset
<a href="#"><u>CDS MESSAGE TYPE</u></a>	Changed Dataset
<a href="#"><u>CDS MESSAGE VERSION NUMBER</u></a>	Changed Dataset
<a href="#"><u>CDS PROTOCOL IDENTIFIER CODE</u></a>	Changed Dataset
<a href="#"><u>CDS RECORD IDENTIFIER</u></a>	Changed Dataset, Description
<a href="#"><u>CDS REPORT PERIOD END DATE</u></a>	Changed Dataset
<a href="#"><u>CDS REPORT PERIOD START DATE</u></a>	Changed Dataset
<a href="#"><u>CDS TYPE CODE</u></a>	Changed Dataset
<a href="#"><u>CDS UNIQUE IDENTIFIER</u></a>	Changed Dataset
<a href="#"><u>CDS UPDATE TYPE</u></a>	Changed Dataset
<a href="#"><u>CLINICAL TRIAL IDENTIFIER</u></a>	Changed Dataset, Description
<a href="#"><u>CODED ASSESSMENT TOOL TYPE (SNOMED CT)</u></a>	Changed Dataset
<a href="#"><u>CODED CLINICAL ENTRY SEQUENCE NUMBER</u></a>	Changed Dataset
<a href="#"><u>CODED FINDING (SNOMED CT)</u></a>	Changed Dataset
<a href="#"><u>CODED FINDING TIMESTAMP</u></a>	Changed Dataset, Description
<a href="#"><u>CODED OBSERVATION (SNOMED CT)</u></a>	Changed Dataset

<a href="#"><u>CODED OBSERVATION TIMESTAMP</u></a>	Changed Dataset, Description
<a href="#"><u>CODED PROCEDURE TIMESTAMP (URGENT AND EMERGENCY CARE CLINICAL INVESTIGATION)</u></a>	New Data Element
<a href="#"><u>CODED PROCEDURE TIMESTAMP (URGENT AND EMERGENCY CARE PROCEDURE)</u></a>	New Data Element
<a href="#"><u>COMMISSIONER REFERENCE IDENTIFIER</u></a>	Changed Dataset
<a href="#"><u>COMORBIDITY (SNOMED CT)</u></a>	Changed Dataset
<a href="#"><u>CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE)</u></a>	New Data Element
<a href="#"><u>DECIDED TO ADMIT DATE AND TIME</u></a>	New Data Element
<a href="#"><u>DISEASE OUTBREAK NOTIFICATION (SNOMED CT)</u></a>	Changed Dataset
<a href="#"><u>DISEASE OUTBREAK NOTIFICATION DESCRIPTION</u></a>	Changed Dataset, Description
<a href="#"><u>EMED3 FIT NOTE ASSESSMENT DATE</u></a>	Changed Dataset
<a href="#"><u>EMED3 FIT NOTE CONDITION (SNOMED CT)</u></a>	New Data Element
<a href="#"><u>EMED3 FIT NOTE DIAGNOSIS (ICD)</u></a>	Changed Dataset
<a href="#"><u>EMED3 FIT NOTE DURATION</u></a>	Changed Dataset
<a href="#"><u>EMED3 FIT NOTE END DATE</u></a>	Changed Dataset
<a href="#"><u>EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR</u></a>	Changed Dataset
<a href="#"><u>EMED3 FIT NOTE ISSUER</u></a>	Changed Dataset
<a href="#"><u>EMED3 FIT NOTE RECORDED DATE</u></a>	Changed Dataset
<a href="#"><u>EMED3 FIT NOTE START DATE</u></a>	Changed Dataset
<a href="#"><u>EMERGENCY CARE DEPARTMENT TYPE (PATIENT LEVEL INFORMATION COSTING)</u></a>	Changed linked Attribute, Description
<a href="#"><u>EMERGENCY CARE EXPECTED DATE AND TIMESTAMP OF TREATMENT</u></a>	Changed Dataset
<a href="#"><u>EMERGENCY CARE INJURY ACTIVITY STATUS (SNOMED CT)</u></a>	Changed Dataset
<a href="#"><u>EMERGENCY CARE INJURY ACTIVITY TYPE (SNOMED CT)</u></a>	Changed Dataset
<a href="#"><u>EMERGENCY CARE INJURY ALCOHOL OR DRUG INVOLVEMENT (SNOMED CT)</u></a>	Changed Dataset
<a href="#"><u>EMERGENCY CARE INJURY INTENT (SNOMED CT)</u></a>	Changed Dataset
<a href="#"><u>EMERGENCY CARE INJURY MECHANISM (SNOMED CT)</u></a>	Changed Dataset
<a href="#"><u>EMERGENCY CARE PLACE OF INJURY (LATITUDE)</u></a>	Changed Dataset
<a href="#"><u>EMERGENCY CARE PLACE OF INJURY (LONGITUDE)</u></a>	Changed Dataset
<a href="#"><u>EMERGENCY CARE PLACE OF INJURY (SNOMED CT)</u></a>	Changed Dataset
<a href="#"><u>EMERGENCY CARE TREATMENT ALLOCATION TIMESTAMP</u></a>	Changed Dataset, Description
<a href="#"><u>END DATE (COMMISSIONER ASSIGNMENT PERIOD)</u></a>	Changed Dataset
<a href="#"><u>ETHNIC CATEGORY</u></a>	Changed Dataset
<a href="#"><u>ETHNIC CATEGORY 2021</u></a>	Changed Dataset
<a href="#"><u>GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION)</u></a>	Changed Dataset
<a href="#"><u>GENERAL MEDICAL PRACTITIONER (SPECIFIED)</u></a>	Changed Dataset
<a href="#"><u>INJURY DATE AND TIME</u></a>	New Data Element
<a href="#"><u>INTERPRETER LANGUAGE (SNOMED CT)</u></a>	Changed Dataset

<a href="#">LOCAL PATIENT IDENTIFIER (EXTENDED)</a>	Changed Dataset
<a href="#">MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START TIMESTAMP</a>	New Data Element
<a href="#">MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE</a>	Changed Dataset
<a href="#">MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION EXPIRY TIMESTAMP</a>	New Data Element
<a href="#">NHS NUMBER</a>	Changed Dataset
<a href="#">NHS NUMBER STATUS INDICATOR CODE</a>	Changed Dataset
<a href="#">NHS SERVICE AGREEMENT IDENTIFIER</a>	Changed Dataset
<a href="#">NHS SERVICE AGREEMENT LINE IDENTIFIER</a>	Changed Dataset
<a href="#">OBSERVATION VALUE</a>	Changed Dataset
<a href="#">ORGANISATION IDENTIFIER (CDS RECIPIENT)</a>	Changed Dataset
<a href="#">ORGANISATION IDENTIFIER (CDS SENDER)</a>	Changed Dataset
<a href="#">ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)</a>	Changed Dataset
<a href="#">ORGANISATION IDENTIFIER (CODE OF PROVIDER)</a>	Changed Dataset
<a href="#">ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST)</a>	Changed Dataset
<a href="#">ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)</a>	Changed Dataset
<a href="#">ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)</a>	Changed Dataset
<a href="#">ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE)</a>	Changed Description
<a href="#">ORGANISATION SITE IDENTIFIER (DISCHARGE FROM URGENT AND EMERGENCY CARE)</a>	New Data Element
<a href="#">ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE)</a>	Changed Description
<a href="#">ORGANISATION SITE IDENTIFIER (OF TREATMENT)</a>	Changed Dataset
<a href="#">ORGANISATION SITE IDENTIFIER (URGENT AND EMERGENCY CARE ATTENDANCE SOURCE)</a>	New Data Element
<a href="#">OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE</a>	Changed Dataset
<a href="#">PATIENT FAMILY NAME</a>	Changed Dataset
<a href="#">PATIENT FULL NAME</a>	Changed Dataset
<a href="#">PATIENT GIVEN NAME</a>	Changed Dataset
<a href="#">PATIENT INITIALS</a>	Changed Dataset
<a href="#">PATIENT NAME SUFFIX</a>	Changed Dataset
<a href="#">PATIENT TITLE</a>	Changed Dataset
<a href="#">PATIENT USUAL ADDRESS (STRUCTURED)</a>	Changed Dataset
<a href="#">PATIENT USUAL ADDRESS (UNSTRUCTURED)</a>	Changed Dataset
<a href="#">PERSON BIRTH DATE</a>	Changed Dataset
<a href="#">PERSON SCORE</a>	Changed Dataset
<a href="#">PERSON STATED GENDER CODE</a>	Changed Dataset
<a href="#">POSTCODE OF USUAL ADDRESS</a>	Changed Dataset
<a href="#">PREFERRED SPOKEN LANGUAGE (SNOMED CT)</a>	Changed Dataset
<a href="#">PROFESSIONAL REGISTRATION ENTRY IDENTIFIER</a>	Changed Dataset
<a href="#">PROFESSIONAL REGISTRATION ISSUER CODE</a>	Changed Dataset
<a href="#">PROVIDER REFERENCE IDENTIFIER</a>	Changed Dataset

<a href="#"><u>REFERRED TO SERVICE (SNOMED CT)</u></a>	Changed Dataset
<a href="#"><u>REFERRED TO SERVICE ASSESSMENT TIMESTAMP</u></a>	New Data Element
<a href="#"><u>SAFEGUARDING CONCERN (SNOMED CT)</u></a>	Changed Dataset
<a href="#"><u>SERVICE CODE</u></a>	Changed Dataset
<a href="#"><u>SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT)</u></a>	Changed Dataset
<a href="#"><u>SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP</u></a>	Changed Dataset, Description
<a href="#"><u>START DATE (COMMISSIONER ASSIGNMENT PERIOD)</u></a>	Changed Dataset
<a href="#"><u>UNIT OF MEASUREMENT (UCUM)</u></a>	Changed Dataset
<a href="#"><u>URGENT AND EMERGENCY CARE ACTIVITY END TIMESTAMP</u></a>	New Data Element
<a href="#"><u>URGENT AND EMERGENCY CARE ACTIVITY IDENTIFIER</u></a>	New Data Element
<a href="#"><u>URGENT AND EMERGENCY CARE ACTIVITY START DATE AND TIME</u></a>	New Data Element
<a href="#"><u>URGENT AND EMERGENCY CARE ACTIVITY TYPE</u></a>	New Data Element
<a href="#"><u>URGENT AND EMERGENCY CARE ACUITY (SNOMED CT)</u></a>	New Data Element
<a href="#"><u>URGENT AND EMERGENCY CARE ARRIVAL MODE (SNOMED CT)</u></a>	New Data Element
<a href="#"><u>URGENT AND EMERGENCY CARE ATTENDANCE CATEGORY</u></a>	New Data Element
<a href="#"><u>URGENT AND EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT)</u></a>	New Data Element
<a href="#"><u>URGENT AND EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT)</u></a>	New Data Element
<a href="#"><u>URGENT AND EMERGENCY CARE CLINICAL INVESTIGATION (SNOMED CT)</u></a>	New Data Element
<a href="#"><u>URGENT AND EMERGENCY CARE CLINICALLY READY TO PROCEED TIMESTAMP</u></a>	New Data Element
<a href="#"><u>URGENT AND EMERGENCY CARE DIAGNOSIS (SNOMED CT)</u></a>	New Data Element
<a href="#"><u>URGENT AND EMERGENCY CARE DIAGNOSIS QUALIFIER (SNOMED CT)</u></a>	New Data Element
<a href="#"><u>URGENT AND EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT)</u></a>	New Data Element
<a href="#"><u>URGENT AND EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT)</u></a>	New Data Element
<a href="#"><u>URGENT AND EMERGENCY CARE DISCHARGE INFORMATION GIVEN INDICATOR</u></a>	New Data Element
<a href="#"><u>URGENT AND EMERGENCY CARE DISCHARGE STATUS (SNOMED CT)</u></a>	New Data Element
<a href="#"><u>URGENT AND EMERGENCY CARE EXTENDED CARE EPISODE IDENTIFIER</u></a>	New Data Element
<a href="#"><u>URGENT AND EMERGENCY CARE INITIAL ASSESSMENT TIMESTAMP</u></a>	New Data Element
<a href="#"><u>URGENT AND EMERGENCY CARE PROCEDURE (SNOMED CT)</u></a>	New Data Element
<a href="#"><u>URGENT AND EMERGENCY CARE TIMESTAMP SEEN FOR TREATMENT</u></a>	New Data Element
<a href="#"><u>WITHHELD IDENTITY REASON</u></a>	Changed Dataset

## XML Schema Constraint

### [EMERGENCY CARE DATA SET VERSION 4 XML SCHEMA CONSTRAINTS](#)

New XML Schema Constraint

**Date:** 9 January 2023

**Sponsor:** Julian Redhead, National Clinical Director for Urgent and Emergency Care, NHS England.

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

#### ECDS V4 TYPE 001 - CDS INTERCHANGE HEADER

Change to Data Set: New Data Set

Notation		DATA GROUP: ECDS V4 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER	
Group Status	Group Repeats	FUNCTION: To carry the details of the mandatory identity and addressing information for the Commissioning Data Set submission.	
M	1..1	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

#### ECDS V4 TYPE 002 - CDS INTERCHANGE TRAILER

Change to Data Set: New Data Set

<b>Notation</b>		<b>DATA GROUP: ECDS V4 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the mandatory identity and addressing information for the Commissioning Data Set submission.</b>			
<b>M</b>	<b>1..1</b>	<b>One per Interchange submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.</b>			
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<b>Rules</b>	
		<b>M</b>	<b>1..1</b>	<b>CDS INTERCHANGE CONTROL REFERENCE</b>	<b>F</b> <b>S8</b>
		<b>M</b>	<b>1..1</b>	<b>CDS INTERCHANGE CONTROL COUNT</b>	<b>F</b> <b>S8</b>
		<b>O</b>	<b>0..1</b>	<b>CDS INTERCHANGE SENDER IDENTITY</b>	<b>F</b>
		<b>O</b>	<b>0..1</b>	<b>CDS INTERCHANGE RECEIVER IDENTITY</b>	<b>F</b>

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**ECDS V4 TYPE 003 - CDS MESSAGE HEADER**

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Change to Data Set: New Data Set

<b>Notation</b>		<b>DATA GROUP: ECDS V4 TYPE 003 - COMMISSIONING DATA SET MESSAGE HEADER</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the mandatory identity controls for each Commissioning Data Set Message.</b>			
<b>M</b>	<b>1..1</b>	<b>One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.</b>			
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<b>Rules</b>	
		<b>M</b>	<b>1..1</b>	<b>CDS MESSAGE TYPE</b>	<b>V</b>
		<b>M</b>	<b>1..1</b>	<b>CDS MESSAGE VERSION NUMBER</b>	<b>F</b>
		<b>M</b>	<b>1..1</b>	<b>CDS MESSAGE REFERENCE</b>	<b>F</b>
		<b>O</b>	<b>0..1</b>	<b>CDS RECORD IDENTIFIER</b>	<b>F</b>

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**ECDS V4 TYPE 004 - CDS MESSAGE TRAILER**

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Change to Data Set: New Data Set

<b>Notation</b>		<b>DATA GROUP: ECDS V4 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER</b>	
		<b>FUNCTION: To carry the details of the mandatory identity controls for each Commissioning Data Set Message.</b>	

<b>Group</b>	<b>Group</b>	<b>One per Commissioning Data Set Message submitted to the Secondary</b>
<b>Status</b>	<b>Repeats</b>	<b>Uses Service. Multiple Commissioning Data Set Messages may be</b>
<b>M</b>	<b>1..1</b>	<b>submitted in a single Commissioning Data Set Interchange.</b>
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>
<b>M</b>	<b>1..1</b>	<b>CDS MESSAGE REFERENCE</b>
		<b>Rules</b>
		<b>F</b>

ECDS V4 TYPE 005B - CDS TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL

Change to Data Set: New Data Set

<b>Notation</b>	<b>DATA GROUP: ECDS V4 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL</b>	
<b>Group</b>	<b>Group</b>	<b>FUNCTION: To carry the details of the mandatory Commissioning Data Set Submission Protocol controls for when using the Bulk Update mechanism.</b>
<b>Status</b>	<b>Repeats</b>	<b>One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.</b>
<b>M</b>	<b>1..1</b>	
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>
		<b>Rules</b>
<b>M</b>	<b>1..1</b>	<b>CDS TYPE CODE</b>
		<b>V</b>
<b>M</b>	<b>1..1</b>	<b>CDS PROTOCOL IDENTIFIER CODE</b>
		<b>V</b>
<b>O</b>	<b>0..1</b>	<b>CDS UNIQUE IDENTIFIER</b>
		<b>F</b>
		<b>S9</b>
<b>M</b>	<b>1..1</b>	<b>CDS BULK REPLACEMENT GROUP CODE</b>
		<b>V</b>
<b>M</b>	<b>1..1</b>	<b>CDS EXTRACT DATE</b>
		<b>F</b>
		<b>S13</b>
<b>M</b>	<b>1..1</b>	<b>CDS EXTRACT TIME</b>
		<b>F</b>
		<b>S14</b>
<b>M</b>	<b>1..1</b>	<b>CDS REPORT PERIOD START DATE</b>
		<b>F</b>
		<b>S6</b>
		<b>S13</b>
<b>M</b>	<b>1..1</b>	<b>CDS REPORT PERIOD END DATE</b>
		<b>F</b>
		<b>S6</b>
		<b>S13</b>
<b>M</b>	<b>1..1</b>	<b>CDS ACTIVITY DATE</b>
		<b>F</b>
		<b>S6</b>
		<b>S13</b>
<b>M</b>	<b>1..1</b>	<b>ORGANISATION IDENTIFIER (CDS SENDER)</b>
		<b>F</b>
		<b>S5</b>
<b>O</b>	<b>0..7</b>	<b>ORGANISATION IDENTIFIER (CDS RECIPIENT)</b>
		<b>F</b>
		<b>S5</b>

ECDS V4 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL

Change to Data Set: New Data Set

<b>Notation</b>		<b>DATA GROUP: ECDS V4 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the mandatory Commissioning Data Set Submission Protocol controls for when using the Net Change mechanism.</b>
<b>M</b>	<b>1..1</b>	<b>One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.</b>

<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>	<b>Rules</b>
<b>M</b>	<b>1..1</b>	<b>CDS TYPE CODE</b>	<b>V</b>
<b>M</b>	<b>1..1</b>	<b>CDS PROTOCOL IDENTIFIER CODE</b>	<b>V</b>
<b>M</b>	<b>1..1</b>	<b>CDS UNIQUE IDENTIFIER</b>	<b>F</b> <b>S9</b>
<b>M</b>	<b>1..1</b>	<b>CDS UPDATE TYPE</b>	<b>V</b>
<b>M</b>	<b>1..1</b>	<b>CDS APPLICABLE DATE</b>	<b>F</b> <b>S8</b> <b>S13</b>
<b>M</b>	<b>1..1</b>	<b>CDS APPLICABLE TIME</b>	<b>F</b> <b>S8</b> <b>S14</b>
<b>M</b>	<b>1..1</b>	<b>CDS ACTIVITY DATE</b>	<b>F</b> <b>S6</b> <b>S13</b>
<b>M</b>	<b>1..1</b>	<b>ORGANISATION IDENTIFIER (CDS SENDER)</b>	<b>F</b> <b>S5</b>
<b>O</b>	<b>0..7</b>	<b>ORGANISATION IDENTIFIER (CDS RECIPIENT)</b>	<b>F</b> <b>S5</b>

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**EMERGENCY CARE DATA SET VERSION 4**

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Change to Data Set: New Data Set

<b>ECDS V4 TYPE 011 - EMERGENCY CARE COMMISSIONING DATA SET</b>	
<b>FUNCTION: To support the details of a Urgent and Emergency Care Activity.</b>	

<b>Notation</b>		<b>DATA GROUP: ECDS V4 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.</b>
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: ECDS V4 Type 001 - CDS Interchange Header</b> <b>One per Interchange submitted to the Secondary Uses Service.</b>

	Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange
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<b>Notation</b>		<b>DATA GROUP: ECDS V4 TYPE 003 - COMMISSIONING DATA SET MESSAGE HEADER</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION:</b> To define the mandatory identity and addressing information for a Commissioning Data Set submission.

<b>M</b>	<b>1..1</b>	<b>DATA GROUP: ECDS V4 Type 003 - CDS Message Header</b> One per Commissioning Data Set Message submitted to the <u>Secondary Uses Service</u> . Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange
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**ONE OF THE FOLLOWING TWO OPTIONS MUST BE USED**

<b>Notation</b>		<b>DATA GROUP: ECDS V4 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION:</b> To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of the Bulk Replacement Update Mechanism of the Commissioning Data Set Submission Protocol.

<b>M</b>	<b>1..1</b>	<b>DATA GROUP: ECDS V4 Type 005B - CDS Transaction Header Group - Bulk Update Protocol</b> One per Commissioning Data Set record submitted to the <u>Secondary Uses Service</u> . Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.
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**OR**

<b>Notation</b>		<b>DATA GROUP: ECDS V4 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION:</b> 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.

<b>M</b>	<b>1..1</b>	<b>DATA GROUP: ECDS V4 Type 005N - CDS Transaction Header Group - Net Change Protocol</b> One per Commissioning Data Set record submitted to the <u>Secondary Uses Service</u> . Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.
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<b>Notation</b>		<b>DATA GROUP: PATIENT IDENTITY</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION:</b> To carry the Identity of the Patient. See Note: S3 in Commissioning Data Set Business Rules.
<b>M</b>	<b>1..1</b>	

**One of the following DATA GROUPS must be used:**

<b>1..1</b>	<b>DATA GROUP: WITHHELD IDENTITY STRUCTURE</b> Must be used where the Commissioning Data Set record has been anonymised		
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>	
	<b>M</b>	<b>1..1</b>	<b>NHS NUMBER STATUS INDICATOR CODE</b>
			<b>Rules</b>
			<b>V</b>

	R	0..1	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	F
	R	0..1	WITHHELD IDENTITY REASON	V

OR

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

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

		M	1..1	PATIENT USUAL ADDRESS (UNSTRUCTURED)	F
		OR	OR		S3
		M	2..5	PATIENT USUAL ADDRESS (STRUCTURED)	I5
M	1..1	<b>Data Element Components</b>			<b>Rules</b>
		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

<b>Notation</b>		<b>DATA GROUP: PATIENT CHARACTERISTICS (URGENT AND EMERGENCY CARE)</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the characteristics of the Patient for Urgent and Emergency Care Activity.</b>			
R	0..1				
		<b>Data Element Components</b>			<b>Rules</b>
		R	0..1	PERSON STATED GENDER CODE	V
		R	0..1	ETHNIC CATEGORY	V
		X	0..1	ETHNIC CATEGORY 2021	N2
		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

<b>Notation</b>		<b>DATA GROUP: PATIENT CHARACTERISTICS (URGENT AND EMERGENCY CARE) - SOCIAL AND PERSONAL CIRCUMSTANCES (SNOMED CT)</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the details of the SNOMED CT coded Social and Personal Circumstances for the Patient.</b>			
R	0..*				
M	1..1	<b>Data Element Components</b>			<b>Rules</b>
		M	1..1	SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT)	F
		M	1..1	SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP	F S13 S14

<b>Notation</b>		<b>DATA GROUP: MENTAL HEALTH ACT LEGAL STATUS</b>			
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION: To carry the Patient's Mental Health Act Legal Status.</b>			
R	0..*				
R	0..1	<b>Data Element Components</b>			<b>Rules</b>
		R	0..1	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START TIMESTAMP	

				F S13 S14
R	0..1	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION EXPIRY TIMESTAMP		F S13 S14
M	1..1	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE		F

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

<b>Notation</b>		<b>DATA GROUP: URGENT AND EMERGENCY CARE ACTIVITY LOCATION</b>		
<b>Group</b>	<b>Group</b>	<b>FUNCTION:</b>		
<b>Status</b>	<b>Repeats</b>	<b>To carry the details of the Urgent and Emergency Care Activity location.</b>		
M	1..1			
M	1..1	Data Element Components		<b>Rules</b>
M	1..1	ORGANISATION SITE IDENTIFIER (OF TREATMENT)		F
M	1..1	URGENT AND EMERGENCY CARE ACTIVITY TYPE		V

<b>Notation</b>		<b>DATA GROUP: AMBULANCE DETAILS</b>		
<b>Group</b>	<b>Group</b>	<b>FUNCTION:</b>		
<b>Status</b>	<b>Repeats</b>	<b>To carry ambulance details relating to the Patients arrival at Urgent and Emergency Care.</b>		
R	0..1			
R	0..1	Data Element Components		<b>Rules</b>
R	0..1	AMBULANCE CALL IDENTIFIER		F
R	0..1	ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST)		F
R	0..1	CARE CONTACT IDENTIFIER (AMBULANCE SERVICE)		F

<b>Notation</b>		<b>DATA GROUP: EXPECTED DATE AND TIME OF TREATMENT</b>		
<b>Group</b>	<b>Group</b>	<b>FUNCTION:</b>		
<b>Status</b>	<b>Repeats</b>	<b>To carry the expected date and time of treatment given to the Patient.</b>		
R	0..1			
R	0..1	Data Element Components		<b>Rules</b>
R	0..1	EMERGENCY CARE EXPECTED DATE AND TIMESTAMP OF TREATMENT		F
R	0..1	EMERGENCY CARE TREATMENT ALLOCATION TIMESTAMP		F S13 S14

<b>Notation</b>	
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Notation		DATA GROUP: URGENT AND EMERGENCY CARE ACTIVITY CHARACTERISTICS	
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION:</b>	
<b>M</b>	<b>1..1</b>	To carry the characteristics of the Urgent and Emergency Care Activity.	
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>	<b>Rules</b>
<b>M</b>	<b>1..1</b>	URGENT AND EMERGENCY CARE ACTIVITY IDENTIFIER	F
<b>R</b>	<b>0..1</b>	CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE)	V
<b>R</b>	<b>0..1</b>	URGENT AND EMERGENCY CARE ARRIVAL MODE (SNOMED CT)	F
<b>R</b>	<b>0..1</b>	URGENT AND EMERGENCY CARE ATTENDANCE CATEGORY	V
<b>R</b>	<b>0..1</b>	URGENT AND EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT)	F
<b>R</b>	<b>0..1</b>	ORGANISATION SITE IDENTIFIER (URGENT AND EMERGENCY CARE ATTENDANCE SOURCE)	F
<b>M</b>	<b>1..1</b>	URGENT AND EMERGENCY CARE ACTIVITY START DATE AND TIME	F S1 S13 S14
<b>M</b>	<b>1..1</b>	AGE AT CDS ACTIVITY DATE	F S8
<b>R</b>	<b>0..1</b>	URGENT AND EMERGENCY CARE INITIAL ASSESSMENT TIMESTAMP	F S13 S14
<b>R</b>	<b>0..1</b>	URGENT AND EMERGENCY CARE ACUITY (SNOMED CT)	F
<b>R</b>	<b>0..1</b>	URGENT AND EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT)	F
<b>R</b>	<b>0..1</b>	URGENT AND EMERGENCY CARE TIMESTAMP SEEN FOR TREATMENT	F S13 S14
<b>R</b>	<b>0..1</b>	URGENT AND EMERGENCY CARE EXTENDED CARE EPISODE IDENTIFIER	F

Notation		DATA GROUP: ASSESSMENT TOOL GROUP (SNOMED CT)	
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION:</b>	
<b>R</b>	<b>0..*</b>	To carry the details of the SNOMED CT coded Assessment Tools for the Patient.	
<b>R</b>	<b>0..*</b>	<b>Data Element Components</b>	<b>Rules</b>
<b>M</b>	<b>1..1</b>	CODED ASSESSMENT TOOL TYPE (SNOMED CT)	F
<b>M</b>	<b>1..1</b>	PERSON SCORE	F
<b>M</b>	<b>1..1</b>	ASSESSMENT TOOL VALIDATION TIMESTAMP	F S13 S14

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

R	0..*	<b>Data Element Components</b>		<b>Rules</b>	
		M	1..1	<u>CODED OBSERVATION (SNOMED CT)</u>	F
		M	1..1	<u>OBSERVATION VALUE</u>	F
		R	0..1	<u>UNIT OF MEASUREMENT (UCUM)</u>	F
		M	1..1	<u>CODED OBSERVATION TIMESTAMP</u>	F S13 S14

<b>Notation</b>		<b>DATA GROUP: FINDING GROUP (SNOMED CT)</b>			
<b>Group</b>	<b>Group</b>	<b>FUNCTION:</b>			
<b>Status</b>	<b>Repeats</b>	<b>To carry the details of the SNOMED CT coded Clinical Findings for the Patient.</b>			
R	0..*				
R	0..*	<b>Data Element Components</b>		<b>Rules</b>	
		M	1..1	<u>CODED FINDING (SNOMED CT)</u>	F
		M	1..1	<u>CODED FINDING TIMESTAMP</u>	F S13 S14

<b>Notation</b>		<b>DATA GROUP: INJURY CHARACTERISTICS</b>			
<b>Group</b>	<b>Group</b>	<b>FUNCTION:</b>			
<b>Status</b>	<b>Repeats</b>	<b>To carry the details of injuries.</b>			
R	0..1				
R	0..1	<b>Data Element Components</b>		<b>Rules</b>	
		M	1..1	<u>INJURY DATE AND TIME</u>	F S13 S14
		R	0..1	<u>EMERGENCY CARE PLACE OF INJURY (SNOMED CT)</u>	F
		O	0..1	<u>EMERGENCY CARE PLACE OF INJURY (LATITUDE)</u>	F
		O	0..1	<u>EMERGENCY CARE PLACE OF INJURY (LONGITUDE)</u>	F
		R	0..1	<u>EMERGENCY CARE INJURY INTENT (SNOMED CT)</u>	F
		R	0..1	<u>EMERGENCY CARE INJURY ACTIVITY STATUS (SNOMED CT)</u>	F
		R	0..1	<u>EMERGENCY CARE INJURY ACTIVITY TYPE (SNOMED CT)</u>	F
		R	0..1	<u>EMERGENCY CARE INJURY MECHANISM (SNOMED CT)</u>	F
		R	0..*	<u>EMERGENCY CARE INJURY ALCOHOL OR DRUG INVOLVEMENT (SNOMED CT)</u>	F
		R	0..1	<u>ASSAULT LOCATION DESCRIPTION</u>	F

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

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

Notation		DATA GROUP: CARE PROFESSIONALS (URGENT AND EMERGENCY CARE)	
Group Status	Group Repeats	FUNCTION: To carry the details of the Care Professionals active during the Urgent and Emergency Care Activity.	
R	0..*		
R	0..1	Data Element Components	Rules
M	1..1	PROFESSIONAL REGISTRATION ISSUER CODE	F
M	1..1	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER	F
M	1..1	CARE PROFESSIONAL TIER (URGENT AND EMERGENCY CARE)	V
M	1..1	CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR (URGENT AND EMERGENCY CARE)	V
R	0..1	CARE PROFESSIONAL CLINICAL RESPONSIBILITY TIMESTAMP	F S13 S14

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

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

<b>Notation</b>		<b>DATA GROUP: URGENT AND EMERGENCY CARE TREATMENTS (SNOMED CT)</b>			
<b>Group</b>	<b>Group</b>	<b>FUNCTION:</b>			
<b>Status</b>	<b>Repeats</b>	<b>To carry the details of SNOMED CT coded Procedures.</b>			
<b>R</b>	<b>0..*</b>				
<b>R</b>	<b>0..1</b>	<b>Data Element Components</b>		<b>Rules</b>	
		<b>M</b>	<b>1..1</b>	URGENT AND EMERGENCY CARE PROCEDURE (SNOMED CT)	F H4
		<b>R</b>	<b>0..1</b>	CODED PROCEDURE TIMESTAMP (URGENT AND EMERGENCY CARE PROCEDURE)	F S13 S14

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

<b>Notation</b>		<b>DATA GROUP: EMED3 FIT NOTE</b>			
<b>Group</b>	<b>Group</b>	<b>FUNCTION: To carry the details of EMED3 Fit Note issued.</b>			
<b>Status</b>	<b>Repeats</b>				
<b>R</b>	<b>0..1</b>				
<b>M</b>	<b>1..1</b>	<b>Data Element Components</b>		<b>Rules</b>	
		<b>R</b>	<b>0..1</b>	EMED3 FIT NOTE ASSESSMENT DATE	F S13
		<b>R</b>	<b>0..1</b>	EMED3 FIT NOTE CONDITION (SNOMED CT)	F
		<b>R</b>	<b>0..1</b>	EMED3 FIT NOTE DIAGNOSIS (ICD)	F

R	0..1	EMED3 FIT NOTE START DATE	F S13
R	0..1	EMED3 FIT NOTE END DATE	F S13
R	0..1	EMED3 FIT NOTE DURATION	F
R	0..1	EMED3 FIT NOTE RECORDED DATE	F S13
R	0..1	EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR	V
X	0..1	EMED3 FIT NOTE ISSUER	N2

Notation		DATA GROUP: DISCHARGE FROM URGENT AND EMERGENCY CARE	
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION:</b>	
R	0..1	To carry the details of discharge from Urgent and Emergency Care.	
R	0..1	<b>Data Element Components</b>	<b>Rules</b>
R	0..1	DECIDED TO ADMIT DATE AND TIME	F S13 S14
R	0..1	ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT)	F
R	0..1	URGENT AND EMERGENCY CARE CLINICALLY READY TO PROCEED TIMESTAMP	F S13 S14
R	0..1	URGENT AND EMERGENCY CARE DISCHARGE STATUS (SNOMED CT)	F H4
R	0..1	URGENT AND EMERGENCY CARE ACTIVITY END TIMESTAMP	F S13 S14
R	0..*	SAFEGUARDING CONCERN (SNOMED CT)	F
R	0..1	URGENT AND EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT)	F
R	0..1	ORGANISATION SITE IDENTIFIER (DISCHARGE FROM URGENT AND EMERGENCY CARE)	F
R	0..1	URGENT AND EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT)	F
M	1..1	URGENT AND EMERGENCY CARE DISCHARGE INFORMATION GIVEN INDICATOR	V

Notation		DATA GROUP: RESEARCH AND DISEASE OUTBREAK NOTIFICATION	
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION:</b>	
R	0..1	To carry details of any Research and/or Disease Outbreak Notifications.	
R	0..1	<b>Data Element Components</b>	<b>Rules</b>
O	0..1	CLINICAL TRIAL IDENTIFIER	F
R Or R	0..1	DISEASE OUTBREAK NOTIFICATION DESCRIPTION Or DISEASE OUTBREAK NOTIFICATION (SNOMED CT)	F  F

<b>Notation</b>		<b>DATA GROUP: ECDS V4 CDS V6-3 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION:</b> To define the mandatory identity and addressing information for a Commissioning Data Set submission.
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: ECDS V4 Type 004 - CDS Message Trailer</b> One per Commissioning Data Set Message submitted to the <a href="#">Secondary Uses Service</a> . Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange

<b>Notation</b>		<b>DATA GROUP: ECDS V4 CDS V6-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER</b>
<b>Group Status</b>	<b>Group Repeats</b>	<b>FUNCTION:</b> To define the mandatory identity and addressing information for a Commissioning Data Set submission.
<b>M</b>	<b>1..1</b>	<b>DATA GROUP: ECDS V4 Type 002 - CDS Interchange Trailer</b> One per Interchange submitted to the <a href="#">Secondary Uses Service</a> . Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange

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## CDS TYPE

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Change to Supporting Information: Changed Description

A [CDS Type](#) forms part of an [ELECTRONIC HEALTH RECORD EXTRACT](#).

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

Note:

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

The [CDS Types](#) are:

- 010 Accident and Emergency Attendance (Retired 1 November 2020)
- 014 ~~Emergency Care Attendance~~
- 011 [Urgent and Emergency Care Activity](#)
- 020 Outpatient  
May also be used to submit a [Referral To Treatment Clock Stop Administrative Event](#)
- 021 Future Outpatient
- 030 Elective Admission List End of Period Census (Standard)
- 040 Elective Admission List End of Period Census (Old)
- 050 Elective Admission List End of Period Census (New)

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

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#### CLINICAL DATA SETS MENU

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Change to Supporting Information: Changed Description

- [Message Documentation](#)
- [Cancer Outcomes and Services](#)
- [Chlamydia Testing Activity](#)
- [Community Services](#)
- [Diagnostic Imaging](#)
- [Electronic Prescribing and Medicines Administration](#)
- [Emergency Care Data Set Version 4](#)
- [Female Genital Mutilation](#)
- [GUMCAD Sexually Transmitted Infection Surveillance System](#)
- [HIV and AIDS Reporting](#)
- [Improving Access to Psychological Therapies](#)
- [Maternity Services](#)
- [Mental Health Services](#)
- [National Cancer Waiting Times Monitoring](#)
- [National Neonatal](#)
- [Radiotherapy](#)
- [Sexual and Reproductive Health Activity](#)
- [Systemic Anti-Cancer Therapy](#)

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#### CLINICAL DATA SETS MESSAGE DOCUMENTATION

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Change to Supporting Information: Changed Description

**XML Schema Download:**

- [XML Schema TRUD Download](#)

**XML Schema Constraints:**

- [Cancer Outcomes and Services Data Set XML Schema Constraints](#)
- [Diagnostic Imaging Data Set XML Schema Constraints](#)
- [Electronic Prescribing and Medicines Administration Data Set XML Schema Constraints](#)
- [HIV and AIDS Reporting Data Set XML Schema Constraints](#)

**Data Set Constraints:**

- [Community Services Data Set Constraints](#)
- [Emergency Care Data Set Version 4 XML Schema Constraints](#)
- [Improving Access to Psychological Therapies Data Set Constraints](#)
- [Mental Health Services Data Set Constraints](#)
- [National Neonatal Data Set Constraints](#)
- [Radiotherapy Data Set Constraints](#)
- [Systemic Anti-Cancer Therapy Data Set Constraints](#)

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**CLINICAL DATA SETS MESSAGE DOCUMENTATION MENU**

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Change to Supporting Information: Changed Description

[Clinical Data Sets Menu](#)

**XML Schema Download:**

- [XML Schema TRUD Download](#)

**XML Schema Constraints:**

- [Cancer Outcomes and Services](#)
- [Diagnostic Imaging](#)
- [Electronic Prescribing and Medicines Administration](#)
- [Emergency Care Data Set Version 4](#)
- [HIV and AIDS](#)

**Data Set Constraints:**

- [Community Services](#)
- [Improving Access to Psychological Therapies](#)
- [Mental Health Services](#)
- [National Neonatal Data Set](#)
- [Radiotherapy](#)
- [Systemic Anti-Cancer Therapy](#)

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**COMMISSIONING DATA SET BUSINESS RULES**

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Change to Supporting Information: Changed Dataset, Description

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

## Population Validation

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

RULE	POPULATION VALIDATION
F	The format is validated, for example the format of a date must comply with the XML standard.
V	The Data Element is validated against an explicit list of permitted values as defined in the NHS Data Model and Dictionary. Note the permitted values differ between CDS-XML schema version 6-2 and CDS-XML version 6-2-0 for <a href="#">CARE PROFESSIONAL MAIN SPECIALTY CODE</a> and <a href="#">ACTIVITY TREATMENT FUNCTION CODE</a> .

## 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 notes, anomalies and issues.
- **Prefix N** = NHS Data Standards and Policy Rules
- **Prefix S** = [Secondary Uses Service](#) Business Rules

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

PREFIX	BUSINESS RULES: I - CDS-XML Schema Notes, Anomalies and Issues
I1	This is a known schema anomaly and has been registered for future resolution.
I2	See the specifications in the NHS Data Model and Dictionary for the specific format characteristics of this Data Element.
I3	There is no national requirement to flow <a href="#">Healthcare Resource Group 4 (HRG4)</a> through the Commissioning Data Sets, see <a href="#">DSCN 17/2008</a> .
I4	From Commissioning Data Set version 6-3 onwards, the NHS Data Model and Dictionary data set layout has been updated to correctly represent the existing requirements of the CDS-XML Schema for <a href="#">PERSON NAME STRUCTURED</a> and <a href="#">PERSON NAME UNSTRUCTURED</a>
I5	From Commissioning Data Set version 6-3 onwards, the NHS Data Model and Dictionary data set layout has been updated to correctly represent the existing requirements of the CDS-XML Schema for <a href="#">ADDRESS STRUCTURED</a> and <a href="#">ADDRESS UNSTRUCTURED</a>
I4	From Commissioning Data Set version 6-3 and Emergency Care Data Set V4 onwards, the NHS Data Model and Dictionary data set layout has been updated to correctly

	represent the existing requirements of the CDS-XML Schema for <a href="#">PERSON NAME STRUCTURED</a> and <a href="#">PERSON NAME UNSTRUCTURED</a>
<b>I5</b>	From Commissioning Data Set version 6-3 and Emergency Care Data Set V4 onwards, the NHS Data Model and Dictionary data set layout has been updated to correctly represent the existing requirements of the CDS-XML Schema for <a href="#">ADDRESS STRUCTURED</a> and <a href="#">ADDRESS UNSTRUCTURED</a>

<b>PREFIX</b>	<b>BUSINESS RULES: N - NHS Data Standards and Policy Rules</b>
<b>N1</b>	Psychiatric PATIENTS only (Retired January 2021).
<b>N2</b>	Not defined or approved by the <a href="#">Data Alliance Partnership Board</a> or its predecessors the <a href="#">Data Coordination Board</a> , <a href="#">Standardisation Committee for Care Information</a> and <a href="#">Information Standards Board for Health and Social Care</a> .
<b>N3</b>	The definition and value list for this data is under review.
<b>N4</b>	Up to 20 codes per daily activity occurrence may be recorded.
<b>N5</b>	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).
<b>N6</b>	This data should only flow in Commissioning Data Set version 6-2 for <a href="#">PATIENTS</a> detained under the Mental Health Act 2007.
<b>N7</b>	From Commissioning Data Set version 6-0 onwards, the use of the <a href="#">DETAINED AND (OR) LONG TERM PSYCHIATRIC CENSUS DATE</a> in the location group is <b>optional</b> as it <b>must</b> be carried in the Episode Characteristics.

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

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#### COMMISSIONING DATA SET MANDATED DATA FLOWS

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Change to Supporting Information: Changed Description

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

The [Secondary Uses Service](#) supports every [CDS Type](#) but only a subset is mandated to flow.

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

CDS TYPE	DESCRIPTION	MIN FREQUENCY	DIRECTIVE	DATA FLOW
CDS010	Accident and Emergency (Retired 01 November 2020)			
CDS 011	Emergency Care	Weekly	<a href="#">Emergency Care Attendances</a> for <a href="#">EMERGENCY CARE DEPARTMENT TYPE</a> 01 and 02 were	Data is expected to flow on a daily basis where possible, but a weekly frequency is

			<p>mandated to flow nationally from 1st October 2017. See <a href="#">SCCI0092-2062</a></p> <p><a href="#">Emergency Care Attendances</a> for <a href="#">EMERGENCY CARE DEPARTMENT TYPES</a> 03 and 04 were mandated to flow from October 2018. See <a href="#">SCCI0092-2062</a></p>	the minimum requirement.
CDS 011	Emergency Care	Weekly	<p><a href="#">Urgent and Emergency Care Activity</a> for <a href="#">EMERGENCY CARE DEPARTMENT TYPES / URGENT AND EMERGENCY CARE ACTIVITY TYPES</a> 01 and 02 were mandated to flow nationally from 1st October 2017. See <a href="#">SCCI0092-2062</a>.</p> <p><a href="#">Urgent and Emergency Care Activity</a> for <a href="#">EMERGENCY CARE DEPARTMENT TYPES / URGENT AND EMERGENCY CARE ACTIVITY TYPE</a> 03 was mandated to flow from October 2018. See <a href="#">SCCI0092-2062</a>.</p> <p><a href="#">Urgent and Emergency Care Activity</a> for <a href="#">URGENT AND EMERGENCY CARE ACTIVITY TYPES</a> 05 and 06 were enabled to flow from July 2023 and mandated to flow from July 2024. see <a href="#">DAPB0092-2062</a>.</p>	Data is expected to flow on a daily basis.

CDS 020	Out-Patient	Weekly	<p>Out-Patient Attendance Commissioning Data Sets (including Ward Attenders) were mandated to be submitted to the <a href="#">Secondary Uses Service</a> from 1st October 2001, see <a href="#">DSCN 05/2001</a>.</p> <p>Out-Patient Attendance Commissioning Data Set records where the activity relates to a <a href="#">Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement</a> must include the PATIENT PATHWAY data group items, from 1st October 2009.</p> <p><a href="#">NURSE</a> and <a href="#">MIDWIFE</a> attendances and Attendances for nursing care were enabled to be carried in the Out-Patient Attendance Commissioning Data Set from 1 April 2005, <a href="#">DSCN 32/2004</a></p> <p>Other Care Professional Attendances where an appropriate Treatment Function exists may also be submitted.</p> <p>Out-patient records where the activity relates to the <a href="#">Allied Health Professional Referral To Treatment Measurement</a> standard must be submitted to the <a href="#">Secondary Uses</a></p>	<p>NHS Acute <a href="#">Health Care Providers</a> must submit data weekly.</p> <p>NHS Community <a href="#">Health Care Providers</a>, NHS Mental <a href="#">Health Care Providers</a> and <a href="#">Independent Sector Healthcare Providers</a> undertaking acute care, must submit data weekly as soon as possible and no later than 31 March 2021.</p>
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			<p><a href="#">Service</a> (in accordance with <a href="#">ISN ISB0092 Amd 7/2013</a>, 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 <a href="#">WAITING TIME MEASUREMENT TYPE</a>.</p>	
CDS 021	<p>Future Out-Patients - <a href="#">Commissioning Data Set version 6-2 only</a></p>	As Required for piloting	From 01/01/2008, submissions to support local activities and commissioning will be supported for piloting purposes only.	
CDS 030	<p>Elective Admission List End of Period (Standard) - <a href="#">Commissioning Data Set version 6-2 only</a></p>	Monthly if used	<p>All Providers should endeavour to support this data flow.</p> <p>Elective Admission List End of Period Census (Standard) Commissioning Data Set records where the activity relates to a <a href="#">Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement</a> must include the PATIENT PATHWAY data group items, from 1st October 2009.</p>	<p>All entries where at the end of the time period being reported and defined by the <a href="#">Commissioning Data Set Submission Protocol</a>, the <a href="#">PATIENT</a> remains on the <a href="#">ELECTIVE ADMISSION LIST</a>. Optionally and by local agreement with commissioners, entries relating to the <a href="#">PATIENTS</a> that have been removed from the <a href="#">ELECTIVE ADMISSION LIST</a> may be included.</p>
CDS 040	<p>Elective Admission List End of Period (New) - <a href="#">Commissioning Data Set version 6-2 only</a></p>	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
CDS 050	<p>Elective Admission List End of Period (Old) - <a href="#">Commissioning Data Set version 6-2 only</a></p>	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) <a href="#">Commissioning Data Set</a> version 6-2 only	Monthly if used	Optional Elective Admission List Event During Period (Add) Commissioning Data Set records where the activity relates to a <a href="#">Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement</a> must include the PATIENT PATHWAY data group items, from 1st October 2009.	May be submitted where an entry has been added to the <a href="#">ELECTIVE ADMISSION LIST</a> during the time period reported.
CDS 070	Elective Admission List Event During Period (Remove) <a href="#">Commissioning Data Set</a> version 6-2 only	Monthly if used	Optional Elective Admission List Event During Period (Remove) Commissioning Data Set records where the activity relates to a <a href="#">Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement</a> must include the PATIENT PATHWAY data group items, from 1st October 2009.	May be submitted where an entry has been removed from the <a href="#">ELECTIVE ADMISSION LIST</a> during the time period reported.
CDS 080	Elective Admission List Event During Period (Offer) <a href="#">Commissioning Data Set</a> version 6-2 only	Monthly if used	Optional Elective Admission List Event During Period (Offer) CDS records where the activity relates to a <a href="#">Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement</a> must include the PATIENT	May be submitted where an offer has been made during the time period reported.

			PATHWAY data group items, from 1st October 2009.	
CDS 090	Elective Admission List Event During Period (Available / Unavailable) - <a href="#">Commissioning Data Set version 6-2 only</a>	Monthly if used	Optional	May be submitted where a patient becomes Available or Unavailable during the time period reported.
CDS 090	Elective Admission List Event During Period (Available / Unavailable) - <a href="#">Commissioning Data Set version 6-2 only</a>	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) <a href="#">Commissioning Data Set version 6-2 only</a>	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) <a href="#">Commissioning Data Set version 6-2 only</a>	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
CDS 120	Finished Birth Episode	Weekly	All finished Admitted Patient Care data must be submitted "at least monthly" (EL - Dec 1995). This includes <a href="#">Non-Contract Activity</a> .	NHS Acute <a href="#">Health Care Providers</a> must submit data weekly.  NHS Community <a href="#">Health Care Providers</a> , NHS Mental <a href="#">Health Care Providers</a> and <a href="#">Independent Sector Healthcare Providers</a> undertaking acute care, must submit data weekly as soon as possible and no later than 31 March 2021.
CDS 130	Finished General Episode	Weekly	All finished Admitted Patient Care data must be submitted "at least monthly" (EL - Dec 1995).	NHS Acute <a href="#">Health Care Providers</a> must submit data weekly.  NHS Community <a href="#">Health Care</a>

			<p>This includes <a href="#">Non-Contract Activity</a>.</p> <p>Finished General Episode Commissioning Data Set records where the activity relates to a <a href="#">Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement</a> must include the PATIENT PATHWAY data group items, from 1st October 2009.</p>	<p><a href="#">Providers</a>, NHS Mental <a href="#">Health Care Providers</a> and <a href="#">Independent Sector Healthcare Providers</a> undertaking acute care, must submit data weekly as soon as possible and no later than 31 March 2021.</p>
CDS 140	Finished Delivery Episode	Weekly	<p>All finished Admitted Patient Care data must be submitted "at least monthly" (EL - Dec 1995).</p> <p>This includes <a href="#">Non-Contract Activity</a>.</p>	<p>NHS Acute <a href="#">Health Care Providers</a> must submit data weekly.</p> <p>NHS Community <a href="#">Health Care Providers</a>, NHS Mental <a href="#">Health Care Providers</a> and <a href="#">Independent Sector Healthcare Providers</a> undertaking acute care, must submit data weekly as soon as possible and no later than 31 March 2021.</p>
CDS 150	Other Birth	Monthly	<p>This includes Home Birth.</p>	<p>All Episodes that have finished relevant to the time period defined by the <a href="#">Commissioning Data Set Submission Protocol</a> being used.</p>
CDS 160	Other Delivery	Monthly	<p>This includes Home Delivery.</p>	<p>All Episodes that have finished relevant to the time period defined by the <a href="#">Commissioning Data Set Submission Protocol</a> being used.</p>
		Annually		

CDS 170	The Detained and/or Long Term Psychiatric Census - <a href="#">Commissioning Data Set version 6-2 only</a>		Required by the <a href="#">NHS Digital</a> .  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 <a href="#">Commissioning Data Set Submission Protocol</a> being used.
CDS 180	Unfinished Birth Episode	Annually	The Annual Census / Unfinished Census. Required by the <a href="#">NHS Digital</a> .  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 <a href="#">Secondary Uses Service</a> in either Finished or Unfinished Commissioning Data Set data, must be submitted to the <a href="#">Secondary Uses Service</a> .
CDS 190	Unfinished General Episode	Annually	The Annual Census / Unfinished Census. Required by the <a href="#">NHS Digital</a>  May optionally be sent more regularly, usually monthly.  Unfinished General Episode Commissioning Data Set records where the activity relates to a <a href="#">Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement</a> 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 <a href="#">Secondary Uses Service</a> in either Finished or Unfinished Commissioning Data Set data, must be submitted to the <a href="#">Secondary Uses Service</a> .

CDS 200	Unfinished Delivery Episode	Annually	The Annual Census / Unfinished Census. Required by the <a href="#">NHS Digital</a>  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 <a href="#">Secondary Uses Service</a> in either Finished or Unfinished Commissioning Data Set data, must be submitted to the <a href="#">Secondary Uses Service</a> .
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#### COMMISSIONING DATA SET NOTATION

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Change to Supporting Information: Changed Dataset, Description

The [Commissioning Data Set](#) is the basic structure used for the submission of commissioning data to the [Secondary Uses Service](#) and is designed to be capable of individually conveying many different Commissioning Data Set structures, encompassing [Emergency Care Attendances](#), [Out-Patient Attendances](#), [Admitted Patient Care](#). 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 [Urgent and Emergency Care Activity](#), [Care Professional Out-Patient Attendances](#), [Care Professional Admitted Care Episodes](#). (Elective Admission List is also defined in [Commissioning Data Set](#) version 6-2 only).

The [Commissioning Data Sets](#) have been defined in specific components known as a [CDS Type](#).

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

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

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

#### Status Column Notation

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

STATUS	MEANING	DESCRIPTION
<b>M</b>	<b>MANDATORY</b>	<p>This signifies that the collection and submission of this Commissioning Data Set data is deemed <b>MANDATORY</b> and its presence is necessary for the <a href="#">CDS Type</a> to be correctly validated and accepted for processing by the <a href="#">Secondary Uses Service</a>.</p> <p>If a data item is shown as <b>MANDATORY</b>, this should also be regarded as <b>REQUIRED</b> by the <a href="#">Department of Health and Social Care</a>.</p> <p>In most instances, data marked as <b>MANDATORY</b> in a Sub Group will result in its parent Data Group also being marked as mandatory, but this is not always the case.</p> <p>For instance, although the Care Episode - Clinical Diagnosis Group (ICD) is marked as <b>R=REQUIRED</b> (and therefore need not actually be populated), if it is used then both the <a href="#">DIAGNOSIS SCHEME IN USE</a> and the <a href="#">PRIMARY DIAGNOSIS (ICD)</a> are marked as <b>M=MANDATORY</b> and must both be present.</p>
<b>R</b>	<b>REQUIRED</b>	<p>This signifies that the collection and submission of this Commissioning Data Set data is deemed <b>REQUIRED</b> by the <a href="#">Department of Health and Social Care</a> to comply with authorised NHS Standards, Policies and Directives. Therefore whenever a Commissioning Data Set is collected and subsequently submitted to the <a href="#">Secondary Uses Service</a>, this data must be supported and populated into the relevant data sets if the data is available.</p> <p>Note that "temporal" conditions may mean that there are instances where this directive cannot be fulfilled.</p> <p>For instance in a <a href="#">CDS V6-3 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set</a>, ICD and OPCS data groups are marked as "Required" indicating that this data should be included. However, if at the time of submission to the <a href="#">Secondary Uses Service</a> this data remains incomplete (perhaps awaiting coding in the <a href="#">ORGANISATION</a>), the remaining data in the CDS record should still be submitted. Once the <a href="#">ORGANISATION</a> has updated its systems with the data, the <a href="#">CDS Type</a> relating to that <a href="#">ACTIVITY</a> should then be resubmitted to the <a href="#">Secondary Uses Service</a>.</p>
<b>O</b>	<b>OPTIONAL</b>	<p>This signifies that the collection and submission of this Commissioning Data Set data is <b>OPTIONAL</b>. Its inclusion in the Commissioning Data Set is therefore determined by "local agreement" between the <a href="#">ORGANISATIONS</a> exchanging the data.</p> <p>Note that even if marked <b>O=OPTIONAL</b>, any data included in a Commissioning Data Set submission to the <a href="#">Secondary Uses Service</a> must comply with its specification published in the NHS Data Model and Dictionary otherwise the data may be deemed invalid and rejected.</p>

<b>X</b>	<b>Not yet authorised</b>	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.
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### Repeats Column Notation

Examples of the Notation used for the "**REPEATS**" column are as follows:

REPEATS	DESCRIPTION
<b>0..1</b>	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.
<b>0..9</b>	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.
<b>0..*</b>	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.
<b>1..1</b>	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.
<b>1..97</b>	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.
<b>1..*</b>	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:

<b>EXAMPLE 1: A MANDATORY Data Group with differing Sub-Groups and component data status conditions.</b>
<p>The following example shows a <b>MANDATORY</b> Data Group - therefore the Data Group must be present for the <a href="#">CDS Type</a> to be validated and accepted for processing by the <a href="#">Secondary Uses Service</a>.</p> <p>When a Data Group is used:</p> <ol style="list-style-type: none"> <li>1. All <b>MANDATORY</b> Sub Groups and/or Data Elements must be present</li> <li>2. Any <b>REQUIRED</b> Sub Groups and/or Data Elements must be present if the data is available</li> <li>3. Any <b>OPTIONAL</b> Sub Groups and/or Data Elements may be omitted</li> </ol>

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

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

#### EXPLANATION:

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

The Sub Group of "DATA GROUP: LOCAL IDENTIFIER STRUCTURE" is marked as **R=REQUIRED** and therefore must be populated if the data is available. The "**Repeats**" notation of 0..1 indicates that population of this Sub Group is not necessary to enable the Commissioning Data Set record to be sent to the [Secondary Uses Service](#). If it is sent, then only one occurrence of this Sub Group may flow in this particular Commissioning Data Set record.

Both Data Elements in the Sub Group are marked **M=MANDATORY** and must both be correctly populated.

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

#### EXAMPLE 2:

**A REQUIRED Data Group with differing component data status conditions.**

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

When the Data Group is used:

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

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

**EXPLANATION:**

The DATA GROUP: CONSULTANT EPISODE - CLINICAL DIAGNOSIS GROUP (ICD) "**Status**" of **R=Required** indicates that this Data Group must be populated in the relevant Commissioning Data Set if the data is available. The Data Group "**Repeats**" = **0..1** indicates that population of this Data Group is not necessary to enable the Commissioning Data Set to be sent to the [Secondary Uses Service](#). If it is sent, then only one occurrence of this Data Group may flow in this particular Commissioning Data Set record.

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

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

If the Data Group is completed then the Sub Group "Secondary Diagnoses", marked as **R=REQUIRED**, must be completed if the data is available, and if populated it must be in the correct format. The "**Repeats**" notation of 0..\* indicates that unlimited occurrences of this Data Element are valid. Each occurrence must contain a valid [SECONDARY DIAGNOSIS \(ICD\)](#).

**EXAMPLE 3:**

An **OPTIONAL** Data Group with differing component data status conditions.

The following example shows an **OPTIONAL** Data Group. Its inclusion in the Commissioning Data Sets is therefore determined by "local agreement" between [ORGANISATIONS](#) exchanging the data.

When the Data Group is used:

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

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

#### EXPLANATION:

The DATA GROUP: PATIENT PATHWAY "**Status**" of **O=OPTIONAL** indicates that this Data Group may be omitted and its inclusion in the Commissioning Data Set is determined by "local agreement" between the [ORGANISATIONS](#) exchanging the data.

Note that even if marked **O=OPTIONAL**, any data included in a Commissioning Data Set submission to the [Secondary Uses Service](#) must comply with its specification published in the NHS Data Model and Dictionary otherwise the data may be deemed invalid and rejected.

The Data Group "**Repeats**" = **0..1** indicates that population of this Data Group is not necessary to enable the Commissioning Data Set to be sent to the [Secondary Uses Service](#). If it is sent, then only one occurrence of this Data Group may flow in this particular Commissioning Data Set record.

If the DATA GROUP: PATIENT PATHWAY is submitted, then both of the sub-groups (DATA GROUP: PATIENT PATHWAY IDENTITY, and DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS) must be submitted. Data Elements marked as **M=MANDATORY**, must be populated. The "**Repeats**" notation of 1..1 indicates that only one occurrence of each of these Data Elements are valid.

In the DATA GROUP: PATIENT PATHWAY sub-group, **either** [UNIQUE BOOKING REFERENCE NUMBER \(CONVERTED\)](#) or [PATIENT PATHWAY IDENTIFIER](#) must be submitted (but not both).

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## COMMISSIONING DATA SETS OVERVIEW

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Change to Supporting Information: Changed Description

The purpose of the [Commissioning Data Sets](#) is to enable conformant health [ACTIVITY](#) information to be generated, independent of the [ORGANISATION](#) or system that maintains it. This enables health [CARE PROFESSIONALS](#) to measure and compare the delivery and quality of care provided and to support them in sharing information with other health professionals and [ORGANISATIONS](#).

[Commissioning Data Sets](#) currently support the following [ACTIVITIES](#):

- monitoring and managing [NHS SERVICE AGREEMENTS](#)
- developing commissioning plans
- supporting the [National Tariff Payment System](#)
- underpinning clinical governance
- understanding the health needs of the population
- reporting waiting time measurement

Information on care provided for all [PATIENTS](#) by [Health Care Providers](#) (both NHS and [Independent Sector Healthcare Providers](#) for NHS [PATIENTS](#) only) must be submitted to the [Secondary Uses Service](#) according to the [Commissioning Data Set Mandated Data Flows](#) guidelines.

Commissioning [ORGANISATIONS](#) need access to data to monitor [Non-Contract Activity](#) as part of the management of their [NHS SERVICE AGREEMENTS](#), and to monitor in-year [REFERRAL REQUESTS](#) to investigate the sources and reasons for [Non-Contract Activity](#).

~~The [Department of Health and Social Care](#) requires accurate data for all [PATIENTS](#) admitted, treated as out-patients or treated as an [Emergency Care Attendance](#) by [Health Care Providers](#), including [PATIENTS](#) receiving private treatment. The [Commissioning Data Sets](#) also includes NHS [PATIENTS](#) treated electively in the independent sector and overseas.~~ [The Department of Health and Social Care](#) requires accurate data for all [PATIENTS](#) admitted, treated as out-patients or treated as Urgent and Emergency Care Activity by [Health Care Providers](#), including [PATIENTS](#) receiving private treatment. [The Commissioning Data Sets](#) also includes NHS-funded [PATIENTS](#) treated electively in the independent sector and overseas.

[Referral To Treatment Clock Stop Administrative Events](#) may also flow using the [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#) or [CDS V6-3 Type 020 - Outpatient Commissioning Data Set](#). This allows the [Secondary Uses Service](#) to build accurate [PATIENT PATHWAYS](#) for the reporting of waiting time measurement.

### [CDS Types](#)

~~The [Commissioning Data Sets](#) are the basic structure used for the submission of commissioning data to the [Secondary Uses Service](#) and is designed to be capable of individually conveying many different Commissioning Data Set structures encompassing [Emergency Care Attendances](#), [Care Professional Out-Patient Attendances](#), and [Care Professional Admitted Care Episodes](#) for both [CDS](#) version 6-2 and [CDS](#) version 6-3.~~ [The Commissioning Data Sets](#) are the basic structure used

for the submission of commissioning data to the [Secondary Uses Service](#) and is designed to be capable of individually conveying many different Commissioning Data Set structures encompassing [Urgent and Emergency Care Activity](#), [Care Professional Out-Patient Attendances](#), and [Care Professional Admitted Care Episodes](#) for both CDS version 6-2 and CDS version 6-3. CDS version 6-2 also supports the submission of Future Out-Patient Attendances and Elective Admission List data.

## Further Information

Further guidance material for submission of data to the [Secondary Uses Service](#) can be found at: [Secondary Uses Service \(SUS Guidance\)](#).

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### COMMISSIONING DATA SET SUBMISSION PROTOCOL

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Change to Supporting Information: Changed Description

The [Commissioning Data Sets](#) submitted by providers carry information to determine the update method to be used by the [Secondary Uses Service](#) in order to update the national database.

These update rules are known as the [Commissioning Data Set Submission Protocol](#) and the set of data controls used to indicate this are carried in the Commissioning Data Set Transaction Header Group which must be present and correct in every [CDS Type](#) submitted to the [Secondary Uses Service](#).

#### Net Change:

~~Net Change processes are managed by specific data settings as defined in the [CDS V6-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#) / [CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#) option of the CDS Transaction Header Group.~~ Net Change processes are managed by specific data settings as defined in the [CDS V6-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#) / [CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#) / [ECDS V4 Type 005N](#) option of the CDS Transaction Header Group. The [Secondary Uses Service](#) uses the following data to manage the database:

- [CDS SENDER IDENTITY/ORGANISATION IDENTIFIER \(CDS SENDER\)](#)
- [CDS UNIQUE IDENTIFIER](#)
- [CDS APPLICABLE DATE](#)
- [CDS APPLICABLE TIME](#)

Note that [CDS SENDER IDENTITY](#) is used for [CDS V6-2](#) and [CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set](#). [ORGANISATION IDENTIFIER \(CDS SENDER\)](#) is used for ~~[CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set](#)~~ and [CDS Version 6-3](#) onwards. [ORGANISATION IDENTIFIER \(CDS SENDER\)](#) is used for [CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set](#) / [Emergency Care Data Set Version 4](#) and [CDS Version 6-3](#) onwards.

Each [CDS Type](#) must have a [CDS UNIQUE IDENTIFIER](#) which must be uniquely maintained throughout the life of that Commissioning Data Set record. This is a particular consideration where mergers and/or healthcare systems are changed or upgraded, see [Commissioning Data Set Submission and Organisation Mergers](#). Any change to the [CDS UNIQUE IDENTIFIER](#) during the "lifetime" of a Commissioning Data Set record will almost certainly result in a duplicate record being lodged in the [Secondary Uses Service](#) database.

A Commissioning Data Set record delete transaction must be sent to the [Secondary Uses Service](#) database when any previously sent Commissioning Data Set record requires deletion/removal, for example to reflect Commissioner changes etc.

Where [CDS UPDATE TYPE](#) 1 is required (delete/cancellation), an empty XML element called 'Delete Transaction' can be used instead of submitting the original [CDS Type](#) record, after the [CDS V6-2 Type 005N - CDS Transaction Header Group - Net Change Protocol](#)/[CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#). See the CDS V6-2 or CDS V6-3 XML Schema Release Notes which can be downloaded via the [XML Schema TRUD Download](#) page.

The [CDS APPLICABLE DATE](#) and [CDS APPLICABLE TIME](#) must be used to ensure that all Commissioning data is updated in the [Secondary Uses Service](#) database in the correct chronological order.

The [CDS SENDER IDENTITY/ORGANISATION IDENTIFIER \(CDS SENDER\)](#) **must not change during the lifetime of the CDS data**. This is particularly significant for multiple and/or merged [ORGANISATIONS](#), and for those services who submit data on behalf of another [NHS Trust](#), [NHS Foundation Trust](#) or [Independent Sector Healthcare Provider](#).

### **Bulk Replacement**

Bulk Replacement processes are managed by specific data settings as defined in the [CDS V6-2 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#)/[CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#) option of the CDS Transaction Header Group. The [Secondary Uses Service](#) uses the following data to manage the database:

- [CDS SENDER IDENTITY/ORGANISATION IDENTIFIER \(CDS SENDER\)](#)
- [CDS BULK REPLACEMENT GROUP CODE](#)
- [CDS EXTRACT DATE](#)
- [CDS EXTRACT TIME](#)
- [CDS REPORT PERIOD START DATE](#)
- [CDS REPORT PERIOD END DATE](#)

Note that [CDS SENDER IDENTITY](#) is used for [CDS V6-2](#) and [CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set](#). ~~[ORGANISATION IDENTIFIER \(CDS SENDER\)](#) is used for [CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set](#) and [CDS V6-3](#) onwards.~~ [ORGANISATION IDENTIFIER \(CDS SENDER\)](#) is used for [CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set / ECDS V4](#) and [CDS V6-3](#) onwards.

Every [CDS Type](#) must be submitted using the correct [CDS BULK REPLACEMENT GROUP CODE](#).

The [CDS REPORT PERIOD START DATE](#) and the [CDS REPORT PERIOD END DATE](#), (i.e. the effective date period), must be valid and consistent, and reflect the dates relevant to the Commissioning data contained in the interchange.

The [CDS SENDER IDENTITY/ORGANISATION IDENTIFIER \(CDS SENDER\)](#) must not change during the lifetime of the Commissioning Data Set record. This is particularly significant for multiple and/or merged [ORGANISATIONS](#), and for those services who submit data on behalf of another [ORGANISATION](#).

For submissions of [CDS V6-2](#) and [CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set](#), the [CDS PRIME RECIPIENT IDENTITY](#) is Mandatory for submission in the CDS Type 005B (CDS Transaction Header Group - Bulk Update Protocol) and CDS Type 005N (CDS Transaction Header Group - Net Change Protocol). However, it no longer forms part of the key for the process of determining duplicate records within the [Secondary Uses Service](#). Note that the [CDS PRIME RECIPIENT IDENTITY](#) continues to be used to determine data access requirements within the [Secondary Uses Service](#) for [Commissioning Data Set](#) version 6-2 submissions. For ~~[Commissioning Data Set](#) version 6-3 and [CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set](#)~~, data element [ORGANISATION IDENTIFIER \(CDS RECIPIENT\)](#) is used for this purpose. For [Commissioning Data Set](#) version 6-3 and [CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set / Emergency Care Data Set Version 4](#), data element [ORGANISATION IDENTIFIER \(CDS RECIPIENT\)](#) is used for this purpose.

If it is necessary to change any of this data during the lifetime of a Commissioning Data Set record, then the [Secondary Uses Service \(SUS\)](#) Service Desk should be contacted for advice. See the [NHS Digital](#) website at: [Secondary Uses Service \(SUS\)](#).

It is strongly advised that users of the Bulk Replacement Mechanism maintain a correctly generated [CDS UNIQUE IDENTIFIER](#) within the Commissioning data. This will establish a migration path towards the use of the Net Change Mechanism and will also then minimise the risk of creating duplicate Commissioning Data Set data.

### Sub contracting

If a [Health Care Provider](#) sub-contracts healthcare provision and its associated Commissioning Data Set submission to a second [ORGANISATION](#) (eg a different [Health Care Provider](#) or a Shared Services Organisation), arrangements to submit the Commissioning Data Set data must be made locally to ensure that only one [ORGANISATION](#) sends the Commissioning Data Set data to the [Secondary Uses Service](#).

If the second [ORGANISATION](#) wishes to add other Commissioning data to the [Secondary Uses Service](#) database to that already submitted by the first [ORGANISATION](#), both parties need to ensure that a different [CDS SENDER IDENTITY/ORGANISATION IDENTIFIER \(CDS SENDER\)](#) is used.

Note: Data sent using the same [CDS SENDER IDENTITY/ORGANISATION IDENTIFIER \(CDS SENDER\)](#) by two different parties will most likely overwrite each other's data in the [Secondary Uses Service](#) database. Further advice can be obtained from the [Secondary Uses Service \(SUS\)](#) Service Desk, see the [NHS Digital](#) website at: [SUS Guidance](#).

Users should be aware of how the 15 character code of their [CDS INTERCHANGE SENDER IDENTITY](#) (also known as the EDI Address) is created. This may depend on how their XML interface solution has been set up. It may not be possible to rely on a change to the [ORGANISATION CODE \(CODE OF PROVIDER\)/ORGANISATION IDENTIFIER \(CODE OF PROVIDER\)](#) in order to change the [CDS INTERCHANGE SENDER IDENTITY](#) should this become necessary.

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## ECDS V4 TYPE 001 - CDS INTERCHANGE HEADER OVERVIEW

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Change to Supporting Information: New Supporting Information

### Introduction

The [Emergency Care Data Set V4 Type 001 - Commissioning Data Set Interchange Header](#) carries mandatory controls for a Commissioning Data Set Interchange and is only used by inclusion in other CDS Types.

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

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

- [Emergency Care Data Set V4 Type 001 - Commissioning Data Set Interchange Header](#) - Mandatory - One per Commissioning Data Set Interchange
- [Emergency Care Data Set V4 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:

- [Emergency Care Data Set V4 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#) - Mandatory, one per CDS Type
- [Emergency Care Data Set V4 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:

- [Emergency Care Data Set V4 Type 004 - Commissioning Data Set Message Trailer](#) - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- [Emergency Care Data Set V4 Type 002 - Commissioning Data Set Interchange Trailer](#) - Mandatory - One per Commissioning Data Set Interchange

To access more detailed information on the Commissioning Data Sets, see the [Commissioning Data Sets Introduction](#).

## **Notation**

See [Commissioning Data Set Notation](#) for an explanation of Group Status and Group Repeats.

## **Business Rules**

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

## **XML Schema**

For guidance on the XML Schema constraints, see the [Emergency Care Data Set Version 4 XML Schema Constraints](#).

For guidance on downloading the XML Schema, see [XML Schema TRUD Download](#).

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## ECDS V4 TYPE 002 - CDS INTERCHANGE TRAILER OVERVIEW

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Change to Supporting Information: New Supporting Information

### Introduction

The [Emergency Care Data Set V4 Type 002 - Commissioning Data Set Interchange Trailer](#) carries mandatory controls for a Commissioning Data Set Interchange and is only used by inclusion in other CDS Types.

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

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

- [Emergency Care Data Set V4 Type 001 - Commissioning Data Set Interchange Header](#) - Mandatory - One per Commissioning Data Set Interchange
- [Emergency Care Data Set V4 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:

- [Emergency Care Data Set V4 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#) - Mandatory, one per CDS Type
- [Emergency Care Data Set V4 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:

- [Emergency Care Data Set V4 Type 004 - Commissioning Data Set Message Trailer](#) - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- [Emergency Care Data Set V4 Type 002 - Commissioning Data Set Interchange Trailer](#) - Mandatory - One per Commissioning Data Set Interchange.

To access more detailed information on the Commissioning Data Sets, see the [Commissioning Data Sets Introduction](#).

## Notation

See [Commissioning Data Set Notation](#) for an explanation of Group Status and Group Repeats.

## Business Rules

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

## XML Schema

For guidance on the XML Schema constraints, see the [Emergency Care Data Set Version 4 XML Schema Constraints](#).

For guidance on downloading the XML Schema, see [XML Schema TRUD Download](#).

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## ECDS V4 TYPE 003 - CDS MESSAGE HEADER OVERVIEW

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Change to Supporting Information: New Supporting Information

### Introduction

The [Emergency Care Data Set V4 Type 003 - Commissioning Data Set Message Header](#) carries mandatory controls for a Commissioning Data Set Message and is only used by inclusion in other CDS Types.

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

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

- [Emergency Care Data Set V4 Type 001 - Commissioning Data Set Interchange Header](#) - Mandatory - One per Commissioning Data Set Interchange
- [Emergency Care Data Set V4 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:

- [Emergency Care Data Set V4 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#) - Mandatory, one per CDS Type
- [Emergency Care Data Set V4 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:

- [Emergency Care Data Set V4 Type 004 - Commissioning Data Set Message Trailer - Mandatory - One per Commissioning Data Set Message](#)

Each Commissioning Data Set Interchange ends with:

- [Emergency Care Data Set V4 Type 002 - Commissioning Data Set Interchange Trailer - Mandatory - One per Commissioning Data Set Interchange.](#)

To access more detailed information on the Commissioning Data Sets, see the [Commissioning Data Sets Introduction](#).

## Notation

See [Commissioning Data Set Notation](#) for an explanation of Group Status and Group Repeats.

## Business Rules

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

## XML Schema

For guidance on the XML Schema constraints, see the [Emergency Care Data Set Version 4 XML Schema Constraints](#).

For guidance on downloading the XML Schema, see [XML Schema TRUD Download](#).

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## ECDS V4 TYPE 004 - CDS MESSAGE TRAILER OVERVIEW

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Change to Supporting Information: New Supporting Information

## Introduction

The [Emergency Care Data Set V4 Type 004 - Commissioning Data Set Message Trailer](#) carries mandatory controls for a Commissioning Data Set Message and is only used by inclusion in other CDS Types.

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

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

- [Emergency Care Data Set V4 Type 001 - Commissioning Data Set Interchange Header - Mandatory - One per Commissioning Data Set Interchange](#)
- [Emergency Care Data Set V4 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:

- [Emergency Care Data Set V4 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#) - Mandatory, one per [CDS Type](#)
- [Emergency Care Data Set V4 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:

- [Emergency Care Data Set V4 Type 004 - Commissioning Data Set Message Trailer](#) - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- [Emergency Care Data Set V4 Type 002 - Commissioning Data Set Interchange Trailer](#) - Mandatory - One per Commissioning Data Set Interchange.

To access more detailed information on the Commissioning Data Sets, see the [Commissioning Data Sets Introduction](#).

## Notation

See [Commissioning Data Set Notation](#) for an explanation of Group Status and Group Repeats.

## Business Rules

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

## XML Schema

For guidance on the XML Schema constraints, see the [Emergency Care Data Set Version 4 XML Schema Constraints](#).

For guidance on downloading the XML Schema, see [XML Schema TRUD Download](#).

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## ECDS V4 TYPE 005B - CDS TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL OVERVIEW

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Change to Supporting Information: New Supporting Information

## Introduction

The [Emergency Care Data Set V4 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#) carries mandatory controls for a Commissioning Data Set Type and is only used by inclusion in other [CDS Types](#).

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

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

- [Emergency Care Data Set V4 Type 001 - Commissioning Data Set Interchange Header](#) - Mandatory - One per Commissioning Data Set Interchange
- [Emergency Care Data Set V4 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:

- [Emergency Care Data Set V4 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#) - Mandatory, one per [CDS Type](#)
- [Emergency Care Data Set V4 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:

- [Emergency Care Data Set V4 Type 004 - Commissioning Data Set Message Trailer](#) - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- [Emergency Care Data Set V4 Type 002 - Commissioning Data Set Interchange Trailer](#) - Mandatory - One per Commissioning Data Set Interchange.

To access more detailed information on the Commissioning Data Sets, see the [Commissioning Data Sets Introduction](#).

## **Notation**

See [Commissioning Data Set Notation](#) for an explanation of Group Status and Group Repeats.

## **Business Rules**

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

## **XML Schema**

For guidance on the XML Schema constraints, see the [Emergency Care Data Set Version 4 XML Schema Constraints](#).

For guidance on downloading the XML Schema, see [XML Schema TRUD Download](#).

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## ECDS V4 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL OVERVIEW

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Change to Supporting Information: New Supporting Information

### Introduction

The [Emergency Care Data Set V4 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#) carries mandatory controls for a Commissioning Data Set Type and is only used by inclusion in other [CDS Types](#).

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

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

- [Emergency Care Data Set V4 Type 001 - Commissioning Data Set Interchange Header - Mandatory - One per Commissioning Data Set Interchange](#)
- [Emergency Care Data Set V4 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:

- [Emergency Care Data Set V4 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol - Mandatory, one per CDS Type](#)
- [Emergency Care Data Set V4 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:

- [Emergency Care Data Set V4 Type 004 - Commissioning Data Set Message Trailer - Mandatory - One per Commissioning Data Set Message](#)

Each Commissioning Data Set Interchange ends with:

- [Emergency Care Data Set V4 Type 002 - Commissioning Data Set Interchange Trailer - Mandatory - One per Commissioning Data Set Interchange.](#)

To access more detailed information on the Commissioning Data Sets, see the [Commissioning Data Sets Introduction](#).

### Notation

See [Commissioning Data Set Notation](#) for an explanation of Group Status and Group Repeats.

## Business Rules

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

## XML Schema

For guidance on the XML Schema constraints, see the [Emergency Care Data Set Version 4 XML Schema Constraints](#).

For guidance on downloading the XML Schema, see [XML Schema TRUD Download](#).

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### EMERGENCY CARE ARRIVAL DATE

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Change to Supporting Information: Changed Description

An [Emergency Care Arrival Date](#) is an [ACTIVITY DATE TIME](#).

An [Emergency Care Arrival Date](#) is the date the [PATIENT](#) self presented at the [Emergency Care Department](#) or arrived in an [Ambulance](#) at the [Emergency Care Department](#).

~~Note that for piloting purposes only, an [Emergency Care Arrival Date](#) may also be the Ambulatory Emergency Care Arrival Date.~~

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### EMERGENCY CARE ARRIVAL TIME

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Change to Supporting Information: Changed Description

An [Emergency Care Arrival Time](#) is an [ACTIVITY DATE TIME](#).

An [Emergency Care Arrival Time](#) is the time the [PATIENT](#) self presented at the [Emergency Care Department](#) or arrived in an [Ambulance](#) at the [Emergency Care Department](#).

The time should be recorded using the 24 hour clock.

~~Note that for piloting purposes only, an [Emergency Care Arrival Time](#) may also be the Ambulatory Emergency Care Arrival Time.~~

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### EMERGENCY CARE ATTENDANCE

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Change to Supporting Information: Changed Description

An [Emergency Care Attendance](#) is a [CARE CONTACT](#).

An [Emergency Care Attendance](#) is an individual visit by one [PATIENT](#) to an [Emergency Care Department](#) to receive treatment.

During an [Emergency Care Attendance](#) the [PATIENT](#) may temporarily leave the [Emergency Care Department](#), e.g. for an X-ray, whilst still under the responsibility of the [Emergency Care Department](#). An [Emergency Care Attendance](#) may occur as an unscheduled presentation by the [PATIENT](#) themselves, but also as a result of a [REFERRAL REQUEST](#) from a [GENERAL MEDICAL PRACTITIONER](#), a direct transfer from an [Emergency Ambulance](#), or via a [REFERRAL REQUEST](#) from the [NHS 111 Service](#).

An [Emergency Care Attendance](#) may be as a result of a request from a [GENERAL PRACTITIONER](#) for help with a diagnosis or treatment. An [Emergency Care Attendance](#) may be conducted face to face, or virtually by a [CARE PROFESSIONAL](#) from an [Emergency Care Department](#) who is qualified to deliver virtual care. In [Emergency Care Data Set Version 4](#), the [CONSULTATION MECHANISM \(URGENT AND EMERGENCY CARE\)](#) is used to differentiate face to face attendances from those conducted virtually.

Attendances at an [Out Patient Clinic](#) run in the [Emergency Care Department](#) should not be recorded as an [Emergency Care Attendance](#) but should be recorded as an [Out Patient Attendance Consultant](#) or [Clinic Attendance Non-Consultant](#) depending upon the type of [Out Patient Clinic](#) attended. An [Emergency Care Attendance](#) may be either a first or follow up attendance. A follow-up attendance is any subsequent [Emergency Care Attendance](#) for the same condition, and this may be planned or unplanned, as defined by the [URGENT AND EMERGENCY CARE ATTENDANCE CATEGORY \(ECDS V4\) / EMERGENCY CARE ATTENDANCE CATEGORY \(CDS 6-2-3\)](#). All planned follow-up [Emergency Care Attendances](#) should follow a clinical decision to discharge the [PATIENT](#) to their normal place of residence, but with an ongoing duty of care to follow up. For [Emergency Care Data Set Version 4](#), where a follow up [Emergency Care Attendance](#) is planned, this triggers the start of an [Urgent and Emergency Care Extended Care Episode](#). The [Urgent and Emergency Care Extended Care Episode](#) starts at the [Urgent and Emergency Care Activity End Timestamp](#) of the [Emergency Care Attendance](#) within which the clinical decision that there should be an ongoing duty of care to follow up was taken.

Any facility set up to receive and treat emergency cases is regarded as an [Emergency Care Department](#) for this purpose. If a [PATIENT](#) with an open [Urgent and Emergency Care Extended Care Episode](#) attends the [Emergency Care Department](#) outside of a scheduled attendance in the [Urgent and Emergency Care Extended Care Episode](#) (for example their condition deteriorates and they attend the [Emergency Care Department](#)), the unscheduled [Emergency Care Attendance](#) should also be recorded as being part of the open [Urgent and Emergency Care Extended Care Episode](#).

[Emergency Care Attendances](#) include both first and follow-up attendances. A follow-up attendance is any subsequent [Emergency Care Attendance](#) at the same [Emergency Care Department](#) for the same incident. All attendances for the same incident will constitute an [Emergency Care Episode](#). The [URGENT AND EMERGENCY CARE ACTIVITY IDENTIFIER](#) which identifies the open [Urgent and Emergency Care Extended Care Episode](#) must be linked in the [ELECTRONIC HEALTH RECORD](#) system, and submitted in the [Emergency Care Data Set Version 4](#) record relating to the [Emergency Care Attendance](#), for all planned and unplanned [Emergency Care Attendances](#) within the [Urgent and Emergency Care Extended Care Episode](#).

Note that for piloting purposes only, an [Emergency Care Attendance](#) may also be an [Ambulatory Emergency Care Attendance](#). During an [Emergency Care Attendance](#) the [PATIENT](#) may temporarily leave the [Emergency Care Department](#), for example for a [Clinical Investigation](#), whilst still under the

clinical responsibility of the Emergency Care Department. Such temporary absences from the Emergency Care Department do not interrupt the Emergency Care Attendance for that PATIENT.

During a Emergency Care Attendance, when the clinical decision is made that the PATIENT no longer requires ongoing care by the Emergency Care Department, this is recorded as the Urgent and Emergency Care Clinically Ready To Proceed Timestamp.

For a face to face Emergency Care Attendance (where the CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE) is National Code '*Face to face*'), the Urgent and Emergency Care Activity End Timestamp (ECDS V4) / Emergency Care Departure Date and Emergency Care Departure Time (CDS v6-2-3) is the time that the PATIENT leaves the Emergency Care Department premises and their clinical care is no longer the responsibility of the Emergency Care Department.

For an Emergency Care Attendance undertaken virtually (where the CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE) is National Codes '*Telephone*', '*Video Consultation*' or '*Chat Room (Synchronous)*'), the Urgent and Emergency Care Activity End Timestamp (ECDS V4) / Emergency Care Departure Date and Emergency Care Departure Time (CDS v6-2-3) is the time that all CARE ACTIVITIES undertaken by the responsible CARE PROFESSIONAL relating to the Emergency Care Attendance are completed.

An Emergency Care Attendance (face to face or virtual) outcome may include:

- The clinical care of the PATIENT is transferred to a different Health Care Provider and the PATIENT leaves the Emergency Care Department premises. This may be before the PATIENT has been formally assessed by a treating CARE PROFESSIONAL (termed '*Streaming*'), or after formal initial assessment (as recorded in the Urgent and Emergency Care Initial Assessment Timestamp), when it is a transfer of care based on that clinical assessment by the responsible CARE PROFESSIONAL in the Emergency Care Department
- The PATIENT leaves the Emergency Care Department following formal discharge, with no further clinical care planned as part of an Urgent and Emergency Care Extended Care Episode
- A decision to admit to a Hospital Provider Spell is taken by the responsible CARE PROFESSIONAL
- The PATIENT leaves the Emergency Care Department for a Same Day Emergency Care Attendance at the same Health Care Provider
- The PATIENT is assessed during the Emergency Care Attendance as requiring ongoing clinical care from the same Urgent and Emergency Care Service, which is to be delivered under a Urgent and Emergency Care Extended Care Episode.

If during the Emergency Care Attendance the PATIENT leaves the Emergency Care Department premises (if being seen face to face), or does not continue engagement with the assigned CARE PROFESSIONAL during virtual care, then the Emergency Care Attendance is completed. The Urgent and Emergency Care Activity End Timestamp (ECDS V4) / Emergency Care Departure Date and Emergency Care Departure Time (CDS v6-2-3) should record the time at which the CARE PROFESSIONAL responsible for the Emergency Care Attendance made the clinical decision to provide no further care. The URGENT AND EMERGENCY CARE DISCHARGE STATUS (SNOMED CT) should indicate that the PATIENT has left the Emergency Care Department/declined further virtual care, and that clinical care responsibility transfers back to their own usual CARE PROFESSIONAL (for example their GENERAL MEDICAL PRACTITIONER).

For further guidance for Emergency Departments on Initial Assessment and Patient Flow, see the NHS England website at: Guidance for emergency departments: initial assessment.

## EMERGENCY CARE ATTENDANCE CONCLUSION DATE

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Change to Supporting Information: Changed Description

An [Emergency Care Attendance Conclusion Date](#) is an [ACTIVITY DATE TIME](#).

An [Emergency Care Attendance Conclusion Date](#) is the date that a [PATIENT](#)'s [Emergency Care Attendance](#) concludes **or** when treatment in the [Emergency Care Department](#) is completed (whichever is the later).

For those [PATIENTS](#) admitted into hospital, the [EMERGENCY CARE ATTENDANCE CONCLUSION DATE](#) is recorded as the date when the [DECISION TO ADMIT](#) was made.

Where the [PATIENT](#) dies in the [Emergency Care Department](#), the [Emergency Care Attendance Conclusion Date](#) is the same as the [PERSON DEATH DATE](#).

~~Note that for piloting purposes only, an [Emergency Care Attendance Conclusion Date](#) may also be the Ambulatory Emergency Care Attendance Conclusion Date.~~

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## EMERGENCY CARE ATTENDANCE CONCLUSION TIME

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Change to Supporting Information: Changed Description

An [Emergency Care Attendance Conclusion Time](#) is an [ACTIVITY DATE TIME](#).

An [Emergency Care Attendance Conclusion Time](#) is the time, recorded using a 24 hour clock that a [PATIENT](#)'s [Emergency Care Attendance](#) concludes **or** when treatment in an [Emergency Care Department](#) is completed (whichever is the later).

For those [PATIENTS](#) admitted into hospital, the [EMERGENCY CARE ATTENDANCE CONCLUSION TIME](#) is recorded as the time when the [DECISION TO ADMIT](#) was made.

Where the [PATIENT](#) dies in the [Emergency Care Department](#), the [Emergency Care Attendance Conclusion Time](#) is the same as the [PERSON DEATH TIME](#).

~~Note that for piloting purposes only, an [Emergency Care Attendance Conclusion Time](#) may also be the Ambulatory Emergency Care Attendance Conclusion Time.~~

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## EMERGENCY CARE DATA SET VERSION 4 OVERVIEW

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Change to Supporting Information: New Supporting Information

The [Emergency Care Data Set Version 4 \(ECDS V4\)](#) collects information about why people attend [Emergency Care Departments](#) and the treatment they receive to improve [PATIENT](#) care through better and more consistent information; allow better planning of healthcare [SERVICES](#); improve communication between [CARE PROFESSIONALS](#).

The [Emergency Care Data Set Version 4](#) carries the data for [Urgent and Emergency Care Activity](#).

Note that [Emergency Care Data Set Version 4](#) is a Commissioning Data Set, see [CDS Type](#).

Previous versions of Emergency Care Data Set can be found at: [CDS V6-2-3 Type 011 - Emergency Care CDS](#).

To access more detailed information on the Commissioning Data Sets, see the [Commissioning Data Sets Introduction](#).

## Notation

See [Commissioning Data Set Notation](#) for an explanation of Group Status and Group Repeats.

## Business Rules

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

## XML Schema

For guidance on the XML Schema constraints, see the [Emergency Care Data Set Version 4 XML Schema Constraints](#).

For guidance on downloading the XML Schema, see [XML Schema TRUD Download](#).

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### EMERGENCY CARE DATE SEEN FOR TREATMENT

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Change to Supporting Information: Changed Description

An [Emergency Care Date Seen For Treatment](#) is an [ACTIVITY DATE TIME](#).

[Emergency Care Date Seen For Treatment](#) is the date that the [PATIENT](#) is seen by a clinical decision maker (a [CARE PROFESSIONAL](#) who can define the management plan and discharge the [PATIENT](#)) to diagnose the problem and arrange or start definitive treatment as necessary.

~~Note that for piloting purposes only, an [Emergency Care Date Seen For Treatment](#) may also be the Ambulatory Emergency Care Date Seen For Treatment.~~

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### EMERGENCY CARE DEPARTMENT

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Change to Supporting Information: Changed Description

An [Emergency Care Department](#) is a [Department](#).

~~[Emergency Care Departments](#) may be either major units, providing a 24 hour service seven days a week to which the great majority of [Emergency Ambulance](#) cases are taken, or smaller units, in~~

which services are often only available for limited hours and which may not deal with [Emergency Ambulance](#) cases. [Emergency Care Departments](#) are one of three types.

An [Emergency Care Department](#) is not always part of a [Hospital Site](#). Additional activities may also take place such as: elective surgical work of a minor nature, observation and treatment of [PATIENTS](#) in [Hospital Beds](#) and the holding of [Out-Patient Clinics](#). A Major [Emergency Care Department](#) is [CONSULTANT](#) led and must be a 24 hour, seven day [SERVICE](#), with full resuscitation facilities and designated accommodation for the reception of [PATIENTS](#) requiring [Emergency Care](#), including those arriving by [Emergency Ambulance](#).

[Hospital Beds](#) either within or adjacent to a [Department](#) will be counted as a [WARD](#) or part of a [WARD](#). Work apart from the emergency care service should be recorded in the appropriate data system. A Mono-specialty [Emergency Care Department](#) is a [CONSULTANT](#) led mono-specialty (for example Ophthalmology, dentistry) [Emergency Care SERVICE](#), with designated accommodation for the reception of [PATIENTS](#) requiring [Emergency Care](#). This may include [PATIENTS](#) arriving by [Emergency Ambulance](#), depending on local arrangements.

An emergency care service offers care to [PATIENTS](#) who arrive with urgent problems and who have not usually been seen previously by a [GENERAL PRACTITIONER](#). An [Urgent Treatment Centre](#) is [GENERAL MEDICAL PRACTITIONER](#) led, open at least 12 hours every day, and offers appointments which can be booked via the [NHS 111 Service](#) or a [GENERAL MEDICAL PRACTITIONER](#) referral.

Note that for piloting purposes only, an [Emergency Care Department](#) may also be an [Ambulatory Emergency Care Service](#). An [Emergency Care Department](#) may be part of a wider [Urgent and Emergency Care Service](#) within a [Health Care Provider](#), and may be co-located with other related services such as [Same Day Emergency Care](#) facilities.

An [Emergency Care Department](#) does not provide [Care Professional Admitted Care Episodes](#) or use [Hospital Beds](#), and does not run [Out-Patient Clinics](#). Activity of this nature is recorded in the appropriate Commissioning Data Set type for [Admitted Patient Care](#) and [Out-Patient Attendances](#).

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## EMERGENCY CARE DEPARTURE DATE

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Change to Supporting Information: Changed Description

An [Emergency Care Departure Date](#) is an [ACTIVITY DATE TIME](#).

An [Emergency Care Departure Date](#) is the date that a [PATIENT](#) leaves an [Emergency Care Department](#) after an [Emergency Care Attendance](#) has concluded.

Notes:

- For [PATIENTS](#) who die in an [Emergency Care Department](#) the [Emergency Care Departure Date](#) is the date the body was removed from the [Emergency Care Department](#).
- The [PATIENT](#) may leave the [Emergency Care Department](#) temporarily during an [Emergency Care Attendance](#), for example for an X-ray, but they remain under the care of an emergency care [CONSULTANT](#).

Note that for piloting purposes only, an [Emergency Care Departure Date](#) may also be the Ambulatory Emergency Care Departure Date.

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#### EMERGENCY CARE DEPARTURE TIME

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Change to Supporting Information: Changed Description

An [Emergency Care Departure Time](#) is an [ACTIVITY DATE TIME](#).

An [Emergency Care Departure Time](#) is the time recorded using a 24 hour clock that a [PATIENT](#) leaves an [Emergency Care Department](#) after an [Emergency Care Attendance](#) has concluded.

Notes:

- For [PATIENTS](#) who die in an [Emergency Care Department](#) the [Emergency Care Departure Time](#) is the time the body was removed from the [Emergency Care Department](#).
- The [PATIENT](#) may leave the [Emergency Care Department](#) temporarily during an [Emergency Care Attendance](#), for example for an X-ray, but they remain under the care of an emergency care [CONSULTANT](#).

Note that for piloting purposes only, an [Emergency Care Departure Time](#) may also be the Ambulatory Emergency Care Departure Time.

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#### EMERGENCY CARE EPISODE (RETIRED)\_ renamed from EMERGENCY CARE EPISODE

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Change to Supporting Information: Changed status to Retired, Name, Description

An [Emergency Care Episode](#) is an [ACTIVITY GROUP](#). **This item has been retired from the NHS Data Model and Dictionary.**

An [Emergency Care Episode](#) involves visits to an [Emergency Care Department](#) by one [PATIENT](#) for a particular incident. The [PATIENT](#) may receive treatment from the emergency care service and from other [MAIN SPECIALTIES](#) during the [Emergency Care Episode](#). **The last live version of this item is available in the ?????? release of the NHS Data Model and Dictionary.**

Each [Emergency Care Episode](#) takes place at a single [Emergency Care Department](#) and consists of one or more [Emergency Care Attendances](#). **Access to this version can be obtained by emailing [information.standards@nhs.net](mailto:information.standards@nhs.net) with "NHS Data Model and Dictionary - Archive Request" in the email subject line.**

The [Emergency Care Episode](#) may result in a [DECISION TO ADMIT](#).

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#### EMERGENCY CARE EPISODE (RETIRED)\_ renamed from EMERGENCY CARE EPISODE

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Change to Supporting Information: Changed status to Retired, Name, Description

- Retired Emergency Care Episode
- Changed Name from Data\_Dictionary.NHS\_Business\_Definitions.E.Emergency\_Care\_Episode to Retired.Data\_Dictionary.NHS\_Business\_Definitions.E.Emergency\_Care\_Episode
- Changed Description

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#### EMERGENCY CARE INITIAL ASSESSMENT DATE

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Change to Supporting Information: Changed Description

An [Emergency Care Initial Assessment Date](#) is an [ACTIVITY DATE TIME](#).

An [Emergency Care Initial Assessment Date](#) is the date that the [PATIENT](#) is first assessed in the [Emergency Care Department](#).

An initial assessment would include:

- the taking of a brief [PATIENT](#) medical history
- pain assessment
- early warning scores (including vital signs).

The assessment should be conducted by a [CARE PROFESSIONAL](#) who has received appropriate training.

~~Note that for piloting purposes only, an [Emergency Care Initial Assessment Date](#) may also be the Ambulatory Emergency Care Initial Assessment Date.~~

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#### EMERGENCY CARE INITIAL ASSESSMENT TIME

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Change to Supporting Information: Changed Description

An [Emergency Care Initial Assessment Time](#) is an [ACTIVITY DATE TIME](#).

An [Emergency Care Initial Assessment Time](#) is the time that the [PATIENT](#) is first assessed in the [Emergency Care Department](#).

An initial assessment would include:

- the taking of a brief [PATIENT](#) medical history
- pain assessment
- early warning scores (including vital signs).

The assessment should be conducted by a [CARE PROFESSIONAL](#) who has received appropriate training.

~~Note that for piloting purposes only, an [Emergency Care Initial Assessment Time](#) may also be the Ambulatory Emergency Care Initial Assessment Time.~~

## EMERGENCY CARE TIME SEEN FOR TREATMENT

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Change to Supporting Information: Changed Description

An [Emergency Care Time Seen For Treatment](#) is an [ACTIVITY DATE TIME](#).

An [Emergency Care Time Seen For Treatment](#) is the time that the [PATIENT](#) is seen by a clinical decision maker (a [CARE PROFESSIONAL](#) who can define the management plan and discharge the [PATIENT](#)) to diagnose the problem and arrange or start definite treatment as necessary.

Note that for piloting purposes only, an [Emergency Care Time Seen For Treatment](#) may also be the ~~Ambulatory Emergency Care Time Seen For Treatment~~.

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## HES DATA DICTIONARY

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Change to Supporting Information: Changed Description

The [HES Data Dictionary](#) contains detailed information on the fields from the Admitted Patient Care, Outpatient Care, Accident and Emergency, Adult Critical Care and the Patient Reported Outcome Measures (PROMs) data sets that are collected by [Hospital Episode Statistics \(HES\)](#). The [HES Data Dictionary](#) contains detailed information on the fields from the Admitted Patient Care, Outpatient Care, Urgent and Emergency Care Activities, Adult Critical Care and the Patient Reported Outcome Measures (PROMs) data sets that are collected by [Hospital Episode Statistics \(HES\)](#). These include the fields submitted directly by data providers and also fields derived and added to the data sets by the [HES Data Dictionary](#) team.

For further information on [HES Data Dictionary](#), see the [NHS Digital](#) website at: [HES data dictionary](#).

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## HOSPITAL EPISODE STATISTICS

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Change to Supporting Information: Changed Description

~~[Hospital Episode Statistics](#) is a data warehouse containing details of all Admitted Patient Care, Outpatient Attendances and Accident and Emergency Attendances in England.~~ [Hospital Episode Statistics](#) is a data warehouse containing details of all Admitted Patient Care, Outpatient Attendances and [Urgent and Emergency Care Activities](#) in England.

It includes private [PATIENTS](#) treated by the NHS, [PATIENTS](#) who were resident outside of England and care delivered by treatment centres (including those in the independent sector) funded by the NHS.

For further information on [Hospital Episode Statistics](#), see the [NHS Digital](#) website at: [Hospital Episode Statistics](#).

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## SAME DAY EMERGENCY CARE

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Change to Supporting Information: New Supporting Information

[Same Day Emergency Care](#) is an [ACTIVITY GROUP](#).

NHS England describes [Same Day Emergency Care](#) as the provision of same day care for emergency [PATIENTS](#) who would otherwise be admitted to hospital.

Under this care model, [PATIENTS](#) presenting at hospital with relevant conditions can be rapidly assessed, diagnosed and treated without being admitted to a [WARD](#), and if clinically safe to do so, will go home the same day their care is provided.

[Same Day Emergency Care](#) is the provision of care to a [PATIENT](#) by specialist [CARE PROFESSIONALS](#) within an Urgent and Emergency Care Service. [Same Day Emergency Care](#) is provided, where possible, within 24 hours of the [Urgent and Emergency Care Initial Assessment Timestamp](#), following formal initial clinical assessment (either virtual or face to face) and referral taking place.

[Same Day Emergency Care](#) is intended to provide an alternative to a [Care Professional Admitted Care Episode](#).

For further information see the [NHS England](#) website at: [Same Day Emergency Care](#).

**This supporting information is also known by these names:**

Context	Alias
<a href="#">shortname</a>	<a href="#">SDEC</a>

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#### **SAME DAY EMERGENCY CARE ATTENDANCE**

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Change to Supporting Information: New Supporting Information

A [Same Day Emergency Care Attendance](#) is a [CARE CONTACT](#).

A [Same Day Emergency Care Attendance](#) is the physical or virtual attendance of a [PATIENT](#) at an [Urgent and Emergency Care Service](#) for the provision of [Same Day Emergency Care](#).

A [Same Day Emergency Care Attendance](#) may be initiated following [Emergency Care Streaming](#) or [Emergency Care Triage](#) where the [PATIENT](#) has been assessed face to face or virtually by an appropriate [CARE PROFESSIONAL](#).

For further guidance for [Emergency Departments](#) on [Initial Assessment](#) and [Patient Flow](#), see the [NHS England](#) website at: [Guidance for emergency departments: initial assessment](#).

A [Same Day Emergency Care Attendance](#) may also be initiated following direct referral for [Same Day Emergency Care](#) by alternative routes, such as:

- A direct [REFERRAL REQUEST](#) from a [GENERAL MEDICAL PRACTITIONER](#)
- A direct transfer from an [Emergency Ambulance](#)
- A direct [REFERRAL REQUEST](#) from the [NHS 111 Service](#)

For a face to face Same Day Emergency Care Attendance (where the CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE) is National Code 'Face to face'), the Urgent and Emergency Care Activity Start Date and Time is the date and time that the PATIENT arrived in person or in an Emergency Ambulance at the Urgent and Emergency Care Service for the provision of Same Day Emergency Care.

For a Same Day Emergency Care Attendance undertaken virtually (where the CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE) is National Codes 'Telephone', 'Video Consultation' or 'Chat Room (Synchronous)'), the Urgent and Emergency Care Activity Start Date and Time is the date and time that contact was made with the PATIENT by a CARE PROFESSIONAL from a Same Day Emergency Care Service who is qualified to deliver virtual clinical care.

During a face to face Same Day Emergency Care Attendance, a PATIENT may reside in a Hospital Bed where this is necessary as a result of their condition, but should NOT be counted as having had a Hospital Provider Spell for statistical purposes. All CARE ACTIVITY taking place in a Same Day Emergency Care Attendance is recorded as a single CARE CONTACT, not a Care Professional Admitted Care Episode; and is submitted in Emergency Care Data Set Version 4 and not the Admitted Patient Care Commissioning Data Sets (CDS TYPES 130 Finished General Episode or 190 Unfinished General Episode).

Any CLINICAL INTERVENTIONS, including Observable Entities, Findings, Clinical Investigations and Patient Procedures, which are undertaken during a Same Day Emergency Care Attendance, must be recorded in the ELECTRONIC HEALTH RECORD and submitted in Emergency Care Data Set Version 4.

A Same Day Emergency Care Attendance, either face to face or virtual, and scheduled or unscheduled, may occur as a CARE CONTACT within an open Urgent and Emergency Care Extended Care Episode. In this circumstance, the URGENT AND EMERGENCY CARE ACTIVITY IDENTIFIER which identifies the open Urgent and Emergency Care Extended Care Episode must be linked to the Same Day Emergency Care Attendance in the ELECTRONIC HEALTH RECORD system, and submitted in the Emergency Care Data Set Version 4 record relating to the Same Day Emergency Care Attendance.

For a face to face Same Day Emergency Care Attendance (where the CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE) is National Code 'Face to face'), the Urgent and Emergency Care Activity End Timestamp is the end date, time and time zone that the PATIENT leaves the Same Day Emergency Care premises and responsibility for their clinical care is no longer the responsibility of the Same Day Emergency Care Service.

For a Same Day Emergency Care Attendance undertaken virtually (where the CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE) is National Codes 'Telephone', 'Video Consultation' or 'Chat Room (Synchronous)'), the Urgent and Emergency Care Activity End Timestamp is the date, time and time zone that all CARE ACTIVITIES undertaken by the responsible CARE PROFESSIONAL relating to the Same Day Emergency Care Attendance are completed.

A Same Day Emergency Care Attendance (face to face or virtual) outcome may include:

- The PATIENT leaves the Same Day Emergency Care Service following formal discharge, with no further clinical care planned as part of the Same Day Emergency Care Attendance (however, if the PATIENT has an open Urgent and Emergency Care Extended Care Episode

for ongoing care which has not been closed during the Same Day Emergency Care Attendance, the Urgent and Emergency Care Extended Care Episode continues)

- A decision to admit to a Hospital Provider Spell is taken by the responsible CARE PROFESSIONAL
- The PATIENT is assessed during the Same Day Emergency Care Attendance as requiring ongoing clinical care from the same Urgent and Emergency Care Service, which is to be delivered under a Urgent and Emergency Care Extended Care Episode
- The clinical care of the PATIENT is transferred to a different Health Care Provider and the PATIENT leaves the Same Day Emergency Care premises.

During a Same Day Emergency Care Attendance, a clinical decision may be taken that the PATIENT no longer requires ongoing care from the Urgent and Emergency Care Service. The time that the clinical decision made is recorded in the URGENT AND EMERGENCY CARE CLINICALLY READY TO PROCEED TIMESTAMP.

If during the Same Day Emergency Care Attendance the PATIENT leaves the Same Day Emergency Care premises (if being seen face to face), or does not continue engagement with assigned CARE PROFESSIONAL during virtual care, and this is against clinical advice, then the Same Day Emergency Care Attendance is completed and the URGENT AND EMERGENCY CARE ACTIVITY END TIMESTAMP should record the date, time and time zone at which the CARE PROFESSIONAL responsible for the Same Day Emergency Care Attendance made the clinical decision to provide no further care.

**This supporting information is also known by these names:**

Context	Alias
plural	Same Day Emergency Care Attendances

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## SECONDARY USES SERVICE

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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 on the [Secondary Uses Service](#) can be found on the [NHS Digital](#) website at: [Secondary Uses Service \(SUS\)](#).

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## URGENT AND EMERGENCY CARE ACTIVITY

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Change to Supporting Information: New Supporting Information

An Urgent and Emergency Care Activity is an ACTIVITY which is undertaken by an Urgent and Emergency Care Service.

An Urgent and Emergency Care Activity may be a Emergency Care Attendance, Same Day Emergency Care Attendance, Urgent and Emergency Care Extended Care Episode or a Hot Clinic Attendance (note that Hot Clinic Attendance is **only** valid for piloting purposes).

**This supporting information is also known by these names:**

Context	Alias
plural	Urgent and Emergency Care Activities

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**URGENT AND EMERGENCY CARE ACTIVITY END TIMESTAMP**

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Change to Supporting Information: New Supporting Information

An Urgent and Emergency Care Activity End Timestamp is an ACTIVITY DATE TIME.

An Urgent and Emergency Care Activity End Timestamp is the date and time that a PATIENT leaves an Emergency Care Department after an Urgent and Emergency Care Activity has concluded.

For an Emergency Care Attendance where the CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE) is National Code 'Face to face', the Urgent and Emergency Care Activity End Timestamp is the same as the Emergency Care Departure Date and the Emergency Care Departure Time.

For an Emergency Care Attendance undertaken virtually (where the CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE) is National Code 'Telephone', 'Video Consultation' or 'Chat Room (Synchronous)'), the Urgent and Emergency Care Activity End Timestamp is the date and time that contact with the PATIENT is completed and the virtual Emergency Care Attendance concludes.

For a Same Day Emergency Care Attendance where the CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE) is National Code 'Face to face', the Urgent and Emergency Care Activity End Timestamp is the date and time that the PATIENT left the Same Day Emergency Care Service.

For a Same Day Emergency Care Attendance undertaken virtually (where the CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE) is National Code 'Telephone', 'Video Consultation' or 'Chat Room (Synchronous)'), the Urgent and Emergency Care Activity End Timestamp is the date and time that contact with the PATIENT is completed and the virtual Same Day Emergency Care Attendance concludes.

For an Urgent and Emergency Care Extended Care Episode the Urgent and Emergency Care Activity End Timestamp is the date and time that the Urgent and Emergency Care Extended Care Episode closes.

**Notes:**

- For PATIENTS who die during an Emergency Care Attendance or Same Day Emergency Care Attendance (or dead on arrival), the Urgent and Emergency Care Activity End Timestamp is the date the body was removed from the Urgent and Emergency Care Service premises
- The PATIENT may leave the Urgent and Emergency Care Service temporarily during an Urgent and Emergency Care Activity, for example for an X-ray, but they remain under the care of a CONSULTANT in the Urgent and Emergency Care Service.

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**URGENT AND EMERGENCY CARE ACTIVITY START DATE AND TIME**

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Change to Supporting Information: New Supporting Information

An Urgent and Emergency Care Activity Start Date and Time is an ACTIVITY DATE TIME.

An Urgent and Emergency Care Activity Start Date and Time is the start date and time which is applicable to a specific type of Urgent and Emergency Care Activity.

For an Emergency Care Attendance where the CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE) is National Code 'Face to face', the Urgent and Emergency Care Activity Start Date and Time is the Emergency Care Arrival Date and Emergency Care Arrival Time.

For an Emergency Care Attendance undertaken virtually (where the CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE) is National Code 'Telephone', 'Video Consultation' or 'Chat Room (Synchronous)'), the Urgent and Emergency Care Activity Start Date and Time is the date and time that contact was made with the PATIENT by a CARE PROFESSIONAL from an Emergency Care Department who is qualified to deliver virtual clinical care.

For a Same Day Emergency Care Attendance where the CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE) is National Code 'Face to face', the Urgent and Emergency Care Activity Start Date and Time is the start date and time that the PATIENT arrived in person or in an Emergency Ambulance at the Same Day Emergency Care Service.

For a Same Day Emergency Care Attendance undertaken virtually (where the CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE) is National Code 'Telephone', 'Video Consultation' or 'Chat Room (Synchronous)'), the Urgent and Emergency Care Activity Start Date and Time is the date and time that contact was made with the PATIENT by a CARE PROFESSIONAL from a Same Day Emergency Care Service who is qualified to deliver virtual clinical care.

For a Urgent and Emergency Care Extended Care Episode, the Urgent and Emergency Care Activity Start Date and Time is the date and time of the start of the Urgent and Emergency Care Extended Care Episode.

**This supporting information is also known by these names:**

Context	Alias
plural	Urgent and Emergency Care Activity Start Dates and Times

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## URGENT AND EMERGENCY CARE CLINICALLY READY TO PROCEED TIMESTAMP

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Change to Supporting Information: New Supporting Information

An Urgent and Emergency Care Clinically Ready To Proceed Timestamp is an ACTIVITY DATE TIME and time zone.

An Urgent and Emergency Care Clinically Ready To Proceed Timestamp is the first date and time that the CARE PROFESSIONAL authorised to discharge the PATIENT from the Emergency Care Attendance or Same Day Emergency Care Attendance, makes a clinical decision that the PATIENT no longer requires ongoing care in the Emergency Care Department or Same Day Emergency Care premises.

**This supporting information is also known by these names:**

Context	Alias
plural	Urgent and Emergency Care Clinically Ready to Proceed Timestamps

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## URGENT AND EMERGENCY CARE EXTENDED CARE EPISODE

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Change to Supporting Information: New Supporting Information

An Urgent and Emergency Care Extended Care Episode is an ACTIVITY GROUP.

An Urgent and Emergency Care Extended Care Episode is an episode of clinical care for a PATIENT under the responsibility of a named CARE PROFESSIONAL in an Urgent and Emergency Care Service, which occurs following initial assessment by a CARE PROFESSIONAL qualified for independent practice in Urgent and Emergency Care. Typically this decision will be taken during a Emergency Care Attendance or Same Day Emergency Care Attendance.

An Urgent and Emergency Care Extended Care Episode starts at the Urgent and Emergency Care Activity End Timestamp of the Emergency Care Attendance or Same Day Emergency Care Attendance within which the clinical decision was taken to discharge the PATIENT to their normal place of residence, but with an ongoing duty of care to follow up under a Urgent and Emergency Care Extended Care Episode.

An Urgent and Emergency Care Extended Care Episode spans a series of planned attendances (typically Same Day Emergency Care Attendances) for ongoing follow up care. If during the same time period the PATIENT attends an Urgent and Emergency Care Service for unplanned attendances (for example their condition deteriorates and they attend the Emergency Care Department within the same Health Care Provider), then the unplanned attendance should also be recorded as being part of the Urgent and Emergency Care Extended Care Episode.

All Emergency Care Attendances and Same Day Emergency Care Attendances, either face to face or virtual, and either scheduled or unscheduled, that occurs during an Urgent and Emergency Care Extended Care Episode period, must be linked to the Urgent and Emergency Care Extended Care Episode. The URGENT AND EMERGENCY CARE ACTIVITY IDENTIFIER which identifies the open

Urgent and Emergency Care Extended Care Episode must be linked in the ELECTRONIC HEALTH RECORD system, and submitted in the Emergency Care Data Set Version 4 record relating to the Emergency Care Attendance or Same Day Emergency Care Attendance.

A Urgent and Emergency Care Extended Care Episode should run for no longer than 4 weeks (28 days); and within this, the maximum interval between scheduled face to face or virtual attendances must be no longer than 8 days.

A Urgent and Emergency Care Extended Care Episode ends when either:

- The PATIENT is formally discharged from the Urgent and Emergency Care Extended Care Episode period of ongoing planned care, having received all necessary treatment (for example to their own GENERAL MEDICAL PRACTITIONER to manage care)
- A decision to admit to a WARD is taken by the responsible CARE PROFESSIONAL during a scheduled or unscheduled face to face or virtual attendance which is part of the Urgent and Emergency Care Extended Care Episode, for example if the condition of the PATIENT has deteriorated such that Admitted Patient Care is now clinically required
- The PATIENT is referred to another speciality or SERVICE within the same Health Care Provider, to continue treatment under a Care Professional Out-Patient Episode.
- When the ongoing clinical care of the PATIENT is transferred to a different Health Care Provider.
- The PATIENT dies

Where the PATIENT is formally discharged from the Urgent and Emergency Care Extended Care Episode by the responsible CARE PROFESSIONAL and this decision is taken during a scheduled or unscheduled attendance, the Urgent and Emergency Care Activity End Timestamp for the Emergency Care Data Set Version 4 record relating to Urgent and Emergency Care Extended Care Episode is the same as the Urgent and Emergency Care Activity End Timestamp of the Emergency Care Attendance or Same Day Emergency Care Attendance where the clinical decision to discharge the PATIENT was taken. In all cases, the PATIENT (and the receiving Health Care Provider if applicable) should receive a written summary of care delivered, and future suggested CARE PLANS.

If a decision to close the Urgent and Emergency Care Extended Care Episode is taken outside of a scheduled or unscheduled attendance (for example if the PATIENT is admitted to another Health Care Provider, dies, leaves the country, fails to attend scheduled attendances etc), the Urgent and Emergency Care Activity End Timestamp for the record relating to the Urgent and Emergency Care Extended Care Episode in the Emergency Care Data Set Version 4 submission would be the date, time and time zone that the clinical decision to close the Urgent and Emergency Care Extended Care Episode was taken. If appropriate/possible, the Health Care Provider to whom the PATIENT'S care is transferred, and the PATIENT themselves, should receive a written summary of care delivered and future suggested CARE PLANS.

**This supporting information is also known by these names:**

Context	Alias
plural	Urgent and Emergency Care Extended Care Episodes

---

**URGENT AND EMERGENCY CARE INITIAL ASSESSMENT TIMESTAMP**

---

Change to Supporting Information: New Supporting Information

An Urgent and Emergency Care Initial Assessment Timestamp is an ACTIVITY DATE TIME.

An Urgent and Emergency Care Initial Assessment Timestamp is the date, time and time zone that the PATIENT is first assessed during an Emergency Care Attendance or a Same Day Emergency Care Attendance.

An initial assessment during an Emergency Care Attendance includes:

- the taking of a brief PATIENT medical history
- pain assessment
- early warning scores (including vital signs).

The assessment should be conducted by a CARE PROFESSIONAL who has received appropriate training.

An initial assessment including the same clinical activities is also required in Same Day Emergency Care, where the PATIENT attends Same Day Emergency Care directly, without first being seen and assessed in the Emergency Care Department.

**This supporting information is also known by these names:**

Context	Alias
plural	Urgent and Emergency Care Initial Assessment Timestamps

---

#### URGENT AND EMERGENCY CARE SERVICE

---

Change to Supporting Information: New Supporting Information

An Urgent and Emergency Care Service is a SERVICE.

An Urgent and Emergency Care Service delivers Urgent and Emergency Care Activity.

For further information see the NHS England website at: About Urgent and Emergency Care.

**This supporting information is also known by these names:**

Context	Alias
plural	Urgent and Emergency Care Services

---

#### URGENT AND EMERGENCY CARE TIMESTAMP SEEN FOR TREATMENT

---

Change to Supporting Information: New Supporting Information

An Urgent and Emergency Care Timestamp Seen For Treatment is an ACTIVITY DATE TIME and time zone.

An Urgent and Emergency Care Timestamp Seen For Treatment is the date, time and time zone that the PATIENT is seen by a clinical decision maker (a CARE PROFESSIONAL who can define the management plan and discharge the PATIENT) to diagnose the problem and arrange or start definite treatment as necessary.

This supporting information is also known by these names:

Context	Alias
plural	Urgent and Emergency Care Timestamps Seen For Treatment

---

## URGENT TREATMENT CENTRE

---

Change to Supporting Information: Changed Description

An [Urgent Treatment Centre \(UTC\)](#) is an [Emergency Care Department](#).

~~Urgent Treatment Centres (UTCs) are GENERAL PRACTITIONER led, open at least 12 hours a day every day, and offer APPOINTMENTS that can be booked via the NHS 111 Service or a GENERAL PRACTITIONER referral.~~ Urgent Treatment Centres (UTCs) are GENERAL MEDICAL PRACTITIONER led, open at least 12 hours a day every day, and offer APPOINTMENTS that can be booked via the NHS 111 Service or a GENERAL MEDICAL PRACTITIONER referral.

For further information on [Urgent Treatment Centres](#) see the [NHS England](#) website at: [Urgent Treatment Centres](#).

---

## ACTIVITY

---

Change to Class: Changed Attributes

*Attributes of this Class are:*

K      ACTIVITY IDENTIFIER  
 ACTIVITY COUNT  
 ACTIVITY DURATION  
 ACTIVITY PERCENTAGE  
 CONTRACT MONITORING ACTUAL ACTIVITY  
 GS1 SERVICE RELATION INSTANCE NUMBER  
 PATIENT LEVEL INFORMATION COSTING CARE ACTIVITY IDENTIFIER  
 URGENT AND EMERGENCY CARE ACTIVITY TYPE

---

## ACTIVITY GROUP

---

Change to Class: Changed Attributes

*Attributes of this Class are:*

ADJUSTED LENGTH OF STAY

ADMISSION METHOD  
ADMISSION SOURCE  
CANCER OR SYMPTOMATIC BREAST REFERRAL PATIENT STATUS  
CANCER TRANSFER REASON FOR INTER PROVIDER TRANSFER  
CANCER TREATMENT INTENT  
CARE PACKAGE IDENTIFIER FOR NHS CONTINUING HEALTHCARE  
CARE PACKAGE REVIEW ELIGIBILITY OUTCOME FOR NHS CONTINUING HEALTHCARE  
CARE PACKAGE REVIEW OUTCOME CODE FOR NHS CONTINUING HEALTHCARE  
CARE PACKAGE REVIEW TYPE FOR NHS CONTINUING HEALTHCARE  
CARER RESIDENT INDICATION CODE FOR NATIONAL NEONATAL DATA SET  
CHILDREN TEENAGERS AND YOUNG ADULTS AGE CATEGORY  
CLINICAL COMMISSIONING GROUP ELIGIBILITY DECISION OUTCOME FOR NHS CONTINUING HEALTHCARE STANDARD  
CLINICAL COMMISSIONING GROUP REVIEW ELIGIBILITY DECISION OUTCOME FOR NHS CONTINUING HEALTHCARE  
COMMUNITY PERINATAL MENTAL HEALTH PARTNER ASSESSMENT OFFER INDICATOR  
COMMUNITY TREATMENT ORDER END REASON  
CONSULTANT EPISODE COMPLETION STATUS FOR PATIENT LEVEL INFORMATION COSTING  
CONTINUITY OF CARER PATHWAY INDICATOR  
DAUGHTER BORN AT THIS ENCOUNTER INDICATOR  
DELIVERY PLACE CHANGE REASON  
DESTINATION OF DISCHARGE  
DISCHARGE DESTINATION  
DISCHARGED TO HOSPITAL AT HOME SERVICE INDICATOR  
DISCHARGED TO NHS AT HOME SERVICE INDICATOR  
DISCHARGE FROM IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES SERVICE REASON  
DISCHARGE METHOD  
DISCHARGE REASON FOR MOTHER MATERNITY SERVICES  
ESTIMATED DATE OF DELIVERY  
FIRST REGULAR DAY OR NIGHT ADMISSION  
FITNESS ASSESSMENT FOR OLDER PATIENTS WITH BREAST CANCER INDICATOR  
HOLISTIC NEEDS ASSESSMENT POINT OF PATHWAY FOR CANCER  
HOSPITAL PROVIDER SPELL COMPLETION STATUS FOR PATIENT LEVEL INFORMATION COSTING  
ILLICIT SUBSTANCE USE TYPE  
LABOUR ONSET METHOD CODE FOR NATIONAL NEONATAL DATA SET  
LAST EPISODE IN SPELL INDICATOR CODE  
LENGTH OF STAY ADJUSTMENT  
LENGTH OF STAY ADJUSTMENT REASON  
MATERNAL CRITICAL INCIDENT INDICATOR  
MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY

MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION  
MENTAL HEALTH CONDITIONAL DISCHARGE END REASON  
MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE  
MENTAL HEALTH DELAYED DISCHARGE REASON  
METHOD OF ADMISSION  
METHOD OF DISCHARGE  
MULTIDISCIPLINARY TEAM RECOMMENDATION FOR NHS CONTINUING  
HEALTHCARE STANDARD  
NEONATAL CRITICAL INCIDENT INDICATOR  
NEONATAL LEVEL OF CARE  
NHS CONTINUING HEALTHCARE ACTIVITY TYPE  
NHS CONTINUING HEALTHCARE COMMISSIONED SERVICES INDICATOR  
NHS CONTINUING HEALTHCARE PREVIOUSLY UNASSESSED PERIOD OF CARE  
DECISION OUTCOME  
NHS CONTINUING HEALTHCARE REFERRAL EXCEEDING 28 DAYS TIME BAND  
CATEGORY  
NHS CONTINUING HEALTHCARE TYPE  
NON SMOKING CONFIRMATION STATUS AT 4 WEEKS  
OPERATION FUNDING FOR NATIONAL JOINT REGISTRY  
OUTCOME AT 4 WEEK FOLLOW UP FOR STOP SMOKING  
OUTPATIENT ATTENDANCE OUTCOME  
PALLIATIVE CARE SPECIALIST SEEN INDICATOR  
PALLIATIVE TREATMENT REASON FOR UPPER GASTROINTESTINAL  
PATIENT ATTENDANCE SYMPTOMATIC INDICATOR FOR SEXUAL HEALTH  
SERVICE  
PATIENT CLASSIFICATION  
PATIENT ON PATIENT INITIATED OUTPATIENT FOLLOW UP PATHWAY INDICATOR  
PATIENT RECEIVING ONE TO ONE NURSING CARE INDICATOR  
PERSONALISED CARE AND SUPPORT PLANNING POINT OF CANCER PATHWAY  
PHARMACOTHERAPY STOP SMOKING AID RECEIVED  
PLANNED DELIVERY SETTING CHANGE REASON  
PLANNED DESTINATION OF DISCHARGE  
PREGNANCY OUTCOME  
PSYCHIATRIC PATIENT STATUS  
SEXUAL INTERCOURSE UNDER THE INFLUENCE OF SUBSTANCE INDICATOR  
SOURCE OF ADMISSION  
SUBSTANCE INJECTED IN THE LAST THREE MONTHS INDICATOR  
SUBSTANCE INJECTED SHARED EQUIPMENT IN THE LAST THREE MONTHS  
INDICATOR  
SUBSTANCE USE IN THE LAST THREE MONTHS INDICATOR  
URGENT AND EMERGENCY CARE DISCHARGE INFORMATION GIVEN INDICATOR

---

**CARE CONTACT**

---

Change to Class: Changed Attributes

*Attributes of this Class are:*

ACUTE ONCOLOGY ASSESSMENT PATIENT PRESENTATION TYPE  
ACUTE ONCOLOGY EPISODE OUTCOME  
AMBULANCE CALL IDENTIFIER  
AMBULANCE CALL OUTCOME FOR PATIENT LEVEL INFORMATION COSTING  
AMBULANCE CALL RESPONSE CATEGORY  
AMBULANCE CALL RESPONSE TYPE  
AMBULANCE CALL SOURCE  
AMBULANCE MULTI PATIENT INCIDENT INDICATOR  
CARE CONTACT CANCELLATION REASON  
CARE CONTACT PATIENT THERAPY MODE  
CARE CONTACT SUBJECT  
CHILD DIFFICULT TO TEST REASON  
CLINICAL NURSE SPECIALIST INDICATION CODE  
CLINIC ATTENDANCE PURPOSE CODE FOR HIV  
CONSULTATION TYPE  
EMERGENCY CARE ATTENDANCE CATEGORY  
FIRST ATTENDANCE  
GROUP THERAPY INDICATOR  
INFORMATION AND ADVICE PROVIDED INDICATOR  
INFORMATION AND ADVICE TYPE PROVIDED FOR FEMALE GENITAL MUTILATION  
INITIAL CONTACT INDICATOR  
INITIAL DIAGNOSIS CARE SETTING OR SERVICE FOR HIV  
INTERPRETER PRESENT AT CARE CONTACT INDICATION CODE  
LATE ANTENATAL BOOKING APPOINTMENT REASON  
MEDICAL STAFF TYPE SEEING PATIENT  
MENTAL HEALTH DROP IN CONTACT OUTCOME  
MENTAL HEALTH PREDICTION AND DETECTION INDICATOR  
MULTIPROFESSIONAL OR MULTIDISCIPLINARY INDICATION CODE  
NEW HIV DIAGNOSIS IN UNITED KINGDOM INDICATOR  
OTHER PERSON IN ATTENDANCE AT CARE CONTACT  
OUTCOME OF ATTENDANCE  
PATIENT HIV CARE STATUS  
POST EXPOSURE PROPHYLAXIS INDICATOR  
PRE EXPOSURE PROPHYLAXIS INDICATOR  
PSYCHIATRIC CARE INDICATOR FOR HIV  
RADIOTHERAPY ADMITTED PATIENT INDICATOR  
REASONABLE ADJUSTMENT MADE INDICATOR  
SKIN TO SKIN CONTACT INDICATOR  
STAFF ROLE CARRYING OUT HOLISTIC NEEDS ASSESSMENT OR  
PERSONALISED CARE AND SUPPORT PLANNING  
TWO YEAR NEONATAL OUTCOMES ASSESSMENT NOT CARRIED OUT REASON  
URGENT AND EMERGENCY CARE ATTENDANCE CATEGORY

---

## CARE PROFESSIONAL

---

Change to Class: Changed Attributes

*Attributes of this Class are:*

K CARE PROFESSIONAL IDENTIFIER  
CARE PROFESSIONAL DESIGNATION FOR TWO YEAR NEONATAL OUTCOMES ASSESSMENT  
CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR FOR EMERGENCY CARE  
CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR FOR URGENT AND 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 SENIOR OPERATING SURGEON GRADE FOR CANCER  
CARE PROFESSIONAL STAFF GROUP FOR COMMUNITY CARE  
CARE PROFESSIONAL STAFF GROUP FOR MATERNITY  
CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH  
CARE PROFESSIONAL TIER FOR EMERGENCY CARE  
CARE PROFESSIONAL TIER FOR URGENT AND EMERGENCY CARE  
CARE PROFESSIONAL TYPE  
CARE PROFESSIONAL TYPE FOR HIV  
CARE PROFESSIONAL TYPE FOR PREGNANCY FIRST CONTACT  
GENERAL MEDICAL COUNCIL REFERENCE NUMBER  
PRIVATE CONTROLLED DRUG PRESCRIBER CODE  
REFERRING CARE PROFESSIONAL STAFF GROUP FOR COMMUNITY CARE  
REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH  
REFERRING CARE PROFESSIONAL TYPE FOR NHS CONTINUING HEALTHCARE STANDARD

---

## ORGANISATION

---

Change to Class: Changed Attributes

*Attributes of this Class are:*

K ORGANISATION IDENTIFIER  
DEPARTMENT CODE  
EDUCATIONAL ESTABLISHMENT TYPE FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES  
EMERGENCY CARE DEPARTMENT TYPE  
EMERGENCY CARE DEPARTMENT TYPE FOR PATIENT LEVEL INFORMATION COSTING  
GS1 GLOBAL LOCATION NUMBER  
GS1 UNIQUE ORGANISATION PREFIX NUMBER  
HEADCOUNT ORGANISATION CURRENT

LABORATORY CODE  
NHS CONTINUING HEALTHCARE COMMISSIONED SERVICES INDICATOR  
ONS ORGANISATION IDENTIFIER  
ORGANISATION CODE  
ORGANISATION IDENTIFIER FOR NATIONAL BREAST SCREENING PROGRAMME  
ORGANISATION NAME  
SECURE CHILDRENS HOME PLACEMENT TYPE

---

#### **ACTIVITY DATE**

---

Change to Attribute: Changed Dataset

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

---

#### **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: Changed Dataset

The date that a [SERVICE REQUEST](#) for an [ACTIVITY](#) was made.

---

#### **ACTIVITY SERVICE REQUEST TIME**

---

Change to Attribute: Changed Dataset

The time that a [SERVICE REQUEST](#) for an [ACTIVITY](#) was made.

---

#### **ACTIVITY TIME**

---

Change to Attribute: Changed Dataset

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

This may include representation of a time zone.

---

**ADDRESS**

Change to Attribute: Changed Dataset

The identification of a place of relevance to a [PERSON](#), [ORGANISATION](#), [ORGANISATION SITE](#) or [LOCATION](#).

**AMBULANCE CALL IDENTIFIER**

Change to Attribute: Changed Dataset  
A unique identifier for each [Ambulance Call](#).

**CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR FOR URGENT AND EMERGENCY CARE**

Change to Attribute: New Attribute

An indication of whether a [CARE PROFESSIONAL](#) is responsible for discharge of the [PATIENT](#) from an [Urgent and Emergency Care Service](#).

*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 URGENT AND EMERGENCY CARE

**CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR FOR URGENT AND EMERGENCY CARE**

Change to Attribute: New Attribute

**CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR FOR URGENT AND EMERGENCY CARE**

**Data Elements:**

CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR (URGENT AND EMERGENCY CARE)
----------------------------------------------------------------------------------

**CARE PROFESSIONAL TIER FOR URGENT AND EMERGENCY CARE**

Change to Attribute: New Attribute

The tier of [CARE PROFESSIONAL](#) treating the [PATIENT](#) during an [Urgent and Emergency Care Activity](#).

The CARE PROFESSIONAL TIERS FOR URGENT AND 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 URGENT AND EMERGENCY CARE

**CARE PROFESSIONAL TIER FOR URGENT AND EMERGENCY CARE**

Change to Attribute: New Attribute

**CARE PROFESSIONAL TIER FOR URGENT AND EMERGENCY CARE**

**Data Elements:**

CARE PROFESSIONAL TIER (URGENT AND EMERGENCY CARE)
----------------------------------------------------

**CDS BULK REPLACEMENT GROUP CODE**

Change to Attribute: Changed Dataset, Description

The Commissioning Data Set Group into which [CDS Types](#) must be grouped when using the Commissioning Data Set Bulk Replacement Update Mechanism.

**Note:**

- National Code 160 '*Emergency Care Attendance*' is **only** valid for:
  - [CDS V6-2-2 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#)
  - [CDS V6-2-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#)
  - [CDS V6-2-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#)

- [CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#)
- National Code 160 '*Urgent and Emergency Care Activity*' is **only** valid for:
  - [CDS V6-2-2 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#)
  - [CDS V6-2-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#)
  - [CDS V6-2-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#)
  - [CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#)
  - [ECDS V4 Type 005B - CDS Transaction Header Group - Bulk Update Protocol](#)
  - [ECDS V4 Type 005N - CDS Transaction Header Group - Net Change Protocol](#)
- [CDS Type 010 'Accident and Emergency Attendance'](#) was retired from 1 November 2020 and is no longer accepted for submission to the [Secondary Uses Service](#).
- [Commissioning Data Set](#) version 6-3 does not require submission of the following [CDS Types](#):
  - Detained and/or Long Term Psychiatric Census (050)
  - Any Elective Admission List [CDS Type](#) (070, 080, 090, 100, 110, 120, 130)
  - Future Outpatient (150)
  - Emergency Care Attendance (160)

*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 (Retired 1 November 2020)
150	Future Outpatient
160	<del>Emergency Care Attendance</del>
160	<a href="#">Urgent and Emergency Care Activity</a>

---

**CDS INTERCHANGE APPLICATION REFERENCE**

---

Change to Attribute: Changed Dataset

The application content of the Interchange where the Interchange contains only one type of [Commissioning Data Set](#) Message.

*National Codes:*

NHSCDS CDS Interchange

---

**CDS INTERCHANGE CONTROL COUNT**

---

Change to Attribute: Changed Dataset

The count of [Commissioning Data Set](#) Messages contained in the [Commissioning Data Set](#) Interchange.

---

**CDS INTERCHANGE CONTROL REFERENCE**

---

Change to Attribute: Changed Dataset

A unique number (per sender identity) to identify every [Commissioning Data Set](#) Interchange submission.

---

**CDS INTERCHANGE RECEIVER IDENTITY**

---

Change to Attribute: Changed Dataset

The address of the physical site receiving a Commissioning Data Set interchange.

---

**CDS INTERCHANGE SENDER IDENTITY**

---

Change to Attribute: Changed Dataset

The assigned Electronic Data Interchange (EDI) address of the physical [ORGANISATION](#) or [ORGANISATION SITE](#) responsible for sending Commissioning data.

---

**CDS INTERCHANGE TEST INDICATOR**

---

Change to Attribute: Changed Dataset

An indication of whether the [Commissioning Data Set](#) Interchange is a production or test Interchange.

Note: Any [CDS INTERCHANGE TEST INDICATOR](#) not populated, or populated with any code other than the specified National Codes will be treated as Production data.

*National Codes:*

- 1 The whole Interchange contains Test data
  - 0 The whole Interchange contains Production data
- 

**CDS MESSAGE REFERENCE**

---

Change to Attribute: Changed Dataset

A sequentially incremented number for each [Commissioning Data Set](#) message within an interchange.

---

## CDS MESSAGE TYPE

---

Change to Attribute: Changed Dataset

The type of message within a [Commissioning Data Set](#) Interchange.

*National Codes:*

NHSCDS CDS Message

---

## CDS MESSAGE VERSION NUMBER

---

Change to Attribute: Changed Dataset, Description

The version number of the [Commissioning Data Set](#) XML Schema in use.

The [Commissioning Data Set](#) message version numbers are updated as required during the on-going message development processes.

*National Codes:*

NHS003 The 2000 / 2001 Specification

NHS004 The 2004 / 2005 CDS XML Specification

NHS005 The 2005 / 2006 CDS XML Specification: For implementation of XML messaging in the [Secondary Uses Service](#)

CDS006 The 2007 CDS-XML Specification (CDS V6-0/6-1/6-1-1): Note the change to the prefix **CDS**

CDS062 The 2012 CDS XML Specification (V6-2/6-2-1/6-2-2/6-2-3/6-2-0): Note the change to the format which represents the sub-version identifier (version 6-2)

CDS063 The 2022 CDS XML Specification (V6-3)

**ECDS04** The 2023 ECDS XML Specification (ECDS V4)

---

## CDS PROTOCOL IDENTIFIER CODE

---

Change to Attribute: Changed Dataset

A code to identify the [Commissioning Data Set Submission Protocol](#) associated with the transaction.

*National Codes:*

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

020 Bulk Replacement Update Mechanism

---

## CDS TYPE CODE

---

Change to Attribute: Changed Dataset, Description

A code to identify the specific type of [Commissioning Data Set](#) data.

Note:

- National Code 011 '~~Emergency Care Attendance~~' is **only** valid for:
  - ~~CDS V6-2-2 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol~~
  - ~~CDS V6-2-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol~~
  - ~~CDS V6-2-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol~~
  - ~~CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol~~
- National Code 011 '**Urgent and Emergency Care Activity**' is **only** valid for:
  - **CDS V6-2-2 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol**
  - **CDS V6-2-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol**
  - **CDS V6-2-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol**
  - **CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol**
  - **ECDS V4 Type 005B - CDS Transaction Header Group - Bulk Update Protocol**
  - **ECDS V4 Type 005N - CDS Transaction Header Group - Net Change Protocol**
- **CDS Type 010 'Accident and Emergency Attendance'** was retired on 1 November 2020 and is no longer accepted for submission to the [Secondary Uses Service](#).
- **Commissioning Data Set** version 6-3 does not require submission of the following **CDS Types**:
  - ~~Detained and/or Long Term Psychiatric Census (170)~~
  - ~~Any Elective Admission List **CDS Type** (030, 040, 050, 060, 070, 080, 090, 100, 110)~~
  - ~~Future Outpatient (021)~~
  - ~~Emergency Care Attendance (011)~~
- **Commissioning Data Set** version 6-3 does not require submission of the following **CDS Types**:
  - **Detained and/or Long Term Psychiatric Census (170)**
  - **Any Elective Admission List **CDS Type** (030, 040, 050, 060, 070, 080, 090, 100, 110)**
  - **Future Outpatient (021)**
  - **Urgent and Emergency Care Activity (011)**

**National Codes:**

010	Accident and Emergency Attendance (Retired 1 November 2020)
014	<del>Emergency Care Attendance</del>
011	<b>Urgent and Emergency Care Activity</b>
020	Outpatient May also be used to submit a <a href="#">Referral To Treatment Clock Stop Administrative Event</a>
021	Future Outpatient
030	Elective Admission List End of Period Census (Standard)
040	Elective Admission List End of Period Census (Old)
050	Elective Admission List End of Period Census (New)
060	Elective Admission List Event During Period (Add)
070	Elective Admission List Event During Period (Remove)
080	Elective Admission List Event During Period (Offer)
090	Elective Admission List Event During Period (Available/Unavailable)

100	Elective Admission List Event During Period (Old Service Agreement)
110	Elective Admission List Event During Period (New Service Agreement)
120	Finished Birth Episode
130	Finished General Episode
140	Finished Delivery Episode
150	Other Birth
160	Other Delivery
170	Detained and/or Long-Term Psychiatric Census
180	Unfinished Birth Episode
190	Unfinished General Episode
200	Unfinished Delivery Episode

---

#### **CDS UPDATE TYPE**

---

Change to Attribute: Changed Dataset

A code to indicate the required database update process for the submitted [Commissioning Data Set Message](#).

*National Codes:*

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

---

#### **CLINICAL CLASSIFICATION CODE**

---

Change to Attribute: Changed Dataset

A unique clinical classification identifier for a [CODED CLINICAL ENTRY](#).

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

See [Clinical Coding](#) for further information about the types of [CODED CLINICAL ENTRIES](#).

---

#### **CLINICAL 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.

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#### CLINICAL TRIAL IDENTIFIER

---

Change to Attribute: Changed Dataset

A unique identifier assigned to a [CLINICAL TRIAL](#).

---

#### CODED CLINICAL ENTRY SEQUENCE NUMBER

---

Change to Attribute: Changed Dataset

The sequence number of a [CODED CLINICAL ENTRY](#), recorded to enable correct sequential processing of data.

---

#### COMMISSIONER REFERENCE IDENTIFIER

---

Change to Attribute: Changed Dataset

The identifier of a [SERVICE REQUEST](#) allocated by the commissioner of a [SERVICE](#).

**[COMMISSIONER REFERENCE NUMBER](#) will be replaced with [COMMISSIONER REFERENCE IDENTIFIER](#), which is the most recent approved national information standard to describe the required definition.**

---

#### CONSULTATION MECHANISM

---

Change to Attribute: Changed Dataset, Description

The communication mechanism used to relay information between the [CARE PROFESSIONAL](#) and the [PERSON](#) who is the subject of the consultation, during a [CARE CONTACT](#).

~~A non-face to face consultation should directly support diagnosis and care planning and must replace a face to face [Out-Patient Attendance Consultant](#), [Clinic Attendance Nurse](#) or [Clinic Attendance Midwife](#), or other types of [CARE CONTACT](#).~~ A non-face to face consultation should directly support diagnosis and care planning and must replace a face to face [Care Professional Out-Patient Attendance](#), [Emergency Care Attendance](#) or [Same Day Emergency Care Attendance](#), or other types of [CARE CONTACT](#).

A record of the consultation must be retained in the [PATIENT](#)'s records.

Contact with [PATIENTS](#) solely for the purpose of informing them of the outcome of Diagnostic Test results, with no other clinical interaction, are not classified as [CARE CONTACTS](#).

*National Codes:*

- 01 Face to face
- 02 Telephone
- 03 [Telemedicine](#)
- 04 Talk type for a [PERSON](#) unable to speak
- 05 Email
- 09 Text message (Asynchronous)
- 10 Instant messaging (Synchronous)
- 11 [Video Consultation](#)
- 12 [Message Board \(Asynchronous\)](#)
- 13 [Chat Room \(Synchronous\)](#)
- 98 Other (not listed)

**[CONSULTATION MEDIUM USED](#) will be replaced with [CONSULTATION MECHANISM](#), which is the most recent approved national information standard to describe the required definition.**

---

**DECIDED TO ADMIT DATE**

Change to Attribute: Changed Dataset

The date a [DECISION TO ADMIT](#) was made.

---

**DECIDED TO ADMIT TIME**

Change to Attribute: Changed Dataset

The time a [DECISION TO ADMIT](#) was made.

---

**EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR**

Change to Attribute: Changed Dataset

An indication of whether a follow up [CARE CONTACT](#) is required at the end of the [eMED3 Fit Note Applicable Period](#).

*National Codes:*

- Y Yes - a follow up [CARE CONTACT](#) is required at the end of the [eMED3 Fit Note Applicable Period](#)
- N No - a follow up [CARE CONTACT](#) is not required at the end of the [eMED3 Fit Note Applicable Period](#)

---

**EMED3 FIT NOTE ISSUER**

---

Change to Attribute: Changed Dataset

**This item is being used for development purposes and has not yet been approved.**

---

#### EMERGENCY CARE DEPARTMENT TYPE

---

Change to Attribute: Changed Description

The type of [Emergency Care Department](#).

Additional Guidance for National Code 01: A Major [Emergency Care Department](#) is [CONSULTANT](#)-led and must be a 24 hour, seven day [SERVICE](#), with full resuscitation facilities and designated accommodation for the reception of [PATIENTS](#) receiving 'Emergency Care'.

Additional Guidance National Code 02: A Mono-specialty [Emergency Care Department](#) is a [CONSULTANT](#)-led mono specialty emergency care service (e.g. ophthalmology, dental) with designated accommodation for the reception of [PATIENTS](#) receiving 'Emergency Care'.

*National Codes:*

- 01 ~~Emergency departments are a [CONSULTANT](#) led 24 hour service with full resuscitation facilities and designated accommodation for the reception of emergency care [PATIENTS](#)~~
- 02 ~~[CONSULTANT](#) led mono specialty emergency care 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 emergency care [PATIENTS](#). The department may be doctor led, [GENERAL PRACTITIONER](#) 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. Includes [Urgent Treatment Centres](#). Excludes NHS walk in centres~~
- 04 ~~NHS walk in centres~~
- 05 ~~Ambulatory Emergency Care Service. Note this is **only** valid for piloting purposes in the [CDS V6 2 2 Type 011 – Emergency Care Commissioning Data Set](#)/[CDS V6 2 3 Type 011 – Emergency Care Commissioning Data Set](#) and must not be submitted in the [Patient Level Information Costing System Integrated Data Set – Emergency Care \(Acute\)](#).~~
- 01 [Emergency Care Attendance](#) at an [Emergency Care Department](#) Type '[Major Emergency Care Department](#)'
- 02 [Emergency Care Attendance](#) at an [Emergency Care Department](#) Type '[Mono-specialty Emergency Care Department](#)'
- 03 [Emergency Care Attendance](#) at an [Emergency Care Department](#) Type '[Urgent Treatment Centre](#)'
- 04 [NHS walk in centres](#). Note this item will be retired 01 July 2023
- 05 [Same Day Emergency Care](#). No longer in use for pilot data collection of Same Day Emergency Care Activity.

---

#### EMERGENCY CARE DEPARTMENT TYPE FOR PATIENT LEVEL INFORMATION COSTING

---

Change to Attribute: New Attribute

The type of Emergency Care Department for the purposes of reporting for Patient Level Information Costing.

**National Codes:**

- 01 Emergency departments are a **CONSULTANT** led 24 hour service with full resuscitation facilities and designated accommodation for the reception of emergency care **PATIENTS**
- 02 **CONSULTANT** led mono specialty emergency care 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 emergency care **PATIENTS**. The department may be doctor led, **GENERAL PRACTITIONER** 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. Includes **Urgent Treatment Centres**. Excludes NHS walk-in centres
- 04 NHS walk in centres

Note: National Codes 01 and 03 have been updated as a result of changes made in **DCB0092-2062: Commissioning Data Sets: Emergency Care Data Set**. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where they are not already correct.

**This attribute is also known by these names:**

Context	Alias
plural	EMERGENCY CARE DEPARTMENT TYPES FOR PATIENT LEVEL INFORMATION COSTING

---

**EMERGENCY CARE DEPARTMENT TYPE FOR PATIENT LEVEL INFORMATION COSTING**

---

Change to Attribute: New Attribute

**EMERGENCY CARE DEPARTMENT TYPE FOR PATIENT LEVEL INFORMATION COSTING**

**Data Elements:**

EMERGENCY CARE DEPARTMENT TYPE (PATIENT LEVEL INFORMATION COSTING)
--------------------------------------------------------------------

---

**ETHNIC CATEGORY 2021**

---

Change to Attribute: Changed Dataset

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

[ETHNIC CATEGORY 2021](#) is the classification used for the 2021 census.

**Note:** This item has not been approved by the [Data Alliance Partnership Board](#). It has been introduced to provide advance notice to data providers and system suppliers of the intention to report this item at a later date. This item should not be submitted until further development by [NHS Digital](#) has been undertaken.

---

#### ETHNIC CATEGORY CODE 2001

---

Change to Attribute: Changed Dataset

The ethnicity of a [PERSON](#), as specified by the [PERSON](#).

[ETHNIC CATEGORY CODE 2001](#) 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.

Note: the National Code descriptions have been updated. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where they are not already correct.

#### *National Codes:*

- A White - British
- B White - Irish
- C White - Any other White background
- D Mixed - White and Black Caribbean
- E Mixed - White and Black African
- F Mixed - White and Asian
- G Mixed - Any other mixed background
- H Asian or Asian British - Indian
- J Asian or Asian British - Pakistani
- K Asian or Asian British - Bangladeshi
- L Asian or Asian British - Any other Asian background
- M Black or Black British - Caribbean
- N Black or Black British - African
- P Black or Black British - Any other Black background
- R Other Ethnic Groups - Chinese
- S Other Ethnic Groups - Any other ethnic group
- Z Not stated

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

---

#### EVENT DATE

---

Change to Attribute: Changed Dataset

The date, month, year and century, or any combination of these elements, of an [EVENT](#).

---

#### EVENT TIME

---

Change to Attribute: Changed Dataset

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

This may include representation of a time zone.

---

#### GENERAL MEDICAL PRACTITIONER PPD CODE

---

Change to Attribute: Changed Dataset

The [NHS Prescription Services](#) code to identify a [GENERAL MEDICAL PRACTITIONER](#).

The [GENERAL MEDICAL PRACTITIONER PPD CODE](#) is based on the [NHS Digital](#) issued [DOCTOR INDEX NUMBER](#) and is issued by the [NHS Prescription Services](#). The [GENERAL MEDICAL PRACTITIONER PPD CODE](#) is the [DOCTOR INDEX NUMBER](#) prefixed with a leading character and with a check digit added.

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'.
- For further information on 'spurious' codes, see the [NHS Business Services Authority](#) website at: [Information on spurious codes](#).

For further information, see the [Organisation Data Service](#) pages of the [NHS Digital](#) website at:

- [Technical guides: Standards repository guide](#)
- [GP and GP practice related data](#).

---

#### GEOGRAPHIC CO-ORDINATE

---

Change to Attribute: Changed Dataset

A [GEOGRAPHIC CO-ORDINATE](#) specifies a point on the earth's surface.

---

## 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 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 Refset](#):

- [Refset](#) FSN: Mental Health Act legal status findings simple reference set
- [Refset](#) Id: 999003071000000100

For further details relating to the [SNOMED CT Refset](#), see the [SNOMED CT Browser](#) at: [Mental Health Act legal status findings simple reference set \(foundation metadata concept\)](#).

### *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 emergency care, sexual health and major incidents, as defined in existing national policies.

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

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

**Digit Position**

(starting from the left) Factor:

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

8	3
9	2

**Step 2** Add the results of each multiplication together.

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

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

If the result is 11 then a check digit of 0 is used. If the result is 10 then the [NHS NUMBER](#) is invalid and not used.

**Step 5** Check the remainder matches the check digit. If it does not, the [NHS NUMBER](#) is invalid.

Further guidance is available from the [NHS Digital](#) website at: [NHS Number](#).

Note:

This was [e-GIF](#) approved for use in NHS England.

[e-GIF](#) and the [Government Data Standards Catalogue](#) **have been archived** and are available for reference only.

#### NHS NUMBER STATUS INDICATOR CODE

Change to Attribute: Changed Dataset

The trace status of the [NHS NUMBER](#).

*National Codes:*

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

#### NHS SERVICE AGREEMENT IDENTIFIER

Change to Attribute: Changed Dataset

The unique identifier of an [NHS SERVICE AGREEMENT](#).

The [NHS SERVICE AGREEMENT IDENTIFIER](#) is issued by the [ORGANISATION](#) acting as commissioner of a [SERVICE](#).

[NHS SERVICE AGREEMENT NUMBER](#) will be replaced with [NHS SERVICE AGREEMENT IDENTIFIER](#), which is the most recent approved national information standard to describe the required definition.

---

#### NHS SERVICE AGREEMENT LINE IDENTIFIER

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Change to Attribute: Changed Dataset

A unique identifier for an [NHS SERVICE AGREEMENT LINE](#).

[NHS SERVICE AGREEMENT LINE NUMBER](#) will be replaced with [NHS SERVICE AGREEMENT LINE IDENTIFIER](#), which is the most recent approved national information standard to describe the required definition.

---

#### OBSERVATION VALUE

---

Change to Attribute: Changed Dataset

The value of a [CLINICAL INVESTIGATION RESULT ITEM](#).

---

#### ORGANISATION CODE

---

Change to Attribute: Changed Dataset

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 Update Distribution \(TRUD\)](#)
- [Organisation Data Service](#) contact details can be found at [Contact Details](#).

All NHS [ORGANISATIONS](#) are coded using coding frames, as shown in the tables at: [Organisation Coding Frames](#).

---

#### 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 IDENTIFIER

---

Change to Attribute: Changed Dataset

A unique identifier for an [ORGANISATION SITE](#).

Note:

- [ORGANISATION SITE 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 SITE 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 SITE](#) is min an5 max an9.

---

#### OVERSEAS VISITOR CHARGING CATEGORY

---

Change to Attribute: Changed Dataset

The charging category relating to an [OVERSEAS VISITOR STATUS](#).

See [Overseas Visitor Charging 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](#)
- P Decision Pending on [OVERSEAS VISITOR CHARGING CATEGORY](#)

[OVERSEAS VISITOR STATUS](#) information must be collected in accordance with the [Overseas Visitor Charging Category Information Standard: DCB3017](#).

---

#### PERSON AGE

---

Change to Attribute: Changed Dataset

The age in years of the [PERSON](#).

---

#### **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 NAME WORD TEXT**

---

Change to Attribute: Changed Dataset

The character or string of characters comprising an element of a [PERSON](#)'s name which has been recorded for at least one [PERSON](#).

For example, Dr, John, Smith.

This can be a [PERSON NAME STRUCTURED](#) or [PERSON NAME UNSTRUCTURED](#).

---

#### **PERSON OBSERVATION TEXT STRING**

---

Change to Attribute: Changed Dataset

A free text string to record a [PERSON PROPERTY](#).

---

#### **PERSON PROPERTY ASSIGNMENT PERIOD DURATION**

---

Change to Attribute: Changed Dataset

The duration of a [PERSON PROPERTY ASSIGNMENT PERIOD](#).

---

#### **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 PROPERTY EFFECTIVE START DATE**

---

Change to Attribute: Changed Dataset

The date when a [PERSON PROPERTY](#) became effective for a [PATIENT](#).

Examples may be the date when the [PATIENT](#) experienced a symptom or gave up smoking.

---

**PERSON PROPERTY EFFECTIVE START TIME**

---

Change to Attribute: Changed Dataset

The time when a [PERSON PROPERTY](#) became effective for a [PATIENT](#).

---

**PERSON PROPERTY RECORDED DATE**

---

Change to Attribute: Changed Dataset

The date when the [PERSON PROPERTY](#) was recorded by a [PERSON](#).

---

**PERSON PROPERTY RECORDED TIME**

---

Change to Attribute: Changed Dataset

The time when the [PERSON PROPERTY](#) was recorded by a [PERSON](#).

This may include a representation of a time zone.

In a computerised system this data would be derived from the time the information was entered.

---

**PERSON SCORE**

---

Change to Attribute: Changed Dataset

The score taken from an [ASSESSMENT TOOL](#).

This could be for an individual element of, or question within, an [ASSESSMENT TOOL](#), a subtotal or total score.

The purpose of the [PERSON SCORE](#) is to measure changes in health and wellbeing.

---

#### PERSON STATED GENDER CODE

---

Change to Attribute: Changed Dataset

The gender of a [PERSON](#).

[PERSON STATED GENDER CODE](#) is self declared or inferred by observation for those unable to declare their [PERSON STATED GENDER](#).

*National Codes:*

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

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

---

#### PLANNED ACTIVITY DATE

---

Change to Attribute: Changed Dataset

Any date that is of relevance to a [PLANNED ACTIVITY](#).

---

#### PLANNED ACTIVITY TIME

---

Change to Attribute: Changed Dataset

Any time that is of relevance to a [PLANNED ACTIVITY](#).

This may include representation of a time zone.

---

#### 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](#).

Notes:

- The National Code description for 05 '[Social Care Wales](#)' has been updated as a result of the work undertaken for the development of the [National Workforce Data Set](#). The [Maternity Services Data Set](#) specification will be updated in the next version of the Information Standards where it is not already correct.
- National Code 17 '[General Osteopathic Council](#)' is **not** valid for use in the [Maternity Services Data Set](#).
- National Code 18 '[Social Work England](#)' is **not** valid for use in the [Maternity Services Data Set](#).

*National Codes:*

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

---

**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](#).

---

#### PROVIDER REFERENCE IDENTIFIER

---

Change to Attribute: Changed Dataset

The reference identifier agreed locally between a [Health Care Provider](#) and the Commissioner of a [SERVICE PROVIDED UNDER AGREEMENT](#).

**[PROVIDER REFERENCE NUMBER](#) will be replaced with [PROVIDER REFERENCE IDENTIFIER](#), which is the most recent approved national information standard to describe the required definition.**

---

#### RECORD IDENTIFIER

---

Change to Attribute: Changed Dataset

The unique identifier, used in conjunction with [ORGANISATION CODE \(CODE OF PROVIDER\)](#) or [ORGANISATION IDENTIFIER \(CODE OF PROVIDER\)](#), to identify a record within a data set submission.

---

#### SERVICE CODE

---

Change to Attribute: Changed Dataset

The code for the type of [SERVICE](#) provided in a [SERVICE PROVIDED UNDER AGREEMENT](#).

---

#### TREATMENT FUNCTION CODE

---

Change to Attribute: Changed Dataset

A unique identifier for a [TREATMENT FUNCTION](#).

A [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 data sets/collections unless otherwise stated e.g. [National Workforce Data Set](#) uses [MAIN SPECIALTY CODES](#).

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

Joint [Consultant Clinic ACTIVITY](#) should be recorded against the [TREATMENT FUNCTION](#) which best describes the specialised service.

### Assigning a Treatment Function Code:

Further information on the groupings and scope of each [TREATMENT FUNCTION CODE](#) is provided at: [Main Specialty and Treatment Function Codes Table](#).

- 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](#).

### Note:

- New National Codes for [TREATMENT FUNCTION CODE](#) were introduced from 2 April 2020 as part of the update to the [DCB0028: Treatment Function and Main Specialty Standard](#). Submission of these codes for the Commissioning Data Sets is only possible where the healthcare provider has updated their CDS-XML schema version to CDS-XML version 6-2-0. Users of the original CDS-XML schema version 6-2 will be unable to submit the new codes introduced in the release of [DCB0028: Treatment Function and Main Specialty Standard](#) in April 2020 or the addendum to DCB0028 released in January 2021 to add a new [TREATMENT FUNCTION CODE](#) to represent Post-COVID-19 Syndrome Services.

### National Codes:

- |     |                                              |
|-----|----------------------------------------------|
| 100 | General Surgery Service                      |
| 101 | Urology Service                              |
| 102 | Transplant Surgery Service                   |
| 103 | Breast Surgery Service                       |
| 104 | Colorectal Surgery Service                   |
| 105 | Hepatobiliary and Pancreatic Surgery Service |
| 106 | Upper Gastrointestinal Surgery Service       |
| 107 | Vascular Surgery Service                     |
| 108 | Spinal Surgery Service                       |

109 Bariatric Surgery Service  
110 Trauma and Orthopaedic Service  
111 Orthopaedic Service  
113 Endocrine Surgery Service  
115 Trauma Surgery Service  
120 Ear Nose and Throat Service  
130 Ophthalmology Service  
140 Oral Surgery Service  
141 Restorative Dentistry Service  
143 Orthodontic Service  
144 Maxillofacial Surgery Service  
145 Oral and Maxillofacial Surgery Service  
150 Neurosurgical Service  
160 Plastic Surgery Service  
161 Burns Care Service  
170 Cardiothoracic Surgery Service  
172 Cardiac Surgery Service  
173 Thoracic Surgery Service  
174 Cardiothoracic Transplantation Service  
191 Pain Management Service  
142 Paediatric Dentistry Service  
171 Paediatric Surgery Service  
211 Paediatric Urology Service  
212 Paediatric Transplantation Surgery Service  
213 Paediatric Gastrointestinal Surgery Service  
214 Paediatric Trauma and Orthopaedic Service  
215 Paediatric Ear Nose and Throat Service  
216 Paediatric Ophthalmology Service  
217 Paediatric Oral and Maxillofacial Surgery Service  
218 Paediatric Neurosurgery Service  
219 Paediatric Plastic Surgery Service  
220 Paediatric Burns Care Service  
221 Paediatric Cardiac Surgery Service  
222 Paediatric Thoracic Surgery Service  
223 Paediatric Epilepsy Service  
230 Paediatric Clinical Pharmacology Service  
240 Paediatric Palliative Medicine Service  
241 Paediatric Pain Management Service  
242 Paediatric Intensive Care Service  
250 Paediatric Hepatology Service  
251 Paediatric Gastroenterology Service  
252 Paediatric Endocrinology Service  
253 Paediatric Clinical Haematology Service  
254 Paediatric Audio Vestibular Medicine Service  
255 Paediatric Clinical Immunology and Allergy Service  
256 Paediatric Infectious Diseases Service

257 Paediatric Dermatology Service  
258 Paediatric Respiratory Medicine Service  
259 Paediatric Nephrology Service  
260 Paediatric Medical Oncology Service  
261 Paediatric Inherited Metabolic Medicine Service  
262 Paediatric Rheumatology Service  
263 Paediatric Diabetes Service  
264 Paediatric Cystic Fibrosis Service  
270 Paediatric Emergency Medicine Service  
280 Paediatric Interventional Radiology Service  
290 Community Paediatric Service  
291 Paediatric Neurodisability Service  
321 Paediatric Cardiology Service  
421 Paediatric Neurology Service  
180 Emergency Medicine Service  
190 Anaesthetic Service  
192 Intensive Care Medicine Service  
200 Aviation and Space Medicine Service  
300 General Internal Medicine Service  
301 Gastroenterology Service  
302 Endocrinology Service  
303 Clinical Haematology Service  
304 Clinical Physiology Service  
305 Clinical Pharmacology Service  
306 Hepatology Service  
307 Diabetes Service  
308 Blood and Marrow Transplantation Service  
309 Haemophilia Service  
310 Audio Vestibular Medicine Service  
311 Clinical Genetics Service  
313 Clinical Immunology and Allergy Service  
314 Rehabilitation Medicine Service  
315 Palliative Medicine Service  
316 Clinical Immunology Service  
317 Allergy Service  
318 Intermediate Care Service  
319 Respite Care Service  
320 Cardiology Service  
322 Clinical Microbiology Service  
323 Spinal Injuries Service  
324 Anticoagulant Service  
325 Sport and Exercise Medicine Service  
326 Acute Internal Medicine Service  
327 Cardiac Rehabilitation Service  
328 Stroke Medicine Service  
329 Transient Ischaemic Attack Service

330 Dermatology Service  
331 Congenital Heart Disease Service  
333 Rare Disease Service  
335 Inherited Metabolic Medicine Service  
340 Respiratory Medicine Service  
341 Respiratory Physiology Service  
342 Pulmonary Rehabilitation Service  
343 Adult Cystic Fibrosis Service  
344 Complex Specialised Rehabilitation Service  
345 Specialist Rehabilitation Service  
346 Local Specialist Rehabilitation Service  
347 Sleep Medicine Service  
348 Post-COVID-19 Syndrome Service  
350 Infectious Diseases Service  
352 Tropical Medicine Service  
360 Genitourinary Medicine Service  
361 Renal Medicine Service  
370 Medical Oncology Service  
371 Nuclear Medicine Service  
400 Neurology Service  
401 Clinical Neurophysiology Service  
410 Rheumatology Service  
420 Paediatric Service  
422 Neonatal Critical Care Service  
424 Well Baby Service  
430 Elderly Medicine Service  
431 Orthogeriatric Medicine Service  
450 Dental Medicine Service  
451 Special Care Dentistry Service  
460 Medical Ophthalmology Service  
461 Ophthalmic and Vision Science Service  
501 Obstetrics Service  
502 Gynaecology Service  
503 Gynaecological Oncology Service  
504 Community Sexual and Reproductive Health Service  
505 Fetal Medicine Service  
510 Retired but retained for historical purposes  
520 Retired but retained for historical purposes  
560 Midwifery Service  
610 Retired but retained for historical purposes  
620 Retired but retained for historical purposes  
656 Clinical Psychology Service  
700 Learning Disability Service  
710 Adult Mental Health Service  
711 Child and Adolescent Psychiatry Service  
712 Forensic Psychiatry Service

- 713 Medical Psychotherapy Service
- 715 Old Age Psychiatry Service
- 720 Eating Disorders Service
- 721 Addiction Service
- 722 Liaison Psychiatry Service
- 723 Psychiatric Intensive Care Service
- 724 Perinatal Mental Health Service
- 725 Mental Health Recovery and Rehabilitation Service
- 726 Mental Health Dual Diagnosis Service
- 727 Dementia Assessment Service
- 730 Neuropsychiatry Service
- 800 Clinical Oncology Service
- 811 Interventional Radiology Service
- 812 Diagnostic Imaging Service
- 822 Chemical Pathology Service
- 832 Retired but retained for historical purposes
- 834 Medical Virology Service
- 650 Physiotherapy Service
- 651 Occupational Therapy Service
- 652 Speech and Language Therapy Service
- 653 Podiatry Service
- 654 Dietetics Service
- 655 Orthoptics Service
- 657 Prosthetics Service
- 658 Orthotics Service
- 659 Dramatherapy Service
- 660 Art Therapy Service
- 661 Music Therapy Service
- 662 Optometry Service
- 663 Podiatric Surgery Service
- 670 Urological Physiology Service
- 673 Vascular Physiology Service
- 675 Cardiac Physiology Service
- 677 Gastrointestinal Physiology Service
- 840 Audiology Service
- 920 Diabetic Education Service
- 990 Retired but retained for historical purposes

---

#### UCUM UNIT OF MEASUREMENT

---

Change to Attribute: Changed Dataset

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

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

---

**URGENT AND EMERGENCY CARE ACTIVITY TYPE**

---

Change to Attribute: New Attribute

The type of Urgent and Emergency Care Activity.

**National Codes:**

- 01 Emergency Care Attendance at an Emergency Care Department Type 'Major Emergency Care Department'
- 02 Emergency Care Attendance at an Emergency Care Department Type 'Mono-specialty Emergency Care Department'
- 03 Emergency Care Attendance at an Emergency Care Department Type 'Urgent Treatment Centre'
- 05 Same Day Emergency Care Attendance
- 06 Urgent and Emergency Care Extended Care Episode
- 07 Hot Clinic Attendance. Note this is **only** valid for piloting purposes.

**This attribute is also known by these names:**

Context	Alias
plural	URGENT AND EMERGENCY CARE ACTIVITY TYPES

---

**URGENT AND EMERGENCY CARE ACTIVITY TYPE**

---

Change to Attribute: New Attribute

**URGENT AND EMERGENCY CARE ACTIVITY TYPE**

**Data Elements:**

<u>URGENT AND EMERGENCY CARE ACTIVITY TYPE</u>
------------------------------------------------

---

**URGENT AND EMERGENCY CARE ATTENDANCE CATEGORY**

---

Change to Attribute: New Attribute

The category of Emergency Care Attendance or Same Day Emergency Care Attendance.

**National Codes:**

- 1 Unplanned First Emergency Care Attendance or Same Day Emergency Care Attendance for a new clinical condition (or deterioration of a chronic condition)
- 2 Unplanned Follow-up Emergency Care Attendance or Same Day Emergency Care Attendance for the same or a related clinical condition and within 7 days of the First Emergency Care Attendance or Same Day Emergency Care Attendance at **THIS** Urgent and Emergency Care Service
- 3

Unplanned Follow-up Emergency Care Attendance or Same Day Emergency Care Attendance for the same or a related clinical condition and within 7 days of the First Emergency Care Attendance or Same Day Emergency Care Attendance at **ANOTHER** Urgent and Emergency Care Service

- 4 Planned Follow-up Emergency Care Attendance or Same Day Emergency Care Attendance within 7 days of the First Emergency Care Attendance or Same Day Emergency Care Attendance at **THIS** Urgent and Emergency Care Service

**This attribute is also known by these names:**

Context	Alias
plural	URGENT AND EMERGENCY CARE ATTENDANCE CATEGORIES

**URGENT AND EMERGENCY CARE ATTENDANCE CATEGORY**

Change to Attribute: New Attribute

## URGENT AND EMERGENCY CARE ATTENDANCE CATEGORY

Data Elements:

URGENT AND EMERGENCY CARE ATTENDANCE CATEGORY
-----------------------------------------------

**URGENT AND EMERGENCY CARE DISCHARGE INFORMATION GIVEN INDICATOR**

Change to Attribute: New Attribute

An indication of whether a copy of a letter to their GENERAL MEDICAL PRACTITIONER has been given to the PATIENT on discharge from an Urgent and Emergency Care Service.

National Codes:

- Y Yes - a copy of the discharge letter was given to the PATIENT
- N No - a copy of the discharge letter was NOT given to the PATIENT

**This attribute is also known by these names:**

Context	Alias
plural	URGENT AND EMERGENCY CARE DISCHARGE INFORMATION GIVEN INDICATORS

**URGENT AND EMERGENCY CARE DISCHARGE INFORMATION GIVEN INDICATOR**

Change to Attribute: New Attribute

## URGENT AND EMERGENCY CARE DISCHARGE INFORMATION GIVEN INDICATOR

Data Elements:

## URGENT AND EMERGENCY CARE DISCHARGE INFORMATION GIVEN INDICATOR

### WITHHELD IDENTITY REASON

Change to Attribute: Changed Dataset

A code used in the Data Group 'Withheld Identity Structure' in the Commissioning Data Sets (version 6-2 onwards) to allow 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.

*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

### 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 Refset:](#)

- [Refset](#) FSN: Accessible information - requires communication professional simple reference set (foundation metadata concept)
- [Refset](#) Id: 999002151000000104

For further details relating to the [SNOMED CT Refset](#), see the [SNOMED CT Browser](#) at: [Accessible information - requires communication professional simple reference set \(foundation metadata concept\)](#).

### ACCOMMODATION STATUS (SNOMED CT)

Change to Data Element: Changed Dataset

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 Refset:](#)

- [Refset](#) FSN: Emergency care usual residence type simple reference set (foundation metadata concept)
- [Refset](#) Id: 999003051000000109

For further details relating to the [SNOMED CT Refset](#), see the [SNOMED CT Browser](#) at: [Emergency care usual residence type simple reference set \(foundation metadata concept\)](#) .

---

**ACTIVITY SERVICE REQUEST TIMESTAMP (URGENT AND EMERGENCY CARE)**

---

Change to Data Element: New Data Element

Format/Length:	max an25
National Codes:	
Default Codes:	

**Notes:**

[ACTIVITY SERVICE REQUEST TIMESTAMP \(URGENT AND EMERGENCY CARE\)](#) is the same as attribute [ACTIVITY SERVICE REQUEST DATE](#) and [ACTIVITY SERVICE REQUEST TIME](#).

[ACTIVITY SERVICE REQUEST TIMESTAMP \(URGENT AND EMERGENCY CARE\)](#) is the date, time and time zone that a [PATIENT](#) was referred to another [SERVICE](#) during an [Urgent and Emergency Care Activity](#).

A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time.

In most cases offset time is restricted to:

- +01:00
- +00:00
- -00:00

Examples of valid formats are:

- 2020-08-21T10:15:20+01:00 British Summer Time (GMT + 1 Hour)
- 2020-12-21T10:15:20+00:00 Greenwich Mean Time
- 2020-12-21T10:15:20-00:00 Greenwich Mean Time
- 2020-12-21T09:18:00Z Greenwich Mean Time.

This data element is also known by these names:

Context	Alias
plural	ACTIVITY SERVICE REQUEST TIMESTAMPS (URGENT AND EMERGENCY CARE)

---

ACTIVITY SERVICE REQUEST TIMESTAMP (URGENT AND EMERGENCY CARE)

---

Change to Data Element: New Data Element

## ACTIVITY SERVICE REQUEST TIMESTAMP (URGENT AND EMERGENCY CARE)

Attribute:

ACTIVITY SERVICE REQUEST DATE
ACTIVITY SERVICE REQUEST TIME

---

ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT)

---

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	See <a href="#">TREATMENT FUNCTION CODE</a>
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.

Further information on the groupings and scope of each [TREATMENT FUNCTION CODE](#) is provided at: [Main Specialty and Treatment Function Codes Table](#).

---

AGE AT CDS ACTIVITY DATE

---

Change to Data Element: Changed Dataset

Format/Length:	max an3
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 the same as attribute [PERSON AGE](#).

[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](#).

Note: the Format/Length has been updated in [Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements"](#). The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

#### AMBULANCE CALL IDENTIFIER

---

Change to Data Element: Changed Dataset

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

#### Notes:

[AMBULANCE CALL IDENTIFIER](#) is the same as attribute [AMBULANCE CALL IDENTIFIER](#).

---

#### ASSAULT LOCATION DESCRIPTION

---

Change to Data Element: Changed Dataset, Description

Format/Length:	max an255
National Codes:	
Default Codes:	

#### Notes:

[ASSAULT LOCATION DESCRIPTION](#) is the same as attribute [PERSON OBSERVATION TEXT STRING](#).

[ASSAULT LOCATION DESCRIPTION](#) provides further comment and/or details of the [LOCATION](#) where an assault took place.

[ASSAULT LOCATION DESCRIPTION](#) may only be completed when the assault [LOCATION](#) is **NOT** a Home or Private Address, as this could identify the [PATIENT](#).

[ASSAULT LOCATION DESCRIPTION](#) must **NOT** contain any text information which could identify the [PATIENT](#) or any treatment or other activities related to the assault which were undertaken by [CARE PROFESSIONALS](#) and [Health Care Providers](#).

[ASSAULT LOCATION DESCRIPTION](#) 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.

---

## ASSESSMENT TOOL VALIDATION TIMESTAMP

---

Change to Data Element: Changed Dataset

Format/Length:	max an25
National Codes:	
Default Codes:	

### Notes:

[ASSESSMENT TOOL VALIDATION TIMESTAMP](#) is the same as attribute [ACTIVITY DATE](#) and [ACTIVITY TIME](#) for the '[Assessment Tool Validation Timestamp](#)'.

A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time.

In most cases offset time is restricted to:

- +01:00
- +00:00
- -00:00

Examples of valid formats are:

- 2022-12-01T10:15:20+01:00 British Summer Time (GMT + 1 Hour)
- 2022-12-01T10:15:20+00:00 Greenwich Mean Time
- 2022-12-01T10:15:20-00:00 Greenwich Mean Time
- 2022-12-01T09:18:00Z Greenwich Mean Time.

---

## CARE CONTACT IDENTIFIER (AMBULANCE SERVICE)

---

Change to Data Element: Changed Dataset

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

### Notes:

[CARE CONTACT IDENTIFIER \(AMBULANCE SERVICE\)](#) is the same as attribute [ACTIVITY IDENTIFIER](#) for a [CARE CONTACT](#) allocated by the [Ambulance Service](#).

[CARE CONTACT IDENTIFIER \(AMBULANCE SERVICE\)](#) is an identifier allocated to each [Ambulance Incident](#) for each [PATIENT](#).

The [PATIENT](#) can have more than one [CARE CONTACT IDENTIFIER \(AMBULANCE SERVICE\)](#) if the [PATIENT](#) is treated more than once in separate [Ambulance Incidents](#).

---

## CARE PROFESSIONAL CLINICAL RESPONSIBILITY TIMESTAMP

---

Change to Data Element: Changed Dataset, Description

Format/Length:	max an25
National Codes:	
Default Codes:	

**Notes:**

CARE PROFESSIONAL CLINICAL RESPONSIBILITY TIMESTAMP is the same as attribute ACTIVITY DATE and ACTIVITY TIME for the 'Care Professional Clinical Responsibility Timestamp'.

A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time.

In most cases offset time is restricted to:

- +01:00
- +00:00
- -00:00

Examples of valid formats are:

- 2020-08-21T10:15:20+01:00 British Summer Time (GMT + 1 Hour)
- ~~2020-08-21T10:15:20+00:00 Greenwich Mean Time~~
- ~~2020-08-21T10:15:20-00:00 Greenwich Mean Time~~
- ~~2020-08-21T09:18:00Z Greenwich Mean Time.~~
- 2020-12-21T10:15:20+00:00 Greenwich Mean Time
- 2020-12-21T10:15:20-00:00 Greenwich Mean Time
- 2020-12-21T09:18:00Z Greenwich Mean Time.

---

**CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR (URGENT AND EMERGENCY CARE)**

---

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See <u>CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR FOR URGENT AND EMERGENCY CARE</u>
Default Codes:	

**Notes:**

CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR (URGENT AND EMERGENCY CARE) is the same as attribute CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR FOR URGENT AND EMERGENCY CARE.

**This data element is also known by these names:**

Context	Alias
plural	

CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATORS (URGENT AND EMERGENCY CARE)

CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR (URGENT AND EMERGENCY CARE)

Change to Data Element: New Data Element

CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR (URGENT AND EMERGENCY CARE)

Attribute:

CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR FOR URGENT AND EMERGENCY CARE

CARE PROFESSIONAL TIER (URGENT AND EMERGENCY CARE)

Change to Data Element: New Data Element

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

Notes:

CARE PROFESSIONAL TIER (URGENT AND EMERGENCY CARE) is the same as attribute CARE PROFESSIONAL TIER FOR URGENT AND EMERGENCY CARE.

This data element is also known by these names:

Context	Alias
plural	CARE PROFESSIONAL TIERS (URGENT AND EMERGENCY CARE)

CARE PROFESSIONAL TIER (URGENT AND EMERGENCY CARE)

Change to Data Element: New Data Element

CARE PROFESSIONAL TIER (URGENT AND EMERGENCY CARE)

Attribute:

CARE PROFESSIONAL TIER FOR URGENT AND EMERGENCY CARE

CDS ACTIVITY DATE

Change to Data Element: Changed Dataset, Description

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

**Notes:**

[CDS ACTIVITY DATE](#) is the same as attribute [ACTIVITY DATE](#).

For Commissioning data, every [CDS Type](#) has a "CDS Originating Date" contained within the Commissioning Data Set data that must be used to populate the [CDS ACTIVITY DATE](#).

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

For Bulk Update use, see:

- [CDS V6-2 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#)
- [CDS V6-2-2 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#)
- [CDS V6-2-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#)
- [CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#)
- [ECDS V4 Type 005B - CDS Transaction Header Group - Bulk Update Protocol](#)

For Net Change Use, see:

- [CDS V6-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#)
- [CDS V6-2-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#)
- ~~[CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#)~~
- ~~[CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#)~~
- [CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#)
- [CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#)
- [ECDS V4 Type 005N - CDS Transaction Header Group - Net Change Protocol](#)

Note: [CDS Type](#) 010 'Accident and Emergency Attendance' was retired from 1 November 2020 and is no longer accepted for submission to the [Secondary Uses Service](#).

The [CDS ACTIVITY DATE](#) has an associated "CDS Originating Date" specifically identified for each [CDS Type](#) as follows:

<b>CDS TYPE</b>	<b>DESCRIPTION</b>	<b>CDS ORIGINATING DATE (used to populate the CDS ACTIVITY DATE)</b>
010	Accident and Emergency Attendance (Retired 1 November 2020)	
011	<del>Emergency Care Attendance</del>	<del><a href="#">EMERGENCY CARE ARRIVAL DATE</a>, <a href="#">EMERGENCY CARE ARRIVAL TIME</a></del>

011	<u>Urgent and Emergency Care Activity</u>	<u>EMERGENCY CARE ARRIVAL DATE, EMERGENCY CARE ARRIVAL TIME (CDS V6-2-2 and CDS V6-2-3) / URGENT AND EMERGENCY CARE ACTIVITY START DATE AND TIME (ECDS V4)</u>
020	Outpatient (known in the Schema as Care Activity)	<u>APPOINTMENT DATE</u>
021	Future Outpatient (known in the Schema as Future Care Activity)	<u>APPOINTMENT DATE</u>
030	EAL End Of Period Census - STANDARD	<u>DECIDED TO ADMIT DATE</u>
040	EAL End Of Period Census - OLD	<u>NHS SERVICE AGREEMENT CHANGE DATE</u>
050	EAL End Of Period Census - NEW	<u>NHS SERVICE AGREEMENT CHANGE DATE</u>
060	EAL Event During Period - ADD	<u>DECIDED TO ADMIT DATE</u>
070	EAL Event During Period - REMOVE	<u>ELECTIVE ADMISSION LIST REMOVAL DATE</u>
080	EAL Event During Period - OFFER	<u>OFFERED FOR ADMISSION DATE</u>
090	EAL Event During Period - AVAILABLE / UNAVAILABLE	<u>SUSPENSION START DATE</u>
100	EAL Event During Period - OLD SERVICE AGREEMENT	<u>NHS SERVICE AGREEMENT CHANGE DATE</u>
110	EAL Event During Period - NEW SERVICE AGREEMENT	<u>NHS SERVICE AGREEMENT CHANGE DATE</u>
120	Finished Birth Episode	<u>END DATE (EPISODE)</u>
130	Finished General Episode	<u>END DATE (EPISODE)</u>
140	Finished Delivery Episode	<u>END DATE (EPISODE)</u>
150	Other Birth	<u>DELIVERY DATE (CDS V6-2) / DELIVERY TIMESTAMP (CDS V6-3)</u>
160	Other Delivery	<u>DELIVERY DATE (VDS V6-2) / DELIVERY TIMESTAMP (CDS V6-3)</u>
170	Detained and/or Long-Term Psychiatric Census	<u>DETAINED AND (OR) LONG TERM PSYCHIATRIC CENSUS DATE</u>
180	Unfinished Birth Episode	<u>START DATE (EPISODE)</u>
190	Unfinished General Episode	<u>START DATE (EPISODE)</u>
200	Unfinished Delivery Episode	<u>START DATE (EPISODE)</u>

**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:	an10 CCYY-MM-DD
National Codes:	
Default Codes:	

**Notes:**

[CDS APPLICABLE DATE](#) is the same as attribute [EVENT DATE](#).

[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:	an8 HH:MM:SS
National Codes:	
Default Codes:	

**Notes:**

[CDS APPLICABLE TIME](#) is the same as attribute [EVENT TIME](#).

[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 Dataset

Format/Length:	an3
National Codes:	See <a href="#">CDS BULK REPLACEMENT GROUP CODE</a>
Default Codes:	

### Notes:

[CDS BULK REPLACEMENT GROUP CODE](#) is the same as attribute [CDS BULK REPLACEMENT GROUP CODE](#).

[CDS BULK REPLACEMENT GROUP CODE](#) is not required when the Commissioning Data Set Net Change Update Mechanism is used.

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

- [CDS REPORT PERIOD START DATE](#)
- [CDS REPORT PERIOD END DATE](#)
- [CDS INTERCHANGE SENDER IDENTITY](#)

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

For specific National Code usage in different data sets, see [CDS BULK REPLACEMENT GROUP CODE](#).

---

## CDS EXTRACT DATE

---

Change to Data Element: Changed Dataset

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

### Notes:

[CDS EXTRACT DATE](#) is the same as attribute [EVENT DATE](#).

[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:	an8 HH:MM:SS
National Codes:	
Default Codes:	

**Notes:**

[CDS EXTRACT TIME](#) is the same as attribute [EVENT TIME](#).

[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:	min an1 max an14
National Codes:	
Default Codes:	

**Notes:**

[CDS INTERCHANGE APPLICATION REFERENCE](#) is the same as attribute [CDS INTERCHANGE APPLICATION REFERENCE](#).

**Usage:**

This facility enables submitted interchanges to be marked to enable interchange content to be identified and recorded.

All [Commissioning Data Set](#) Interchanges must contain this data element.

**CDS XML Schema Interchanges:**

[Commissioning Data Set](#) XML Schema interchanges submitted may contain the optional [CDS INTERCHANGE APPLICATION REFERENCE](#).

Note: the Format/Length has been updated in [Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements"](#). The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

**CDS INTERCHANGE CONTROL COUNT**

---

Change to Data Element: Changed Dataset

Format/Length:	max n7
National Codes:	
Default Codes:	

**Notes:**

[CDS INTERCHANGE CONTROL COUNT](#) is the same as attribute [CDS INTERCHANGE CONTROL COUNT](#).

**Usage:**

Senders of [Commissioning Data Set](#) Interchanges must generate this data. Recipients of [Commissioning Data Set](#) Interchanges are advised to recount the received [Commissioning Data Set](#) messages and match this control count to ensure all [Commissioning Data Set](#) data submitted has been correctly received.

Note: the Format/Length has been updated in [Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements"](#). The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

**CDS INTERCHANGE CONTROL REFERENCE**

---

Change to Data Element: Changed Dataset, Description

Format/Length:	max n7
National Codes:	
Default Codes:	

**Notes:**

[CDS INTERCHANGE CONTROL REFERENCE](#) is the same as attribute [CDS INTERCHANGE CONTROL REFERENCE](#).

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

**Usage:**

[CDS INTERCHANGE CONTROL REFERENCE](#) is a mandatory data element when submitting

Commissioning Data Set Interchanges and is used to uniquely identify and if required, to sequence check Commissioning Data Set submissions.

For [Commissioning Data Sets](#) 6-2, 6-2-2 and 6-2-3, the XML schemas allow a maximum of an14 alphanumeric characters. This Format/Length was defined historically, but the [Secondary Uses Service](#) has always allowed a maximum of 7 numeric characters with a maximum value of 99999999. In [Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements"](#) this anomaly has been corrected. From ~~[Commissioning Data Set](#) version 6-3 onwards, the XML schema has been amended to carry the correct format/length of max n7.~~ From [Commissioning Data Set](#) version 6-3 onwards and [Emergency Care Data Set Version 4](#), the XML schema has been amended to carry the correct format/length of max n7.

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

#### **CDS XML Schema Interchanges:**

All CDS XML Schema interchanges submitted must contain a [CDS INTERCHANGE CONTROL REFERENCE](#).

Note: the Format/Length has been updated in [Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements"](#). The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

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#### **CDS INTERCHANGE DATE OF PREPARATION**

---

Change to Data Element: Changed Dataset

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

#### **Notes:**

[CDS INTERCHANGE DATE OF PREPARATION](#) is the same as attribute [EVENT DATE](#).

[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 [Commissioning Data Set](#) XML Schema interchanges submitted must contain a [CDS INTERCHANGE DATE OF PREPARATION](#).

---

#### **CDS INTERCHANGE RECEIVER IDENTITY**

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Change to Data Element: Changed Dataset

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Format/Length:	min an1 max an15
National Codes:	
Default Codes:	

**Notes:**

[CDS INTERCHANGE RECEIVER IDENTITY](#) is the same as attribute [CDS INTERCHANGE RECEIVER IDENTITY](#).

**Usage:**

The collection facility for Commissioning data is the [Secondary Uses Service](#).

**CDS XML Schema Interchanges:**

All [Commissioning Data Set](#) XML Schema interchanges submitted must contain the [CDS INTERCHANGE RECEIVER IDENTITY](#) of the [Secondary Uses Service](#).

Note: the Format/Length has been updated in [Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements"](#). The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

**CDS INTERCHANGE SENDER IDENTITY**

---

Change to Data Element: Changed Dataset

Format/Length:	min an1 max an15
National Codes:	
Default Codes:	

**Notes:**

[CDS INTERCHANGE SENDER IDENTITY](#) is the same as attribute [CDS INTERCHANGE SENDER IDENTITY](#).

**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 Electronic Data Interchange (EDI) address of the sending site.

**CDS XML Schema Interchanges:**

All [Commissioning Data Set](#) XML Schema interchanges submitted must contain a [CDS INTERCHANGE SENDER IDENTITY](#).

Note: the Format/Length has been updated in [Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements"](#). The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

**CDS INTERCHANGE TEST INDICATOR**

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Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See <a href="#">CDS INTERCHANGE TEST INDICATOR</a>
Default Codes:	

**Notes:**

[CDS INTERCHANGE TEST INDICATOR](#) is the same as attribute [CDS INTERCHANGE TEST INDICATOR](#).

**Usage:**

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

Whilst [CDS INTERCHANGE TEST INDICATOR](#) 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:

- All normal validation processes will be carried out
- The Interchange data will not be entered into the [Secondary Uses Service](#) database.

**CDS XML Schema Interchanges:**

All [Commissioning Data Set](#) XML Schema interchanges submitted may contain a [CDS INTERCHANGE TEST INDICATOR](#).

---

**CDS INTERCHANGE TIME OF PREPARATION**

---

Change to Data Element: Changed Dataset

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

**Notes:**

[CDS INTERCHANGE TIME OF PREPARATION](#) is the same as attribute [EVENT TIME](#).

[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 [Commissioning Data Set](#) 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:	max n7
National Codes:	
Default Codes:	

**Notes:**

[CDS MESSAGE REFERENCE](#) is the same as attribute [CDS MESSAGE REFERENCE](#).

**Usage:**

Each message within an interchange the [CDS MESSAGE REFERENCE](#) is assigned to provide a unique identity (within an interchange).

For [Commissioning Data Sets](#) 6-2, 6-2-2 and 6-2-3, the XML schemas allow a maximum of an14 alphanumeric characters. This Format/Length was defined historically, but the [Secondary Uses Service](#) has always allowed a maximum of 7 numeric characters with a maximum value of 9999999. In [Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements"](#) this anomaly has been corrected. From [Commissioning Data Set](#) version 6-3 onwards, the XML schema has been amended to carry the correct format/length of max n7.

Note: the Format/Length has been updated in [Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements"](#). The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

**CDS MESSAGE TYPE**

Change to Data Element: Changed Dataset

Format/Length:	an6
National Codes:	See <a href="#">CDS MESSAGE TYPE</a>
Default Codes:	

**Notes:**

[CDS MESSAGE TYPE](#) is the same as attribute [CDS MESSAGE TYPE](#).

**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 Dataset

Format/Length:	an8
National Codes:	
Default Codes:	

**Notes:**

[CDS MESSAGE VERSION NUMBER](#) is the same as attribute [CDS MESSAGE VERSION NUMBER](#)

**Usage:**

Interchanges must only contain [Commissioning Data Set](#) Messages of the same [CDS MESSAGE VERSION NUMBER](#) and each and every [CDS Type](#) must contain a [CDS MESSAGE VERSION NUMBER](#).

---

**CDS PROTOCOL IDENTIFIER CODE**

---

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	See <a href="#">CDS PROTOCOL IDENTIFIER CODE</a>
Default Codes:	

**Notes:**

[CDS PROTOCOL IDENTIFIER CODE](#) is the same as attribute [CDS PROTOCOL IDENTIFIER CODE](#).

---

**CDS RECORD IDENTIFIER**

---

Change to Data Element: Changed Dataset, Description

Format/Length:	min an1 max an35
National Codes:	
Default Codes:	

**Notes:**

[CDS RECORD IDENTIFIER](#) is the same as attribute [RECORD IDENTIFIER](#).

[CDS RECORD IDENTIFIER](#) may also be referred to as the [CDS-RID](#).

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

The [CDS RECORD IDENTIFIER](#) consists of the following components:

REF	RID COMPONENT	FORMAT	CODES / VALUES
4	<a href="#">CDS SENDER IDENTITY/ORGANISATION IDENTIFIER (CDS SENDER)</a>	an5	As generated in the <a href="#">CDS V6-2 Type 005B – CDS Transaction Header Group – Bulk Update Protocol</a> or the <a href="#">CDS V6-2 Type 005N – CDS Transaction Header Group – Net Change Protocol</a> Or As generated in the <a href="#">CDS V6-2-2 Type 005B – CDS Transaction Header Group – Bulk Update Protocol</a> or the <a href="#">CDS V6-2-2 Type 005N – CDS Transaction Header Group – Net Change Protocol</a> Or As generated in the <a href="#">CDS V6-3 Type 005B – Commissioning Data Set Transaction Header Group</a>

			<del>Bulk Update Protocol</del> or <del>CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol</del>
1	CDS SENDER IDENTITY/ORGANISATION IDENTIFIER (CDS SENDER)	an5	As generated in the <u>CDS V6-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol</u> or the <u>CDS V6-2 Type 005N - CDS Transaction Header Group - Net Change Protocol</u> Or As generated in the <u>CDS V6-2-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol</u> or the <u>CDS V6-2-2 Type 005N - CDS Transaction Header Group - Net Change Protocol</u> Or As generated in the <u>CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol</u> or <u>CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol</u> Or As generated in the <u>ECDS V4 Type 005B - CDS Transaction Header Group - Bulk Update Protocol</u> or <u>ECDS V4 Type 005N - CDS Transaction Header Group - Net Change Protocol</u>
2	Not Used	an2	Set = Blank
3	<del>CDS INTERCHANGE CONTROL REFERENCE</del>	max n7	As generated in the <u>CDS V6-2 Type 001 - CDS Interchange Header</u> or <u>CDS V6-3 Type 001 - CDS Interchange Header</u>
4	<del>CDS MESSAGE REFERENCE</del>	max n7	As generated in the <u>CDS V6-2 Type 003 - CDS Message Header</u> or <u>CDS V6-3 Type 003 - CDS Message Header</u>
3	CDS INTERCHANGE CONTROL REFERENCE	max n7	As generated in the <u>CDS V6-2 Type 001 - CDS Interchange Header</u> Or As generated in the <u>CDS V6-2-3 Type 001 - CDS Interchange Header</u> Or As generated in the <u>CDS V6-3 Type 001 - CDS Interchange Header</u> Or As generated in the <u>ECDS V4 Type 001 - CDS Interchange Header</u>
4	CDS MESSAGE REFERENCE	max n7	As generated in the <u>CDS V6-2 Type 003 - CDS Message Header</u> Or As generated in the <u>CDS V6-2-3 Type 003 - CDS Message Header</u> Or As generated in the <u>CDS V6-3 Type 003 - CDS Message Header</u>

Or

As generated in the [ECDS V4 Type 003 - CDS Message Header](#)

### Usage:

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

### CDS XML Schema Interchanges:

The [CDS-RID](#) data element is carried in the CDS Message Header (~~[CDS V6-2 Type 003 - CDS Message Header](#) / [CDS V6-2-2 Type 003 - CDS Message Header](#) / [CDS V6-2-3 Type 003 - CDS Message Header](#) / [CDS V6-3 Type 003 - CDS Message Header](#)~~). The [CDS-RID](#) data element is carried in the CDS Message Header ([CDS V6-2 Type 003 - CDS Message Header](#) / [CDS V6-2-2 Type 003 - CDS Message Header](#) / [CDS V6-2-3 Type 003 - CDS Message Header](#) / [CDS V6-3 Type 003 - CDS Message Header](#) / [ECDS V4 Type 003 - CDS Message Header](#)).

Note: the Format/Length has been updated in [Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements"](#). The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

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### CDS REPORT PERIOD END DATE

---

Change to Data Element: Changed Dataset

Format/Length: an10 CCYY-MM-DD

National Codes:

Default Codes:

### Notes:

[CDS REPORT PERIOD END DATE](#) is the same as attribute [EVENT DATE](#).

[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.

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**CDS REPORT PERIOD START DATE**

---

Change to Data Element: Changed Dataset

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

**Notes:**

[CDS REPORT PERIOD START DATE](#) is the same as attribute [EVENT DATE](#).

[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.

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**CDS TYPE CODE**

---

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	See <a href="#">CDS TYPE CODE</a>
Default Codes:	

**Notes:**

[CDS TYPE CODE](#) is the same as attribute [CDS TYPE CODE](#).

For specific National Code usage in different data sets, see [CDS TYPE CODE](#).

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**CDS UNIQUE IDENTIFIER**

---

Change to Data Element: Changed Dataset

Format/Length:	min an1 max an35
National Codes:	
Default Codes:	

**Notes:**

[CDS UNIQUE IDENTIFIER](#) is the same as attribute [RECORD IDENTIFIER](#).

[CDS UNIQUE IDENTIFIER](#) provides a unique identity for the life-time of an episode carried in a Commissioning Data Set message.

Note that the [CDS UNIQUE IDENTIFIER](#) must be constructed without the use of [PATIENT Confidential Information](#). This includes [PATIENT Identifiers](#) such as [NHS NUMBER](#) or [LOCAL PATIENT IDENTIFIER \(EXTENDED\)](#), as well as any text which may identify the [PATIENT DIAGNOSIS](#) of the [PATIENT](#) or any [PATIENT](#) procedures being undertaken.

See the [Commissioning Data Set Submission Protocol](#) for detailed information.

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

The [CDS UNIQUE IDENTIFIER](#) has three components. The recommended constructs are given below.

**For All CDS Types EXCEPT the EAL CDS Types:**

REF	UID	FORMAT	CODES / VALUES	COMMENT
1	<b>NHS Organisation Code Type</b>	an1	A = Pre 1996 <a href="#">ORGANISATION CODE</a> B = Post 1996 NHS <a href="#">ORGANISATION CODE / ORGANISATION IDENTIFIER</a>	Mandatory For all <a href="#">CDS Types</a>
2	<b>Provider Code</b>	an5	The NHS <a href="#">ORGANISATION CODE / ORGANISATION IDENTIFIER</a> 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 <a href="#">CDS Types</a>
3a	<b>Application Specific CDS Identity</b>	an29	A code of up to <b>29 alpha-numeric characters</b> generated by the Sender's application to uniquely identify the CDS within its CDS Type or family of CDS Types	Mandatory for all <a href="#">CDS Types</a> <b>Except for EAL CDS Types</b>

**For EAL End Of Period (EOP) CDS Types only (CDS 6-2 only):**

REF	UID	FORMAT	CODES / VALUES	COMMENT
1	<b>NHS Organisation Code Type</b>	an1	A = Pre 1996 <a href="#">ORGANISATION CODE</a> B = Post 1996 NHS <a href="#">ORGANISATION CODE / ORGANISATION IDENTIFIER</a>	Mandatory For all <a href="#">CDS Types</a>
2	<b>Provider Code</b>	an5	The NHS <a href="#">ORGANISATION CODE / ORGANISATION IDENTIFIER</a> 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 <a href="#">CDS Types</a>

3b	<b>Application Specific CDS Identity</b>	an9	A code of up to <b>9 alpha-numeric characters</b> 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.	<b>Mandatory for all EAL EOP CDS Types</b>
3c	<b>Filler</b>	an20	Additional data positions must be left blank.	

**For EAL Event During Period (EDP) CDS Types only (CDS 6-2 only):**

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

**Usage:**

[CDS UNIQUE IDENTIFIER](#) is a mandatory data item when the Net Change Update Mechanism is used. *It is strongly advised that users of the Bulk Replacement Mechanism maintain a correctly generated [CDS UNIQUE IDENTIFIER](#) within the Commissioning Data Set data. This will establish a migration path towards the use of the Net Change Mechanism and will also*

**then minimise the risk of creating duplicate Commissioning Data Set data in the [Secondary Uses Service](#) database.**

- Note that senders of Commissioning Data Set data remain directly responsible for the integrity of the [CDS UNIQUE IDENTIFIER](#)
- It is a mandatory requirement for all submissions using the Net Change Update Mechanism that these two components are constructed correctly to ensure uniqueness of [CDS UNIQUE IDENTIFIERS](#) across the NHS.
- The structure of 3b and 3c allows the EAL End of Period Census and the EAL Event During Period Census for the same EAL Entry to be linked (CDS 6-2 only).

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

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

Each use of an NHS [ORGANISATION CODE](#) within a Commissioning Data Set message must be associated with the release version of the NHS Organisation Code scheme. At present this may be derived locally by NHS IT systems.

The following values have been informally used in many Commissioning Data Set implementations and are recommended to be used:

- A or O\* Signifying "OLD" (pre-April 1996) to denote an [ORGANISATION CODE](#) issued before, and in use up to the 1996 major re-issue
- B or N\* Signifying "NEW" (post-April 1996) to denote an [ORGANISATION CODE](#) / [ORGANISATION IDENTIFIER](#) issued from April 1996

\* The values of **A** and **B** must be used in the formatting of the [CDS UNIQUE IDENTIFIER](#).

Note: the Format/Length has been updated in [Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements"](#). The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

---

#### CDS UPDATE TYPE

---

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See <a href="#">CDS UPDATE TYPE</a>
Default Codes:	

#### Notes:

[CDS UPDATE TYPE](#) is the same as attribute [CDS UPDATE TYPE](#).

**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: Changed Dataset, Description

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

**Notes:**

[CLINICAL TRIAL IDENTIFIER](#) is the same as attribute [CLINICAL TRIAL IDENTIFIER](#).

~~Use in the [CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set](#) / [CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set](#):~~ Use in the [CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set](#) / [CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set](#) / [Emergency Care Data Set Version 4](#):

- 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.

---

**CODED ASSESSMENT TOOL TYPE (SNOMED CT)**

---

Change to Data Element: Changed Dataset

Format/Length:	See <a href="#">SNOMED CT CODE</a>
National Codes:	
Default Codes:	

**Notes:**

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

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

Nationally published [SNOMED CT](#) content relating to [ASSESSMENT TOOLS](#) can be found in the [SNOMED CT Browser](#) at: [staging and scales \(staging scale\)](#).

---

**CODED CLINICAL ENTRY SEQUENCE NUMBER**

---

Change to Data Element: Changed Dataset

Format/Length:	min n1 max n5
National Codes:	
Default Codes:	

**Notes:**

[CODED CLINICAL ENTRY SEQUENCE NUMBER](#) is the same as attribute [CODED CLINICAL ENTRY SEQUENCE NUMBER](#).

---

**CODED FINDING (SNOMED CT)**

Change to Data Element: Changed Dataset

Format/Length:	See <a href="#">SNOMED CT CODE</a>
National Codes:	
Default Codes:	

**Notes:**

[CODED FINDING \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

[CODED FINDING \(SNOMED CT\)](#) is the [SNOMED CT®](#) concept ID which is used to identify a [Finding](#).

For further information on [Findings](#), see the [SNOMED CT®](#) information at: [SNOMED CT Fact Sheet](#).

---

**CODED FINDING TIMESTAMP**

Change to Data Element: Changed Dataset, Description

Format/Length:	max an25
National Codes:	
Default Codes:	

**Notes:**

[CODED FINDING TIMESTAMP](#) is the same as attribute [PERSON PROPERTY RECORDED DATE](#) and [PERSON PROPERTY RECORDED TIME](#).

[CODED FINDING TIMESTAMP](#) is the date, time and time zone that the [Clinical Finding](#) was recorded by a [CARE PROFESSIONAL](#).

A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time.

In most cases offset time is restricted to:

- +01:00
- +00:00
- -00:00

Examples of valid formats are:

- 2020-08-21T10:15:20+01:00 British Summer Time (GMT + 1 Hour)
- ~~2020-08-21T10:15:20+00:00 Greenwich Mean Time~~
- ~~2020-08-21T10:15:20-00:00 Greenwich Mean Time~~
- ~~2020-08-21T09:18:00Z Greenwich Mean Time.~~
- 2020-12-21T10:15:20+00:00 Greenwich Mean Time
- 2020-12-21T10:15:20-00:00 Greenwich Mean Time
- 2020-12-21T09:18:00Z Greenwich Mean Time.

---

#### CODED OBSERVATION (SNOMED CT)

---

Change to Data Element: Changed Dataset

Format/Length:	See <a href="#">SNOMED CT CODE</a>
National Codes:	
Default Codes:	

**Notes:**

[CODED OBSERVATION \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

[CODED OBSERVATION \(SNOMED CT\)](#) is the [SNOMED CT](#)® concept ID which is used to identify an [Observable Entity](#).

For further information on observations, see the see the: [SNOMED CT Fact Sheet](#).

---

#### CODED OBSERVATION TIMESTAMP

---

Change to Data Element: Changed Dataset, Description

Format/Length:	max an25
National Codes:	
Default Codes:	

**Notes:**

[CODED OBSERVATION TIMESTAMP](#) is the same as attribute [PERSON PROPERTY RECORDED DATE](#) and [PERSON PROPERTY RECORDED TIME](#).

[CODED OBSERVATION TIMESTAMP](#) is the date, time and time zone that the [Observable Entity](#) was recorded by a [CARE PROFESSIONAL](#).

A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time.

In most cases offset time is restricted to:

- +01:00

- +00:00
- -00:00

Examples of valid formats are:

- 2020-08-21T10:15:20+01:00 British Summer Time (GMT + 1 Hour)
- ~~2020-08-21T10:15:20+00:00 Greenwich Mean Time~~
- ~~2020-08-21T10:15:20-00:00 Greenwich Mean Time~~
- ~~2020-08-21T09:18:00Z Greenwich Mean Time.~~
- 2020-12-21T10:15:20+00:00 Greenwich Mean Time
- 2020-12-21T10:15:20-00:00 Greenwich Mean Time
- 2020-12-21T09:18:00Z Greenwich Mean Time.

### **CODED PROCEDURE TIMESTAMP (URGENT AND EMERGENCY CARE CLINICAL INVESTIGATION)**

Change to Data Element: New Data Element

Format/Length:	max an25
National Codes:	
Default Codes:	

#### **Notes:**

**CODED PROCEDURE TIMESTAMP (URGENT AND EMERGENCY CARE CLINICAL INVESTIGATION)** is the same as attribute **ACTIVITY DATE** and **ACTIVITY TIME**.

**CODED PROCEDURE TIMESTAMP (URGENT AND EMERGENCY CARE CLINICAL INVESTIGATION)** is the date, time and time zone a **Clinical Investigation** was performed during an **Urgent and Emergency Care Activity**.

A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time.

In most cases offset time is restricted to:

- +01:00
- +00:00
- -00:00

Examples of valid formats are:

- 2020-08-21T10:15:20+01:00 British Summer Time (GMT + 1 Hour)
- 2020-12-21T10:15:20+00:00 Greenwich Mean Time
- 2020-12-21T10:15:20-00:00 Greenwich Mean Time
- 2020-12-21T09:18:00Z Greenwich Mean Time.

**This data element is also known by these names:**

Context	Alias

plural	CODED PROCEDURE TIMESTAMPS (URGENT AND EMERGENCY CARE CLINICAL INVESTIGATION)
--------	-------------------------------------------------------------------------------

---

**CODED PROCEDURE TIMESTAMP (URGENT AND EMERGENCY CARE CLINICAL INVESTIGATION)**

---

Change to Data Element: New Data Element

**CODED PROCEDURE TIMESTAMP (URGENT AND EMERGENCY CARE CLINICAL INVESTIGATION)**

**Attribute:**

ACTIVITY DATE
ACTIVITY TIME

---

**CODED PROCEDURE TIMESTAMP (URGENT AND EMERGENCY CARE PROCEDURE)**

---

Change to Data Element: New Data Element

Format/Length:	max an25
National Codes:	
Default Codes:	

**Notes:**

**CODED PROCEDURE TIMESTAMP (URGENT AND EMERGENCY CARE PROCEDURE)** is the same as attribute **ACTIVITY DATE** and **ACTIVITY TIME**.

**CODED PROCEDURE TIMESTAMP (URGENT AND EMERGENCY CARE PROCEDURE)** is the date, time and time zone a **Patient Procedure** was performed during an **Urgent and Emergency Care Activity**.

A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time.

In most cases offset time is restricted to:

- +01:00
- +00:00
- -00:00

Examples of valid formats are:

- 2020-08-21T10:15:20+01:00 British Summer Time (GMT + 1 Hour)
- 2020-12-21T10:15:20+00:00 Greenwich Mean Time
- 2020-12-21T10:15:20-00:00 Greenwich Mean Time
- 2020-12-21T09:18:00Z Greenwich Mean Time.

**This data element is also known by these names:**

Context	Alias
plural	CODED PROCEDURE TIMESTAMPS (URGENT AND EMERGENCY CARE PROCEDURE)

---

**CODED PROCEDURE TIMESTAMP (URGENT AND EMERGENCY CARE PROCEDURE)**

---

Change to Data Element: New Data Element

**CODED PROCEDURE TIMESTAMP (URGENT AND EMERGENCY CARE PROCEDURE)**

**Attribute:**

<a href="#">ACTIVITY DATE</a>
<a href="#">ACTIVITY TIME</a>

---

**COMMISSIONER REFERENCE IDENTIFIER**

---

Change to Data Element: Changed Dataset

Format/Length:	max an20
National Codes:	
Default Codes:	8 - Not Applicable 9 - <a href="#">COMMISSIONER REFERENCE IDENTIFIER</a> not known

**Notes:**

[COMMISSIONER REFERENCE IDENTIFIER](#) is the same as attribute [COMMISSIONER REFERENCE IDENTIFIER](#).

[COMMISSIONER REFERENCE NUMBER](#) will be replaced with [COMMISSIONER REFERENCE IDENTIFIER](#), which is the most recent approved national information standard to describe the required definition.

---

**COMORBIDITY (SNOMED CT)**

---

Change to Data Element: Changed Dataset

Format/Length:	See <a href="#">SNOMED CT CODE</a>
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 Refset:](#)

- [Refset](#) FSN: Comorbid conditions for selection simple reference set (foundation metadata concept)
- [Refset](#) Id: 991381000000107

For further details relating to the [SNOMED CT Refset](#), see the [SNOMED CT Browser](#) at: [Comorbid conditions for selection simple reference set \(foundation metadata concept\)](#).

**CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE)**

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	
Default Codes:	

**Notes:**

**CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE)** is the same as attribute **CONSULTATION MECHANISM**.

**CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE)** is the main way in which an **Emergency Care Attendance** or **Same Day Emergency Care Attendance** with the **PATIENT** was conducted by the responsible **CARE PROFESSIONAL** in an **Urgent and Emergency Care Service**.

*Permitted National Codes:*

- 01 Face to face
- 02 Telephone
- 11 Video Consultation
- 13 Chat Room (Synchronous)

**This data element is also known by these names:**

Context	Alias
plural	CONSULTATION MECHANISMS (URGENT AND EMERGENCY CARE)

**CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE)**

Change to Data Element: New Data Element

**CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE)**

**Attribute:**

<b>CONSULTATION MECHANISM</b>
-------------------------------

**DECIDED TO ADMIT DATE AND TIME**

Change to Data Element: New Data Element

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

**Notes:**

[DECIDED TO ADMIT DATE AND TIME](#) is the same as attribute [DECIDED TO ADMIT DATE](#) and [DECIDED TO ADMIT TIME](#).

[DECIDED TO ADMIT DATE AND TIME](#) may be the same as the date and time 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](#) original 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](#).

**This data element is also known by these names:**

Context	Alias
plural	<a href="#">DECIDED TO ADMIT DATES AND TIMES</a>

---

**DECIDED TO ADMIT DATE AND TIME**

---

Change to Data Element: [New Data Element](#)

**DECIDED TO ADMIT DATE AND TIME**

**Attribute:**

<a href="#">DECIDED TO ADMIT DATE</a>
<a href="#">DECIDED TO ADMIT TIME</a>

---

**DISEASE OUTBREAK NOTIFICATION (SNOMED CT)**

---

Change to Data Element: [Changed Dataset](#)

Format/Length:	See <a href="#">SNOMED CT CODE</a>
National Codes:	
Default Codes:	

**Notes:**

[DISEASE OUTBREAK NOTIFICATION \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

[DISEASE OUTBREAK NOTIFICATION \(SNOMED CT\)](#) is the [SNOMED CT](#)® concept ID describing nationally-notifiable outbreaks of disease.

[DISEASE OUTBREAK NOTIFICATION \(SNOMED CT\)](#) 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 DESCRIPTION

---

Change to Data Element: Changed Dataset, Description

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

**Notes:**

[DISEASE OUTBREAK NOTIFICATION DESCRIPTION](#) is the same as attribute [PERSON OBSERVATION TEXT STRING](#).

~~[DISEASE OUTBREAK NOTIFICATION DESCRIPTION](#) is used in [CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set](#) to support the collection of nationally-notifiable data relating to outbreaks of disease, which are identified in [Emergency Care Departments](#), where a [SNOMED CT CODE](#) is NOT available.~~ [DISEASE OUTBREAK NOTIFICATION DESCRIPTION](#) is used in [CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set / Emergency Care Data Set Version 4](#) to support the collection of nationally-notifiable data relating to outbreaks of disease, which are identified during an [Urgent and Emergency Care Activity](#), where a [SNOMED CT CODE](#) is NOT available.

[DISEASE OUTBREAK NOTIFICATION DESCRIPTION](#) 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.

---

#### EMED3 FIT NOTE ASSESSMENT DATE

---

Change to Data Element: Changed Dataset

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

**Notes:**

[EMED3 FIT NOTE ASSESSMENT DATE](#) is the same as attribute [ACTIVITY DATE](#) for the '[eMED3 Fit Note Assessment Date](#)'.

---

#### EMED3 FIT NOTE CONDITION (SNOMED CT)

---

Change to Data Element: New Data Element

Format/Length:	See <a href="#">SNOMED CT CODE</a>
National Codes:	
Default Codes:	

**Notes:**

[EMED3 FIT NOTE CONDITION \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

[EMED3 FIT NOTE CONDITION \(SNOMED CT\)](#) is the [SNOMED CT®](#) concept ID which is used to describe the reason that a [CARE PROFESSIONAL](#) issued an [eMED3 Fit Note](#) for a [PATIENT](#).

For further guidance on the conditions appropriate to Urgent and Emergency Care Fit Note completion, see the [NHS Digital](#) website at: [ECDS Guidance and Documents](#).

**This data element is also known by these names:**

Context	Alias
plural	<a href="#">EMED3 FIT NOTE CONDITIONS (SNOMED CT)</a>

**EMED3 FIT NOTE CONDITION (SNOMED CT)**

Change to Data Element: New Data Element

**EMED3 FIT NOTE CONDITION (SNOMED CT)**

**Attribute:**

<a href="#">CLINICAL TERMINOLOGY CODE</a>
-------------------------------------------

**EMED3 FIT NOTE DIAGNOSIS (ICD)**

Change to Data Element: Changed Dataset

Format/Length:	See <a href="#">ICD-10 CODE</a>
National Codes:	
Default Codes:	

**Notes:**

[EMED3 FIT NOTE DIAGNOSIS \(ICD\)](#) is the same as attribute [CLINICAL CLASSIFICATION CODE](#).

[EMED3 FIT NOTE DIAGNOSIS \(ICD\)](#) is the [International Classification of Diseases \(ICD\)](#) code used to describe the reason that a [CARE PROFESSIONAL](#) issued an [eMED3 Fit Note](#) for a [PATIENT](#).

**EMED3 FIT NOTE DURATION**

Change to Data Element: Changed Dataset

Format/Length:	max an3
National Codes:	
Default Codes:	999 - <a href="#">eMED3 Fit Note</a> is for an indefinite period

**Notes:**

[EMED3 FIT NOTE DURATION](#) is the same as attribute [PERSON PROPERTY ASSIGNMENT PERIOD DURATION](#).

[EMED3 FIT NOTE DURATION](#) is the number of days duration of an [eMED3 Fit Note Applicable Period](#).

---

**EMED3 FIT NOTE END DATE**

---

Change to Data Element: Changed Dataset

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

**Notes:**

[EMED3 FIT NOTE END DATE](#) is the same as attribute [PERSON PROPERTY EFFECTIVE END DATE](#).

[EMED3 FIT NOTE END DATE](#) is the date that the [eMED3 Fit Note Applicable Period](#) ended.

---

**EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR**

---

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See <a href="#">EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR</a>
Default Codes:	

**Notes:**

[EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR](#) is the same as attribute [EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR](#).

---

**EMED3 FIT NOTE ISSUER**

---

Change to Data Element: Changed Dataset

**This item is being used for development purposes and has not yet been approved.**

---

**EMED3 FIT NOTE RECORDED DATE**

---

Change to Data Element: Changed Dataset

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

**Notes:**

[EMED3 FIT NOTE RECORDED DATE](#) is the same as attribute [ACTIVITY DATE](#) for the '[eMED3 Fit Note Recorded Date](#)'.

---

#### EMED3 FIT NOTE START DATE

---

Change to Data Element: Changed Dataset

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

#### Notes:

[EMED3 FIT NOTE START DATE](#) is the same as attribute [PERSON PROPERTY EFFECTIVE START DATE](#).

[EMED3 FIT NOTE START DATE](#) is the date that the [eMED3 Fit Note Applicable Period](#) commenced.

---

#### EMERGENCY CARE DEPARTMENT TYPE (PATIENT LEVEL INFORMATION COSTING)

---

Change to Data Element: Changed linked Attribute, Description

Format/Length:	an2
National Codes:	
National Codes:	See <a href="#">EMERGENCY CARE DEPARTMENT TYPE FOR PATIENT LEVEL INFORMATION COSTING</a>
Default Codes:	

#### Notes:

~~[EMERGENCY CARE DEPARTMENT TYPE \(PATIENT LEVEL INFORMATION COSTING\)](#) is the same as attribute [EMERGENCY CARE DEPARTMENT TYPE](#) for the purposes of reporting for [Patient Level Information Costing](#).~~

#### *Permitted National Codes:*

- 01 ~~Emergency departments are a [CONSULTANT](#) led 24-hour service with full resuscitation facilities and designated accommodation for the reception of emergency care [PATIENTS](#)~~
- 02 ~~[CONSULTANT](#) led mono-specialty emergency care 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 emergency care [PATIENTS](#). The department may be doctor led, [GENERAL PRACTITIONER](#) 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. Includes [Urgent Treatment Centres](#). Excludes NHS walk-in centres~~
- 04 ~~NHS walk-in centres~~

Note: National Codes 01 and 03 have been updated as a result of changes made in [DCB0092-2062: Commissioning Data Sets: Emergency Care Data Set](#). The Data Set specifications that contain this item will be updated in the next version of the Information Standard where they are not already correct.

[EMERGENCY CARE DEPARTMENT TYPE \(PATIENT LEVEL INFORMATION COSTING\)](#) is the same as attribute [EMERGENCY CARE DEPARTMENT TYPE FOR PATIENT LEVEL INFORMATION COSTING](#).

---

#### EMERGENCY CARE DEPARTMENT TYPE (PATIENT LEVEL INFORMATION COSTING)

---

Change to Data Element: Changed linked Attribute, Description

### EMERGENCY CARE DEPARTMENT TYPE (PATIENT LEVEL INFORMATION COSTING)

**Attribute:**

<a href="#">EMERGENCY CARE DEPARTMENT TYPE</a>
<a href="#">EMERGENCY CARE DEPARTMENT TYPE FOR PATIENT LEVEL INFORMATION COSTING</a>

---

#### EMERGENCY CARE EXPECTED DATE AND TIMESTAMP OF TREATMENT

---

Change to Data Element: Changed Dataset

Format/Length:	max an25
National Codes:	
Default Codes:	

**Notes:**

[EMERGENCY CARE EXPECTED DATE AND TIMESTAMP OF TREATMENT](#) is the same as attribute [PLANNED ACTIVITY DATE](#) and [PLANNED ACTIVITY TIME](#) for the '[Emergency Care Expected Date and Timestamp of Treatment](#)'.

A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time.

In most cases offset time is restricted to:

- +01:00
- +00:00
- -00:00

Examples of valid formats are:

- 2022-12-01T10:15:20+01:00 British Summer Time (GMT + 1 Hour)
- 2022-12-01T10:15:20+00:00 Greenwich Mean Time
- 2022-12-01T10:15:20-00:00 Greenwich Mean Time
- 2022-12-01T09:18:00Z Greenwich Mean Time.

## EMERGENCY CARE INJURY ACTIVITY STATUS (SNOMED CT)

---

Change to Data Element: Changed Dataset

Format/Length:	See <a href="#">SNOMED CT CODE</a>
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 Refset:](#)

- [Refset](#) FSN: Emergency care injury activity status simple reference set (foundation metadata concept)
- [Refset](#) Id: 999003031000000102

For further details relating to the [SNOMED CT Refset](#), see the [SNOMED CT Browser](#) at: [Emergency care injury activity status simple reference set \(foundation metadata concept\)](#).

---

## EMERGENCY CARE INJURY ACTIVITY TYPE (SNOMED CT)

---

Change to Data Element: Changed Dataset

Format/Length:	See <a href="#">SNOMED CT CODE</a>
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 Refset:](#)

- [Refset](#) FSN: Emergency care injury activity type simple reference set (foundation metadata concept)
- [Refset](#) Id: 1024501000000108

For further details relating to the [SNOMED CT Refset](#), see the [SNOMED CT Browser](#) at: [Emergency care injury activity type simple reference set \(foundation metadata concept\)](#).

---

## EMERGENCY CARE INJURY ALCOHOL OR DRUG INVOLVEMENT (SNOMED CT)

---

Change to Data Element: Changed Dataset

Format/Length:	See <a href="#">SNOMED CT CODE</a>
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 Refset](#):

- [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 Refset](#), see the [SNOMED CT Browser](#) at: [Emergency care drug or alcohol use related to injury simple reference set \(foundation metadata concept\)](#).

---

## EMERGENCY CARE INJURY INTENT (SNOMED CT)

---

Change to Data Element: Changed Dataset

Format/Length:	See <a href="#">SNOMED CT CODE</a>
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 Refset](#):

- [Refset](#) FSN: Emergency care injury intent type simple reference set (foundation metadata concept)
- [Refset](#) Id: 991431000000101

For further details relating to the [SNOMED CT Refset](#), see the [SNOMED CT Browser](#) at: [Emergency care injury intent type simple reference set \(foundation metadata concept\)](#).

---

## EMERGENCY CARE INJURY MECHANISM (SNOMED CT)

---

Change to Data Element: Changed Dataset

Format/Length:	See <a href="#">SNOMED CT CODE</a>
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 Refset](#):

- [Refset](#) FSN: Emergency care mechanism of injury simple reference set (foundation metadata concept)
- [Refset](#) Id: 991281000000103

For further details relating to the [SNOMED CT Refset](#), see the [SNOMED CT Browser](#) at: [Emergency care mechanism of injury simple reference set \(foundation metadata concept\)](#).

---

## EMERGENCY CARE PLACE OF INJURY (LATITUDE)

---

Change to Data Element: Changed Dataset

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

### Notes:

[EMERGENCY CARE PLACE OF INJURY \(LATITUDE\)](#) is the same as attribute [GEOGRAPHIC CO-ORDINATE](#).

[EMERGENCY CARE PLACE OF INJURY \(LATITUDE\)](#) is the latitude of the [EMERGENCY CARE PLACE OF INJURY \(SNOMED CT\)](#), expressed in decimal degrees.

---

## EMERGENCY CARE PLACE OF INJURY (LONGITUDE)

---

Change to Data Element: Changed Dataset

Format/Length:	max n3.n6
National Codes:	
Default Codes:	

### Notes:

[EMERGENCY CARE PLACE OF INJURY \(LONGITUDE\)](#) is the same as attribute [GEOGRAPHIC CO-ORDINATE](#).

[EMERGENCY CARE PLACE OF INJURY \(LONGITUDE\)](#) is the longitude of the [EMERGENCY CARE PLACE OF INJURY \(SNOMED CT\)](#), expressed in decimal degrees.

---

#### EMERGENCY CARE PLACE OF INJURY (SNOMED CT)

---

Change to Data Element: Changed Dataset

Format/Length:	See <a href="#">SNOMED CT CODE</a>
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 Refset](#):

- [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 Refset](#), see the [SNOMED CT Browser](#) at: [Emergency care place of injury type simple reference set \(foundation metadata concept\)](#).

---

#### EMERGENCY CARE TREATMENT ALLOCATION TIMESTAMP

---

Change to Data Element: Changed Dataset, Description

Format/Length:	max an25
National Codes:	
Default Codes:	

#### Notes:

[EMERGENCY CARE TREATMENT ALLOCATION TIMESTAMP](#) is the same as attribute [EVENT DATE](#) and [EVENT TIME](#).

[EMERGENCY CARE TREATMENT ALLOCATION TIMESTAMP](#) is the date, time and time zone that an [Emergency Care Expected Date and Timestamp of Treatment](#) was allocated to the [PATIENT](#).

A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time.

In most cases offset time is restricted to:

- +01:00
- +00:00
- -00:00

Examples of valid formats are:

- 2022-12-01T10:15:20+01:00 British Summer Time (GMT + 1 Hour)
- 2022-12-01T10:15:20+00:00 Greenwich Mean Time
- 2022-12-01T10:15:20-00:00 Greenwich Mean Time
- 2022-12-01T09:18:00Z Greenwich Mean Time.
- 2020-08-21T10:15:20+01:00 British Summer Time (GMT + 1 Hour)
- 2020-12-21T10:15:20+00:00 Greenwich Mean Time
- 2020-12-21T10:15:20-00:00 Greenwich Mean Time
- 2020-12-21T09:18:00Z Greenwich Mean Time.

#### END DATE (COMMISSIONER ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

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

**Notes:**

[END DATE \(COMMISSIONER ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY DATE](#).

[END DATE \(COMMISSIONER ASSIGNMENT PERIOD\)](#) is the [End Date](#) of the [Commissioner Assignment Period](#).

#### ETHNIC CATEGORY

Change to Data Element: Changed Dataset

Format/Length:	an2
<a href="#">NWDS</a> ID:	PETH
<a href="#">NWDS</a> Field Name:	Ethnic Category
<a href="#">ESR</a> Field Name:	Ethnic Origin
National Codes:	See <a href="#">ETHNIC CATEGORY CODE 2001</a>
Default Codes:	99 - Not known

**Notes:**

[ETHNIC CATEGORY](#) is the same as attribute [ETHNIC CATEGORY CODE 2001](#).

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.

Note: for the [Stop Smoking Services Quarterly Data Set](#) default code 99 'Not Known' is **not** valid.

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#### ETHNIC CATEGORY 2021

---

Change to Data Element: Changed Dataset

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

#### Notes:

[ETHNIC CATEGORY 2021](#) is the same as attribute [ETHNIC CATEGORY 2021](#).

**Note: This item has not been approved by the [Data Alliance Partnership Board](#). It has been introduced to provide advance notice to data providers and system suppliers of the intention to report this item at a later date. This item should not be submitted until further development by [NHS Digital](#) has been undertaken.**

---

#### GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION)

---

Change to Data Element: Changed Dataset

Format/Length:	min an6 max an8
National Codes:	
Default Codes:	V81997 - No Registered <a href="#">GP Practice</a> V81998 - <a href="#">GP Practice</a> Code not applicable V81999 - <a href="#">GP Practice</a> Code not known

#### Notes:

[GENERAL MEDICAL PRACTICE \(PATIENT REGISTRATION\)](#) is the same as attribute [ORGANISATION CODE](#).

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

The data for [GENERAL MEDICAL PRACTICE \(PATIENT REGISTRATION\)](#) is supplied by the [NHS Prescription Services](#).

#### 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](#).
- **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 PRACTICE CODE \(PATIENT REGISTRATION\)](#) will be replaced with [GENERAL MEDICAL PRACTICE \(PATIENT REGISTRATION\)](#), which is the most recent approved national information standard to describe the required definition.

---

#### GENERAL MEDICAL PRACTITIONER (SPECIFIED)

---

Change to Data Element: Changed Dataset

Format/Length:	an8
National Codes:	
Default Codes:	G9999998 - <a href="#">GENERAL MEDICAL PRACTITIONER PPD CODE</a> not known
	G9999981 - <a href="#">GENERAL MEDICAL PRACTITIONER PPD CODE</a> 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 AND TIME

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Change to Data Element: New Data Element

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

#### Notes:

INJURY DATE AND TIME is the same as attribute PERSON PROPERTY EFFECTIVE START DATE and the PERSON PROPERTY EFFECTIVE START TIME.

INJURY DATE AND TIME is the date and time that the PATIENT was injured.

Where this information cannot be obtained directly from the PATIENT (or Patient Proxy), the INJURY DATE AND TIME should be estimated.

**This data element is also known by these names:**

Context	Alias
plural	<u>INJURY DATES AND TIMES</u>

---

#### INJURY DATE AND TIME

Change to Data Element: New Data Element

#### **INJURY DATE AND TIME**

Attribute:

<u>PERSON PROPERTY EFFECTIVE START DATE</u>
<u>PERSON PROPERTY EFFECTIVE START TIME</u>

---

#### INTERPRETER LANGUAGE (SNOMED CT)

Change to Data Element: Changed Dataset

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 Refset](#):

- [Refset](#) FSN: Interpreter type findings simple reference set
- [Refset](#) Id: 991231000000102

For further details relating to the [SNOMED CT Refset](#), see the [SNOMED CT Browser](#) at: [Interpreter type findings simple reference set \(foundation metadata concept\)](#).

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#### LOCAL PATIENT IDENTIFIER (EXTENDED)

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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 ASSIGNMENT PERIOD START TIMESTAMP**

Change to Data Element: New Data Element

Format/Length:	max an25
National Codes:	
Default Codes:	

**Notes:**

[MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START TIMESTAMP](#) is the same as attribute [ACTIVITY DATE](#) and [ACTIVITY TIME](#).

[MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START TIMESTAMP](#) is the date, time and time zone of the start of the [Mental Health Act Legal Status Classification Assignment Period](#).

A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time.

In most cases offset time is restricted to:

- +01:00
- +00:00
- -00:00

Examples of valid formats are:

- 2020-08-21T10:15:20+01:00 British Summer Time (GMT + 1 Hour)
- 2020-12-21T10:15:20+00:00 Greenwich Mean Time
- 2020-12-21T10:15:20-00:00 Greenwich Mean Time
- 2020-12-21T09:18:00Z Greenwich Mean Time.

**This data element is also known by these names:**

Context	Alias

plural	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START TIMESTAMPS
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**MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START TIMESTAMP**

---

Change to Data Element: New Data Element

**MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START TIMESTAMP**

**Attribute:**

<a href="#">ACTIVITY DATE</a>
<a href="#">ACTIVITY TIME</a>

---

**MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE**

---

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See <a href="#">MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE</a>
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.

Note: for the [Mental Health Services Data Set](#), 'Not Known' indicates 'Not Recorded'.

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**MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION EXPIRY TIMESTAMP**

---

Change to Data Element: New Data Element

Format/Length:	max an25
National Codes:	
Default Codes:	

**Notes:**

[MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION EXPIRY TIMESTAMP](#) is the same as

attribute PERSON PROPERTY EFFECTIVE END DATE and PERSON PROPERTY EFFECTIVE END TIME.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION EXPIRY TIMESTAMP is the date, time and time zone when a MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION for a PATIENT expires.

A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time.

In most cases offset time is restricted to:

- +01:00
- +00:00
- -00:00

Examples of valid formats are:

- 2020-08-21T10:15:20+01:00 British Summer Time (GMT + 1 Hour)
- 2020-12-21T10:15:20+00:00 Greenwich Mean Time
- 2020-12-21T10:15:20-00:00 Greenwich Mean Time
- 2020-12-21T09:18:00Z Greenwich Mean Time.

**This data element is also known by these names:**

Context	Alias
plural	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION EXPIRY TIMESTAMPS

---

## MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION EXPIRY TIMESTAMP

---

Change to Data Element: New Data Element

## MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION EXPIRY TIMESTAMP

**Attribute:**

<u>PERSON PROPERTY EFFECTIVE END DATE</u>
<u>PERSON PROPERTY EFFECTIVE END TIME</u>

---

## NHS NUMBER

---

Change to Data Element: Changed Dataset

Format/Length:	n10
National Codes:	
Default Codes:	

**Notes:**

[NHS NUMBER](#) is the same as attribute [NHS NUMBER](#).

For the [AIDC for Patient Identification Data Set](#) further guidance can be found on the [NHS Digital](#) website at: [DCB1077: AIDC for Patient Identification](#).

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**NHS NUMBER STATUS INDICATOR CODE**

---

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See <a href="#">NHS NUMBER STATUS INDICATOR CODE</a>
Default Codes:	

**Notes:**

[NHS NUMBER STATUS INDICATOR CODE](#) is the same as attribute [NHS NUMBER STATUS INDICATOR CODE](#).

For specific National Code usage in different data sets, see [NHS NUMBER STATUS INDICATOR CODE](#).

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**NHS SERVICE AGREEMENT IDENTIFIER**

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Change to Data Element: Changed Dataset

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

**Notes:**

[NHS SERVICE AGREEMENT IDENTIFIER](#) is the same as attribute [NHS SERVICE AGREEMENT IDENTIFIER](#).

Where a [PATIENT](#) is receiving [Non-Contract Activity](#) treatment, [Health Care Providers](#) submitting the [Commissioning Data Sets](#) should populate the first 3 characters of the [NHS SERVICE AGREEMENT IDENTIFIER](#) with the letters 'OAT' (in capital letters). The remaining characters continue to be locally-populated as required.

Where the [ACTIVITY](#) in the [Commissioning Data Set](#) record should be excluded from the [National Tariff Payment System](#) tariff, an '=' (equals sign) should be entered as the last character in the [NHS SERVICE AGREEMENT IDENTIFIER](#). The position of the last character depends on any preceding characters; for example where the field is otherwise blank, the '=' sign would be the first character. Where the first three characters are 'OAT' as above, the '=' sign is entered as the 4th character. The '=' sign provides a general exclusion from [National Tariff Payment System](#) processing by the [Secondary Uses Service](#) which should be used for unusual circumstances, or where more specific rules regarding population of other data fields used in the [Healthcare Resource Group](#) Payment Grouper cannot be implemented due to local system restrictions.

[COMMISSIONING SERIAL NUMBER](#) will be replaced with [NHS SERVICE AGREEMENT IDENTIFIER](#), which is the most recent approved national information standard to describe the required definition.

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#### NHS SERVICE AGREEMENT LINE IDENTIFIER

---

Change to Data Element: Changed Dataset

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

**Notes:**

[NHS SERVICE AGREEMENT LINE IDENTIFIER](#) is the same as attribute [NHS SERVICE AGREEMENT LINE IDENTIFIER](#).

[NHS SERVICE AGREEMENT LINE NUMBER](#) will be replaced with [NHS SERVICE AGREEMENT LINE IDENTIFIER](#), which is the most recent approved national information standard to describe the required definition.

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#### OBSERVATION VALUE

---

Change to Data Element: Changed Dataset

Format/Length:	max an10
National Codes:	
Default Codes:	

**Notes:**

[OBSERVATION VALUE](#) is the same as attribute [OBSERVATION VALUE](#).

---

#### ORGANISATION IDENTIFIER (CDS RECIPIENT)

---

Change to Data Element: Changed Dataset

Format/Length:	min an3 max an5
National Codes:	
Default Codes:	TDH00 - <a href="#">Overseas Visitor</a> exempt from charges VPP00 - Private <a href="#">PATIENTS</a> / <a href="#">Overseas Visitor</a> liable for charges

**Notes:**

[ORGANISATION IDENTIFIER \(CDS RECIPIENT\)](#) is the same as attribute [ORGANISATION IDENTIFIER](#).

[ORGANISATION IDENTIFIER \(CDS RECIPIENT\)](#) is the NHS [ORGANISATION IDENTIFIER](#) (or valid [Organisation Data Service Default Code](#)) for an [ORGANISATION](#) identified as a recipient of the commissioning data set data.

**Usage:**

A maximum of 7 [ORGANISATION IDENTIFIERS \(CDS RECIPIENT\)](#) may be submitted. The submission order does not infer the primacy of one recipient over another.

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.

Where [NHS England](#) is the responsible Commissioner for a specialised [SERVICE](#), based on the [NHS England Commissioner Assignment Method \(CAM\)](#), one of the [Specialised Commissioning Hub ORGANISATION IDENTIFIERS](#) should be used depending on which [Health Care Provider](#) delivered the [SERVICE](#), e.g. [NHS Trust](#), [Independent Sector Healthcare Provider](#).

The [NHS Digital](#) website provides a mapping list of which [Health Care Providers](#) map to which [Specialised Commissioning Hub](#). The mapping can be found on the [Organisation Data Service](#) web pages at: [Provider to Commissioning Hub Mapping](#).

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
  - a valid [ORGANISATION IDENTIFIER \(RESIDENCE RESPONSIBILITY\)](#) must be reported where a recipient of commissioning data is specified
- X98 - Primary Care Organisation Not Applicable ([Overseas Visitors](#)).

**[CDS PRIME RECIPIENT IDENTITY](#) and [CDS COPY RECIPIENT IDENTITY](#) will be replaced with [ORGANISATION IDENTIFIER \(CDS RECIPIENT\)](#), which is the most recent approved national information standard to describe the required definition.**

---

#### ORGANISATION IDENTIFIER (CDS SENDER)

---

Change to Data Element: Changed Dataset

Format/Length: min an3 max an5

National Codes:

Default Codes:

#### Notes:

[ORGANISATION IDENTIFIER \(CDS SENDER\)](#) is the same as attribute [ORGANISATION IDENTIFIER](#).

[ORGANISATION IDENTIFIER \(CDS SENDER\)](#) is the mandatory [ORGANISATION IDENTIFIER](#) 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:

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

For further guidance see the [Commissioning Data Set Submission Protocol](#).

[CDS SENDER IDENTITY](#) will be replaced with [ORGANISATION IDENTIFIER \(CDS SENDER\)](#), which is the most recent approved national information standard to describe the required definition.

---

#### ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)

---

Change to Data Element: Changed Dataset

Format/Length:	min an3 max an5
National Codes:	
Default Codes:	VPP00 - Private <a href="#">PATIENTS</a> / <a href="#">Overseas Visitor</a> liable for charge XMD00 - Commissioner Code for Ministry of Defence (MoD) Healthcare YDD82 - Episodes funded directly by the National Commissioning Group for England (Retired September 2018)

#### Notes:

[ORGANISATION IDENTIFIER \(CODE OF COMMISSIONER\)](#) is the same as attribute [ORGANISATION IDENTIFIER](#).

[ORGANISATION IDENTIFIER \(CODE OF COMMISSIONER\)](#) is the [ORGANISATION IDENTIFIER](#) of the [ORGANISATION](#) commissioning health care.

For [Commissioning Data Sets](#), the [ORGANISATION IDENTIFIER \(CODE OF COMMISSIONER\)](#) should always be the [ORGANISATION IDENTIFIER](#) of the original commissioner to support the [National Tariff Payment System](#).

The [NHS England](#) document "[Who Pays? Determining responsibility for NHS payments to providers](#)" sets out a framework for establishing responsibility for commissioning and paying for a [PATIENT](#)'s care within the NHS.

The document includes information on the following:

- General Rules
- Applying the rules to [Integrated Care Board](#) and [NHS England](#) commissioned [SERVICES](#)
- Exceptions to the general rules
- Examples to help clarify the boundaries of responsibility between commissioning [ORGANISATIONS](#).

For further information on this document contact: [england.responsiblecommissioner@nhs.net](mailto:england.responsiblecommissioner@nhs.net).

Where [NHS England](#) is the responsible commissioner for a specialised [SERVICE](#), based on the [NHS England Commissioner Assignment Method \(CAM\)](#), one of the [Specialised Commissioning Hub ORGANISATION IDENTIFIERS](#) should be used depending on which [Health Care Provider](#) delivered the [SERVICE](#), e.g. [NHS Trust](#), [Independent Sector Healthcare Provider](#).

The [NHS Digital](#) website provides a mapping list of which [Health Care Providers](#) map to which [Specialised Commissioning Hub](#). The mapping can be found on the [Organisation Data Service](#) web pages at: [Provider to Commissioning Hub Mapping](#).

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

---

**ORGANISATION IDENTIFIER (CODE OF PROVIDER)**

---

Change to Data Element: Changed Dataset

Format/Length:	min an3 max an6
National Codes:	
Default Codes:	89997 - Non-UK provider where no <a href="#">ORGANISATION IDENTIFIER</a> has been issued
	89999 - Non-NHS UK provider where no <a href="#">ORGANISATION IDENTIFIER</a> has been issued

**Notes:**

[ORGANISATION IDENTIFIER \(CODE OF PROVIDER\)](#) is the same as 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)**, which is the most recent approved national information standard to describe the required definition.

---

**ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST)**

---

Change to Data Element: Changed Dataset

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](#).

[ORGANISATION CODE \(CONVEYING AMBULANCE TRUST\)](#) will be replaced with [ORGANISATION IDENTIFIER \(CONVEYING AMBULANCE TRUST\)](#), which is the most recent approved national information standard to describe the required definition.

---

#### 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 \(LOCAL PATIENT IDENTIFIER\)](#), which is the most recent approved national information standard to describe the required definition.

---

#### ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)

---

Change to Data Element: Changed Dataset

Format/Length:	min an3 max an5
National Codes:	
Default Codes:	Q99 - High Level Health Geography/Primary Care <a href="#">ORGANISATION</a> 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 <a href="#">ORGANISATION</a> Not Applicable ( <a href="#">Overseas Visitors</a> ) 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](#).

This is where the [PATIENT](#) resides within the boundary of a:

- [Sub Integrated Care Board Location](#)
- [Care Trust](#)
- [Local Health Board \(Wales\)](#)
- [Scottish Health Board](#)
- [Northern Ireland Local Commissioning Group](#)
- [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 / ORGANISATION IDENTIFIER \(CDS RECIPIENT\)](#) which is derived from the [ORGANISATION IDENTIFIER \(RESIDENCE RESPONSIBILITY\)](#).

**[ORGANISATION CODE \(RESIDENCE RESPONSIBILITY\)](#) will be replaced with [ORGANISATION IDENTIFIER \(RESIDENCE RESPONSIBILITY\)](#), which is the most recent approved national information standard to describe the required definition.**

---

#### **ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE)**

---

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no <a href="#">ORGANISATION SITE IDENTIFIER</a> has been issued
	89997 - Non-UK Provider where no <a href="#">ORGANISATION SITE IDENTIFIER</a> has been issued

#### **Notes:**

[ORGANISATION SITE IDENTIFIER \(DISCHARGE FROM EMERGENCY CARE\)](#) is the same as attribute [ORGANISATION SITE IDENTIFIER](#).

[ORGANISATION SITE IDENTIFIER \(DISCHARGE FROM EMERGENCY CARE\)](#) is the [ORGANISATION SITE IDENTIFIER](#) of the [ORGANISATION SITE](#) to which a [PATIENT](#) is discharged following an [Emergency Care Attendance](#).

This Data Element should only be completed in [CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set / CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set / Emergency Care Data Set Version 4](#) where the [PATIENT](#) is discharged to continue treatment at another secondary care [ORGANISATION SITE](#), which may be part of the same [Health Care Provider](#) or at a different [NHS Foundation Trust](#) or [NHS Trust](#).

---

**ORGANISATION SITE IDENTIFIER (DISCHARGE FROM URGENT AND EMERGENCY CARE)**

---

Change to Data Element: New Data Element

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no <u>ORGANISATION SITE IDENTIFIER</u> has been issued
	89997 - Non-UK Provider where no <u>ORGANISATION SITE IDENTIFIER</u> has been issued

**Notes:**

ORGANISATION SITE IDENTIFIER (DISCHARGE FROM URGENT AND EMERGENCY CARE) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (DISCHARGE FROM URGENT AND EMERGENCY CARE) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE to which a PATIENT is discharged following Urgent and Emergency Care Activity.

This Data Element should only be completed where the PATIENT is discharged to continue treatment at another secondary care ORGANISATION SITE, which may be part of the same Health Care Provider or at a different NHS Foundation Trust or NHS Trust.

**This data element is also known by these names:**

Context	Alias
plural	<u>ORGANISATION SITE IDENTIFIERS (DISCHARGE FROM URGENT AND EMERGENCY CARE)</u>

---

**ORGANISATION SITE IDENTIFIER (DISCHARGE FROM URGENT AND EMERGENCY CARE)**

---

Change to Data Element: New Data Element

**ORGANISATION SITE IDENTIFIER (DISCHARGE FROM URGENT AND EMERGENCY CARE)****Attribute:**

<u>ORGANISATION SITE IDENTIFIER</u>
-------------------------------------

---

**ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE)**

---

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
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National Codes:

Default Codes: 89999 - Non-NHS UK Provider where no [ORGANISATION SITE IDENTIFIER](#) has been issued  
89997 - Non-UK Provider where no [ORGANISATION SITE IDENTIFIER](#) has been issued

**Notes:**

[ORGANISATION SITE IDENTIFIER \(EMERGENCY CARE ATTENDANCE SOURCE\)](#) is the same as attribute [ORGANISATION SITE IDENTIFIER](#).

[ORGANISATION SITE IDENTIFIER \(EMERGENCY CARE ATTENDANCE SOURCE\)](#) is the [ORGANISATION SITE IDENTIFIER](#) of the [ORGANISATION SITE](#) from which a [PATIENT](#) arrived at an [Emergency Care Department](#).

This Data Element should only be completed in [CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set / CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set / Emergency Care Data Set Version 4](#) where the [PATIENT](#) has arrived from a different secondary care [ORGANISATION SITE](#) which may be part of the same [Health Care Provider](#) or a different [NHS Foundation Trust](#) or [NHS Trust](#).

---

**ORGANISATION SITE IDENTIFIER (OF TREATMENT)**

---

Change to Data Element: Changed Dataset

Format/Length: min an5 max an9  
National Codes:  
Default Codes: R9998 - Not a hospital site  
89999 - Non-NHS UK Provider where no [ORGANISATION SITE IDENTIFIER](#) has been issued  
89997 - Non-UK Provider where no [ORGANISATION SITE IDENTIFIER](#) has been issued

**Notes:**

[ORGANISATION SITE IDENTIFIER \(OF TREATMENT\)](#) is the same as attribute [ORGANISATION SITE IDENTIFIER](#).

[ORGANISATION SITE IDENTIFIER \(OF TREATMENT\)](#) is the [ORGANISATION SITE 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 SITE 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 SITE IDENTIFIER](#) has been issued' is applicable.

Each [ORGANISATION](#) has a unique [ORGANISATION SITE 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 SITE IDENTIFIER](#).

For out-patients, [ACTIVITY](#) may take place outside the hospital, such as in the [PATIENT'S](#) home; in such cases, raising a site code is impractical. Therefore, code R9998 'Not a hospital site' would be used in these circumstances.

*Note: [LOCATION CLASS](#) is used in the Commissioning Data Set (CDS) message to indicate the 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 \(OF TREATMENT\)](#), which is the most recent approved national information standard to describe the required definition.

**ORGANISATION SITE IDENTIFIER (URGENT AND EMERGENCY CARE ATTENDANCE SOURCE)**

Change to Data Element: New Data Element

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no <a href="#">ORGANISATION SITE IDENTIFIER</a> has been issued
	89997 - Non-UK Provider where no <a href="#">ORGANISATION SITE IDENTIFIER</a> has been issued

**Notes:**

[ORGANISATION SITE IDENTIFIER \(URGENT AND EMERGENCY CARE ATTENDANCE SOURCE\)](#) is the same as attribute [ORGANISATION SITE IDENTIFIER](#).

[ORGANISATION SITE IDENTIFIER \(URGENT AND EMERGENCY CARE ATTENDANCE SOURCE\)](#) is the [ORGANISATION SITE IDENTIFIER](#) of the [ORGANISATION SITE](#) from which a [PATIENT](#) arrived at an Urgent and Emergency Care Service.

This Data Element should only be completed where the [PATIENT](#) has arrived from a different secondary care [ORGANISATION SITE](#) which may be part of the same [Health Care Provider](#) or a different [NHS Foundation Trust](#) or [NHS Trust](#).

**This data element is also known by these names:**

Context	Alias

plural

ORGANISATION SITE IDENTIFIERS (URGENT AND EMERGENCY CARE ATTENDANCE SOURCE)

---

**ORGANISATION SITE IDENTIFIER (URGENT AND EMERGENCY CARE ATTENDANCE SOURCE)**

---

Change to Data Element: New Data Element

**ORGANISATION SITE IDENTIFIER (URGENT AND EMERGENCY CARE ATTENDANCE SOURCE)**

**Attribute:**

ORGANISATION SITE IDENTIFIER

---

**OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE**

---

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See <a href="#">OVERSEAS VISITOR CHARGING CATEGORY</a>
Default Codes:	9 - <a href="#">OVERSEAS VISITOR CHARGING CATEGORY</a> Not Known (Not Recorded) X - Not Known (Decision pending on OVERSEAS VISITOR CHARGING CATEGORY): only valid for CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set (Retired March 2022)

**Notes:**

[OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE](#) is the same as attribute [OVERSEAS VISITOR CHARGING CATEGORY](#), recorded at the [CDS ACTIVITY DATE](#).

[OVERSEAS VISITOR STATUS](#) information must be collected in accordance with the [Overseas Visitor Charging Category Information Standard: DCB3017](#).

---

**PATIENT FAMILY NAME**

---

Change to Data Element: Changed Dataset

Format/Length:	max an35
National Codes:	
Default Codes:	

**Notes:**

[PATIENT FAMILY NAME](#) is the same as attribute [PERSON NAME WORD TEXT](#) where the [PERSON NAME WORD TYPE](#) is National Code 'Person Family Name'.

[PATIENT FAMILY NAME](#) is the [PERSON FAMILY NAME](#) of the [PATIENT](#).

---

**PATIENT FULL NAME**

---

Change to Data Element: Changed Dataset

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

**Notes:**

[PATIENT FULL NAME](#) is the same as attribute [PERSON NAME WORD TEXT](#).

[PATIENT FULL NAME](#) is the preferred [PERSON FULL NAME](#) of the [PATIENT](#).

The [PATIENT](#)'s name and [ADDRESS](#) should be withheld from any [Commissioning Data Set](#) that contains a valid [NHS NUMBER](#). For further information, see the [Security Issues and Patient Confidentiality](#).

---

**PATIENT GIVEN NAME**

Change to Data Element: Changed Dataset

Format/Length:	max an35
National Codes:	
Default Codes:	

**Notes:**

[PATIENT GIVEN NAME](#) is the same as attribute [PERSON NAME WORD TEXT](#) where the [PERSON NAME WORD TYPE](#) is National Code '*Person Given Name*'.

[PATIENT GIVEN NAME](#) is the [PERSON GIVEN NAME](#) of the [PATIENT](#).

---

**PATIENT INITIALS**

Change to Data Element: Changed Dataset

Format/Length:	max an35
National Codes:	
Default Codes:	

**Notes:**

[PATIENT INITIALS](#) is the same as attribute [PERSON NAME WORD TEXT](#) where the [PERSON NAME WORD TYPE](#) is National Code '*Person Initials*'.

[PATIENT INITIALS](#) is the [PERSON INITIALS](#) of the [PATIENT](#).

---

**PATIENT NAME SUFFIX**

Change to Data Element: Changed Dataset

Format/Length:	max an35
National Codes:	

Default Codes:

**Notes:**

[PATIENT NAME SUFFIX](#) is the same as attribute [PERSON NAME WORD TEXT](#) where the [PERSON NAME WORD TYPE](#) is National Code '*Person Name Suffix*'.

[PATIENT NAME SUFFIX](#) is the [PERSON NAME SUFFIX](#) of the [PATIENT](#).

---

**PATIENT TITLE**

Change to Data Element: Changed Dataset

Format/Length: max an35

National Codes:

Default Codes:

**Notes:**

[PATIENT TITLE](#) is the same as attribute [PERSON NAME WORD TEXT](#) where the [PERSON NAME WORD TYPE](#) is National Code '*Person Title*'.

[PATIENT TITLE](#) is the [PERSON TITLE](#) of the [PATIENT](#).

---

**PATIENT USUAL ADDRESS (STRUCTURED)**

Change to Data Element: Changed Dataset

Format/Length: max an35

National Codes:

Default Codes:

**Notes:**

[PATIENT USUAL ADDRESS \(STRUCTURED\)](#) is the same as attribute [ADDRESS](#).

[PATIENT USUAL ADDRESS \(STRUCTURED\)](#) is the usual [ADDRESS STRUCTURED](#) nominated by the [PATIENT](#), where the [ADDRESS ASSOCIATION TYPE](#) is National Code '*Main Permanent Residence*' or '*Other Permanent Residence*'.

[PATIENT USUAL ADDRESS \(STRUCTURED\)](#) requires submission of at least the first two lines of the [ADDRESS](#) of the [PATIENT](#). The format refers to the physical layout of the [ADDRESS](#), not the logical layout, and does not require intelligent intervention when splitting the text string into lines. For example:

Flat 1, 21 Arbuthnott Avenue, Pollo (35 characters)

k Estate, Lesser Hinkley, Staffords (35 characters)

hire (4 chars)

If [PATIENTS](#) usually resident elsewhere are staying in hotels, hostels or other residential establishments for a short period of time, they should be recorded as staying at their usual permanent place of residence. However if the [PATIENT](#)s stay is long term, for example if they are

resident at a boarding school, the [School ADDRESS](#) must be recorded. [University](#) students may nominate either their home [ADDRESS](#) or the [ADDRESS](#) of their [University ACCOMMODATION](#).

Where [PATIENTS](#) do not have the capacity to supply this information, because of mental illness, for example, then the [PERSON](#) responsible for the [PATIENT](#) such as a parent, guardian or other representative should nominate the [PATIENT USUAL ADDRESS \(UNSTRUCTURED\)](#).

[PATIENTS](#) not able to provide a current permanent [ADDRESS](#) should be asked for their most recent [ADDRESS](#). If this cannot be established, record the [ADDRESS](#) as 'No fixed abode' or 'Address unknown'. These [PATIENTS](#) are regarded as resident in the local geographical district for commissioning purposes.

For the baby in a birth episode, the [PATIENT USUAL ADDRESS \(UNSTRUCTURED\)](#) should usually refer to the mother's usual permanent place of residence, unless different circumstances apply (for example the baby is to be taken into care after birth).

The [PATIENT](#)'s name and [ADDRESS](#) should be withheld from any [Commissioning Data Set](#) record which contains a valid [NHS NUMBER](#).

---

#### **PATIENT USUAL ADDRESS (UNSTRUCTURED)**

---

Change to Data Element: Changed Dataset

Format/Length: max an175

National Codes:

Default Codes:

#### **Notes:**

[PATIENT USUAL ADDRESS \(UNSTRUCTURED\)](#) is the same as attribute [ADDRESS](#).

[PATIENT USUAL ADDRESS \(UNSTRUCTURED\)](#) is the usual [ADDRESS UNSTRUCTURED](#) nominated by the [PATIENT](#), where the [ADDRESS ASSOCIATION TYPE](#) is National Code 'Main Permanent Residence' or 'Other Permanent Residence'.

If [PATIENTS](#) usually resident elsewhere are staying in hotels, hostels or other residential establishments for a short period of time, they should be recorded as staying at their usual permanent place of residence. However if the [PATIENT](#)'s stay is long term, for example if they are resident at a boarding school, the [School ADDRESS](#) must be recorded. [University](#) students may nominate either their home [ADDRESS](#) or the [ADDRESS](#) of their [University ACCOMMODATION](#).

Where [PATIENTS](#) do not have the capacity to supply this information, because of mental illness, for example, then the [PERSON](#) responsible for the [PATIENT](#) such as a parent, guardian or other representative should nominate the [PATIENT USUAL ADDRESS \(UNSTRUCTURED\)](#).

[PATIENTS](#) not able to provide a current permanent [ADDRESS](#) should be asked for their most recent [ADDRESS](#). If this cannot be established, record the [ADDRESS](#) as 'No fixed abode' or 'Address unknown'. These [PATIENTS](#) are regarded as resident in the local geographical district for commissioning purposes.

For the baby in a birth episode, the [PATIENT USUAL ADDRESS \(UNSTRUCTURED\)](#) should usually refer to the mother's usual permanent place of residence, unless different circumstances apply (for example the baby is to be taken into care after birth).

The [PATIENT](#)'s name and [ADDRESS](#) should be withheld from any [Commissioning Data Set](#) record which contains a valid [NHS NUMBER](#).

---

#### PERSON BIRTH DATE

---

Change to Data Element: Changed Dataset

Format/Length:	an10 CCYY-MM-DD
<a href="#">NWDS</a> ID:	PEBD
<a href="#">NWDS</a> Field Name:	Date of Birth
National Codes:	
Default Codes:	

#### Notes:

[PERSON BIRTH DATE](#) is the same as attribute [PERSON BIRTH DATE](#).

---

#### PERSON SCORE

---

Change to Data Element: Changed Dataset

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

#### Notes:

[PERSON SCORE](#) is the same as attribute [PERSON SCORE](#).

---

#### PERSON STATED GENDER CODE

---

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See <a href="#">PERSON STATED GENDER CODE</a>
Default Codes:	X - Not Known ( <a href="#">PERSON STATED GENDER CODE</a> not recorded)

#### Notes:

[PERSON STATED GENDER CODE](#) is the same as attribute [PERSON STATED GENDER CODE](#).

[PERSON GENDER CODE CURRENT](#) will be replaced with [PERSON STATED GENDER CODE](#) or [PERSON PHENOTYPIC SEX](#), which are the most recent approved national information standards to describe the required definition.

---

#### POSTCODE OF USUAL ADDRESS

---

Change to Data Element: Changed Dataset

Format/Length:	max an8
National Codes:	

Default Codes:

**Notes:**

[POSTCODE OF USUAL ADDRESS](#) is the same as attribute [POSTCODE](#).

[POSTCODE OF USUAL ADDRESS](#) is the [POSTCODE](#) of the [ADDRESS](#) nominated by the [PATIENT](#) where the [ADDRESS ASSOCIATION TYPE](#) is National Code 'Main Permanent Residence' or 'Other Permanent Residence'.

For further information on [POSTCODES](#), see [POSTCODE](#).

---

**PREFERRED SPOKEN LANGUAGE (SNOMED CT)**

Change to Data Element: Changed Dataset

Format/Length:	See <a href="#">SNOMED CT CODE</a>
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 Refset:](#)

- [Refset](#) FSN: Preferred spoken language findings simple reference set
- [Refset](#) Id: 991181000000109

For further details relating to the [SNOMED CT Refset](#), see the [SNOMED CT Browser](#) at: [Preferred spoken language findings simple reference set \(foundation metadata concept\)](#).

---

**PROFESSIONAL REGISTRATION ENTRY IDENTIFIER**

Change to Data Element: Changed Dataset

Format/Length:	max an32
<a href="#">NWDS</a> ID:	EPRN
<a href="#">NWDS</a> 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](#)

*Permitted National Codes:*

- 02 [General Dental Council](#)
- 03 [General Medical Council](#)
- 04 [General Optical Council](#)
- 08 [Health and Care Professions Council](#)
- 09 [Nursing and Midwifery Council](#)
- 16 [General Pharmaceutical Council](#)

Notes:

- National Code 04 '[General Optical Council](#)' is only valid for [CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set / CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set / Commissioning Data Sets](#) version 6-3, and must not be submitted in other [Commissioning Data Set](#) versions
- National Code 16 '[General Pharmaceutical Council](#)' is only valid for [CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set / Commissioning Data Sets](#) version 6-3, and must not be submitted in other [Commissioning Data Set](#) versions.

---

**PROVIDER REFERENCE IDENTIFIER**

Change to Data Element: Changed Dataset

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

**Notes:**

[PROVIDER REFERENCE IDENTIFIER](#) is the same as attribute [PROVIDER REFERENCE IDENTIFIER](#).

**[PROVIDER REFERENCE NUMBER](#) will be replaced with [PROVIDER REFERENCE IDENTIFIER](#), which is the most recent approved national information standard to describe the required definition.**

---

**REFERRED TO SERVICE (SNOMED CT)**

Change to Data Element: Changed Dataset

Format/Length:	See <a href="#">SNOMED CT CODE</a>
----------------	------------------------------------

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 Refset](#):

- [Refset](#) FSN: Emergency care referral procedures simple reference set (foundation metadata concept)
- [Refset](#) Id: 991451000000108

For further details relating to the [SNOMED CT Refset](#), see the [SNOMED CT Browser](#) at: [Emergency care referral procedures simple reference set \(foundation metadata concept\)](#).

---

**REFERRED TO SERVICE ASSESSMENT TIMESTAMP**

---

Change to Data Element: New Data Element

Format/Length: max an25

National Codes:

Default Codes:

**Notes:**

[REFERRED TO SERVICE ASSESSMENT TIMESTAMP](#) is the same as attribute [ACTIVITY DATE](#) and [ACTIVITY TIME](#).

[REFERRED TO SERVICE ASSESSMENT TIMESTAMP](#) is the [Clinical Intervention Date](#), [Clinical Intervention Time](#) and time zone a [PATIENT](#) was assessed by a [CARE PROFESSIONAL](#) from a [SERVICE](#) to which the [PATIENT](#) had been referred.

A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time.

In most cases offset time is restricted to:

- +01:00
- +00:00
- -00:00

Examples of valid formats are:

- 2020-08-21T10:15:20+01:00 British Summer Time (GMT + 1 Hour)
- 2020-12-21T10:15:20+00:00 Greenwich Mean Time

- 2020-12-21T10:15:20-00:00 Greenwich Mean Time
- 2020-12-21T09:18:00Z Greenwich Mean Time.

This data element is also known by these names:

Context	Alias
plural	REFERRED TO SERVICE ASSESSMENT TIMESTAMPS

---

REFERRED TO SERVICE ASSESSMENT TIMESTAMP

---

Change to Data Element: New Data Element

## REFERRED TO SERVICE ASSESSMENT TIMESTAMP

Attribute:

<a href="#">ACTIVITY DATE</a>
<a href="#">ACTIVITY TIME</a>

---

SAFEGUARDING CONCERN (SNOMED CT)

---

Change to Data Element: Changed Dataset

Format/Length:	See <a href="#">SNOMED CT CODE</a>
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 Refset](#):

- [Refset](#) FSN: Safeguarding issues simple reference set (foundation metadata concept)
- [Refset](#) Id: 999002381000000108

For further details relating to the [SNOMED CT Refset](#), see the [SNOMED CT Browser](#) at: [Safeguarding issues simple reference set \(foundation metadata concept\)](#).

---

SERVICE CODE

---

Change to Data Element: Changed Dataset

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

**Notes:**

[SERVICE CODE](#) is the same as attribute [SERVICE CODE](#).

The [SERVICE CODE](#) National Codes are published by [NHS England](#) and can be accessed at: [Directly commissioned services reporting requirements](#).

---

**SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT)**

---

Change to Data Element: Changed Dataset

Format/Length:	See <a href="#">SNOMED CT CODE</a>
National Codes:	
Default Codes:	

**Notes:**

[SOCIAL AND PERSONAL CIRCUMSTANCE \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

[SOCIAL AND PERSONAL CIRCUMSTANCE \(SNOMED CT\)](#) is the [SNOMED CT](#)® concept ID which is used to identify a social and personal circumstance for a [PERSON](#).

---

**SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP**

---

Change to Data Element: Changed Dataset, Description

Format/Length:	max an25
National Codes:	
Default Codes:	

**Notes:**

[SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP](#) is the same as attribute [PERSON PROPERTY RECORDED DATE](#) and [PERSON PROPERTY RECORDED TIME](#).

[SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP](#) is the date, time and time zone when the [SOCIAL AND PERSONAL CIRCUMSTANCE \(SNOMED CT\)](#) was recorded.

A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time.

In most cases offset time is restricted to:

- +01:00
- +00:00
- -00:00

Examples of valid formats are:

- 2020-08-21T10:15:20+01:00 British Summer Time (GMT + 1 Hour)
- 2020-08-21T10:15:20+00:00 Greenwich Mean Time
- 2020-08-21T10:15:20-00:00 Greenwich Mean Time
- 2020-08-21T09:18:00Z Greenwich Mean Time.
- 2020-12-21T10:15:20+00:00 Greenwich Mean Time
- 2020-12-21T10:15:20-00:00 Greenwich Mean Time
- 2020-12-21T09:18:00Z Greenwich Mean Time.

---

#### START DATE (COMMISSIONER ASSIGNMENT PERIOD)

---

Change to Data Element: Changed Dataset

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

#### Notes:

[START DATE \(COMMISSIONER ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY DATE](#).

[START DATE \(COMMISSIONER ASSIGNMENT PERIOD\)](#) is the [Start Date](#) of the [Commissioner Assignment Period](#).

---

#### UNIT OF MEASUREMENT (UCUM)

---

Change to Data Element: Changed Dataset

Format/Length:	an
National Codes:	
Default Codes:	

#### Notes:

[UNIT OF MEASUREMENT \(UCUM\)](#) is the same as attribute [UCUM UNIT OF MEASUREMENT](#).

~~This item is being used for development purposes and has not yet been approved.~~ The allowed length for a [UNIT OF MEASUREMENT \(UCUM\)](#) data element may vary between different data sets. For information about constraints applied to this data element in specific data sets, see [XML Schema and Data Set Constraints](#).

[UCUM UNIT OF MEASUREMENT](#) will be replaced with [UNIT OF MEASUREMENT \(UCUM\)](#), which is the most recent approved national information standards to describe the required definition.

---

#### URGENT AND EMERGENCY CARE ACTIVITY END TIMESTAMP

---

Change to Data Element: New Data Element

Format/Length:	max an25
National Codes:	
Default Codes:	

**Notes:**

URGENT AND EMERGENCY CARE ACTIVITY END TIMESTAMP is the same as attribute ACTIVITY DATE and ACTIVITY TIME for the '*Urgent and Emergency Care Activity End Timestamp*'.

A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time.

In most cases offset time is restricted to:

- +01:00
- +00:00
- -00:00

Examples of valid formats are:

- 2020-08-21T10:15:20+01:00 British Summer Time (GMT + 1 Hour)
- 2020-12-21T10:15:20+00:00 Greenwich Mean Time
- 2020-12-21T10:15:20-00:00 Greenwich Mean Time
- 2020-12-21T09:18:00Z Greenwich Mean Time.

**This data element is also known by these names:**

Context	Alias
plural	URGENT AND EMERGENCY CARE ACTIVITY END TIMESTAMPS

---

**URGENT AND EMERGENCY CARE ACTIVITY END TIMESTAMP**

---

Change to Data Element: New Data Element

**URGENT AND EMERGENCY CARE ACTIVITY END TIMESTAMP**

**Attribute:**

<u>ACTIVITY DATE</u>
<u>ACTIVITY TIME</u>

---

**URGENT AND EMERGENCY CARE ACTIVITY IDENTIFIER**

---

Change to Data Element: New Data Element

Format/Length:	min an1 max an20
National Codes:	
Default Codes:	

**Notes:**

URGENT AND EMERGENCY CARE ACTIVITY IDENTIFIER is same as attribute ACTIVITY IDENTIFIER.

URGENT AND EMERGENCY CARE ACTIVITY IDENTIFIER is an identifier allocated by an Urgent and Emergency Care Service to provide a unique identifier for each URGENT AND EMERGENCY CARE ACTIVITY TYPE.

These are:

- Emergency Care Attendances (where the URGENT AND EMERGENCY CARE ACTIVITY TYPE is National Code *'Emergency Care Attendance at an Emergency Care Department type 'Major Emergency Care Department'* or *'Emergency Care Attendance at an Emergency Care Department Type Mono-specialty 'Emergency Care Department'* or *'Emergency Care Attendance at an Emergency Care Department type 'Urgent Treatment Centre'*)
- Same Day Emergency Care Attendances (where the URGENT AND EMERGENCY CARE ACTIVITY TYPE is *'Same Day Emergency Care Attendance'*)
- Urgent and Emergency Care Extended Care Episodes (where the URGENT AND EMERGENCY CARE ACTIVITY TYPE is *'Urgent and Emergency Care Extended Care Episode'*)
- Hot Clinic Attendances (where the URGENT AND EMERGENCY CARE ACTIVITY TYPE is *'Hot Clinic Attendance'*). Note this is **only** valid for piloting purposes.

Usage in Emergency Care Data Set Version 4:

For an Emergency Care Attendance, URGENT AND EMERGENCY CARE ACTIVITY IDENTIFIER is the same as the EMERGENCY CARE ATTENDANCE IDENTIFIER in previous Emergency Care Data Sets (CDS V6-2-2 Type 011 - Emergency Care CDS and CDS V6-2-3 Type 011 - Emergency Care CDS), but the format/length is extended to max an20 characters for Emergency Care Data Set Version 4.

For a Same Day Emergency Care Attendance, the URGENT AND EMERGENCY CARE ACTIVITY IDENTIFIER should carry a system-generated unique identifier for each Same Day Emergency Care Attendance undertaken by the Health Care Provider.

For an Urgent and Emergency Care Extended Care Episode, the URGENT AND EMERGENCY CARE ACTIVITY IDENTIFIER should carry the URGENT AND EMERGENCY CARE EXTENDED CARE EPISODE IDENTIFIER (which is a system generated unique identifier for each Urgent and Emergency Care Extended Care Episode).

There should be no overlap or duplication of identifiers between URGENT AND EMERGENCY CARE ACTIVITY IDENTIFIERS generated by the Urgent and Emergency Care Service's ELECTRONIC HEALTH RECORD system used to record each of these types of activity.

For example, it is not permissible to generate the same URGENT AND EMERGENCY CARE ACTIVITY IDENTIFIER to be used for both an Emergency Care Attendance and a Same Day Emergency Care Attendance. Each ACTIVITY IDENTIFIER must be unique within the Health Care Provider and ORGANISATION SITE IDENTIFIER (OF TREATMENT).

**This data element is also known by these names:**

Context	Alias
plural	URGENT AND EMERGENCY CARE ACTIVITY IDENTIFIERS

---

**URGENT AND EMERGENCY CARE ACTIVITY IDENTIFIER**

Change to Data Element: New Data Element

**URGENT AND EMERGENCY CARE ACTIVITY IDENTIFIER**

**Attribute:**

<u>ACTIVITY IDENTIFIER</u>
----------------------------

---

**URGENT AND EMERGENCY CARE ACTIVITY START DATE AND TIME**

Change to Data Element: New Data Element

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

**Notes:**

URGENT AND EMERGENCY CARE ACTIVITY START DATE AND TIME is the same as attribute ACTIVITY DATE and ACTIVITY TIME for the '*Urgent and Emergency Care Activity Start Date and Time*'.

**This data element is also known by these names:**

Context	Alias
plural	URGENT AND EMERGENCY CARE ACTIVITY START DATES AND TIMES

---

**URGENT AND EMERGENCY CARE ACTIVITY START DATE AND TIME**

Change to Data Element: New Data Element

**URGENT AND EMERGENCY CARE ACTIVITY START DATE AND TIME**

**Attribute:**

<u>ACTIVITY DATE</u>
<u>ACTIVITY TIME</u>

---

**URGENT AND EMERGENCY CARE ACTIVITY TYPE**

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See <u>URGENT AND EMERGENCY CARE ACTIVITY TYPE</u>
Default Codes:	

**Notes:**

URGENT AND EMERGENCY CARE ACTIVITY TYPE is the same as attribute URGENT AND EMERGENCY CARE ACTIVITY TYPE.

**This data element is also known by these names:**

Context	Alias
plural	<u>URGENT AND EMERGENCY CARE ACTIVITY TYPES</u>

**URGENT AND EMERGENCY CARE ACTIVITY TYPE**

Change to Data Element: New Data Element

**URGENT AND EMERGENCY CARE ACTIVITY TYPE**

**Attribute:**

<u>URGENT AND EMERGENCY CARE ACTIVITY TYPE</u>
------------------------------------------------

**URGENT AND EMERGENCY CARE ACUITY (SNOMED CT)**

Change to Data Element: New Data Element

Format/Length:	<u>See SNOMED CT CODE</u>
National Codes:	
Default Codes:	

**Notes:**

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

URGENT AND 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 Urgent and Emergency Care Initial Assessment Timestamp.

The URGENT AND 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 Refset:**

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

For further details relating to the SNOMED CT Refset, see the SNOMED CT Browser at: Emergency care acuity simple reference set (foundation metadata concept).

**This data element is also known by these names:**

--

Context	Alias
snomedctrefsetname	Emergency care acuity simple reference set (foundation metadata concept)
plural	URGENT AND EMERGENCY CARE ACUITIES (SNOMED CT)
snomedctrefsetid	999003061000000107

---

**URGENT AND EMERGENCY CARE ACUITY (SNOMED CT)**

---

Change to Data Element: New Data Element

**URGENT AND EMERGENCY CARE ACUITY (SNOMED CT)**

Attribute:

CLINICAL TERMINOLOGY CODE
---------------------------

---

**URGENT AND EMERGENCY CARE ARRIVAL MODE (SNOMED CT)**

---

Change to Data Element: New Data Element

Format/Length:	See <a href="#">SNOMED CT CODE</a>
National Codes:	
Default Codes:	

**Notes:**

[URGENT AND EMERGENCY CARE ARRIVAL MODE \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

[URGENT AND 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 [Urgent and Emergency Care Service](#).

**[SNOMED CT Refset:](#)**

- [Refset FSN: Emergency care arrival mode simple reference set \(foundation metadata concept\)](#)
- [Refset Id: 999002981000000107](#)

For further details relating to the [SNOMED CT Refset](#), see the [SNOMED CT Browser](#) at: [Emergency care arrival mode simple reference set \(foundation metadata concept\)](#) .

**This data element is also known by these names:**

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

**URGENT AND EMERGENCY CARE ARRIVAL MODE (SNOMED CT)**

Change to Data Element: New Data Element

**URGENT AND EMERGENCY CARE ARRIVAL MODE (SNOMED CT)**

Attribute:

CLINICAL TERMINOLOGY CODE

**URGENT AND EMERGENCY CARE ATTENDANCE CATEGORY**

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See URGENT AND EMERGENCY CARE ATTENDANCE CATEGORY
Default Codes:	X - Not Applicable (PATIENT dead on arrival in an Urgent and Emergency Care Service)

**Notes:**

URGENT AND EMERGENCY CARE ATTENDANCE CATEGORY is the same as attribute URGENT AND EMERGENCY CARE ATTENDANCE CATEGORY.

**This data element is also known by these names:**

Context	Alias
plural	URGENT AND EMERGENCY CARE ATTENDANCE CATEGORIES

**URGENT AND EMERGENCY CARE ATTENDANCE CATEGORY**

Change to Data Element: New Data Element

**URGENT AND EMERGENCY CARE ATTENDANCE CATEGORY**

Attribute:

URGENT AND EMERGENCY CARE ATTENDANCE CATEGORY

**URGENT AND EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT)**

Change to Data Element: New Data Element

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

**Notes:**

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

**URGENT AND EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT)** is the SNOMED CT® concept ID which is used to indicate the source of an attendance at an Urgent and Emergency Care Service.

**SNOMED CT Refset:**

- Refset FSN: Emergency care attendance source simple reference set (foundation metadata concept)
- Refset Id: 999002991000000109

For further details relating to the SNOMED CT Refset, see the SNOMED CT Browser at: Emergency care attendance source simple reference set (foundation metadata concept).

**This data element is also known by these names:**

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

---

**URGENT AND EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT)**

---

Change to Data Element: New Data Element

**URGENT AND EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT)**

**Attribute:**

CLINICAL TERMINOLOGY CODE

---

**URGENT AND EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT)**

---

Change to Data Element: New Data Element

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

**Notes:**

**URGENT AND EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT)** is the same as attribute **CLINICAL TERMINOLOGY CODE**.

**URGENT AND 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** in an **Urgent and Emergency Care Service**.

**SNOMED CT Refset:**

- **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 Refset**, see the **SNOMED CT Browser** at: **Emergency care presenting complaints or issues simple reference set (foundation metadata concept)**.

**This data element is also known by these names:**

<b>Context</b>	<b>Alias</b>
snomedctrefsetname	Emergency care presenting complaints or issues simple reference set (foundation metadata concept)
plural	URGENT AND EMERGENCY CARE CHIEF COMPLAINTS (SNOMED CT)
snomedctrefsetid	991401000000107

---

**URGENT AND EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT)**

---

Change to Data Element: [New Data Element](#)

**URGENT AND EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT)**

**Attribute:**

[CLINICAL TERMINOLOGY CODE](#)

---

**URGENT AND EMERGENCY CARE CLINICAL INVESTIGATION (SNOMED CT)**

---

Change to Data Element: [New Data Element](#)

<b>Format/Length:</b>	See <a href="#">SNOMED CT CODE</a>
<b>National Codes:</b>	
<b>Default Codes:</b>	

**Notes:**

**URGENT AND EMERGENCY CARE CLINICAL INVESTIGATION (SNOMED CT)** is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

**URGENT AND 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 **Urgent and Emergency Care Service**.

**SNOMED CT Refset:**

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

For further details relating to the SNOMED CT Refset, see the SNOMED CT Browser at: [Emergency care investigations simple reference set \(foundation metadata concept\)](#).

**This data element is also known by these names:**

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

**URGENT AND EMERGENCY CARE CLINICAL INVESTIGATION (SNOMED CT)**

Change to Data Element: New Data Element

**URGENT AND EMERGENCY CARE CLINICAL INVESTIGATION (SNOMED CT)**

**Attribute:**

CLINICAL TERMINOLOGY CODE

**URGENT AND EMERGENCY CARE CLINICALLY READY TO PROCEED TIMESTAMP**

Change to Data Element: New Data Element

Format/Length:	max an25
National Codes:	
Default Codes:	

**Notes:**

URGENT AND EMERGENCY CARE CLINICALLY READY TO PROCEED TIMESTAMP is the same as attribute ACTIVITY DATE and ACTIVITY TIME for the 'Urgent and Emergency Care Clinically Ready To Proceed Timestamp'.

A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time.

In most cases offset time is restricted to:

- +01:00

- +00:00
- -00:00

Examples of valid formats are:

- 2020-08-21T10:15:20+01:00 British Summer Time (GMT + 1 Hour)
- 2020-12-21T10:15:20+00:00 Greenwich Mean Time
- 2020-12-21T10:15:20-00:00 Greenwich Mean Time
- 2020-12-21T09:18:00Z Greenwich Mean Time.

This data element is also known by these names:

Context	Alias
plural	URGENT AND EMERGENCY CARE CLINICALLY READY TO PROCEED TIMESTAMPS

---

URGENT AND EMERGENCY CARE CLINICALLY READY TO PROCEED TIMESTAMP

---

Change to Data Element: New Data Element

## URGENT AND EMERGENCY CARE CLINICALLY READY TO PROCEED TIMESTAMP

Attribute:

ACTIVITY DATE
ACTIVITY TIME

---

URGENT AND EMERGENCY CARE DIAGNOSIS (SNOMED CT)

---

Change to Data Element: New Data Element

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

Notes:

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

URGENT AND EMERGENCY CARE DIAGNOSIS (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the PATIENT DIAGNOSIS recorded during an Urgent and Emergency Care Activity.

SNOMED CT Refset:

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

For further details relating to the [SNOMED CT Refset](#), see the [SNOMED CT Browser](#) at: [Emergency care diagnosis simple reference set \(foundation metadata concept\)](#).

Note that submitters of the [URGENT AND EMERGENCY CARE DIAGNOSIS \(SNOMED CT\)](#) should also consult the [Emergency Care Data Set Version 4 guidance](#) for permitted [SNOMED CT](#) concepts. See the [NHS Digital](#) website at: [Emergency Care Data Set Guidance](#).

**This data element is also known by these names:**

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

---

**URGENT AND EMERGENCY CARE DIAGNOSIS (SNOMED CT)**

---

Change to Data Element: New Data Element

**URGENT AND EMERGENCY CARE DIAGNOSIS (SNOMED CT)**

**Attribute:**

[CLINICAL TERMINOLOGY CODE](#)

---

**URGENT AND EMERGENCY CARE DIAGNOSIS QUALIFIER (SNOMED CT)**

---

Change to Data Element: New Data Element

Format/Length:	<a href="#">See SNOMED CT CODE</a>
National Codes:	
Default Codes:	

**Notes:**

[URGENT AND EMERGENCY CARE DIAGNOSIS QUALIFIER \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

[URGENT AND 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](#) recorded during an [Urgent and Emergency Care Activity](#).

**SNOMED CT Refset:**

- [Refset](#) FSN: Emergency care diagnosis qualifier simple reference set (foundation metadata concept)
- [Refset](#) Id: 999003001000000108

For further details relating to the [SNOMED CT Refset](#), see the [SNOMED CT Browser](#) at: [Emergency care diagnosis qualifier simple reference set \(foundation metadata concept\)](#).

**This data element is also known by these names:**

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

---

**URGENT AND EMERGENCY CARE DIAGNOSIS QUALIFIER (SNOMED CT)**

---

Change to Data Element: New Data Element

## URGENT AND EMERGENCY CARE DIAGNOSIS QUALIFIER (SNOMED CT)

**Attribute:**

<a href="#">CLINICAL TERMINOLOGY CODE</a>
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**URGENT AND EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT)**

---

Change to Data Element: New Data Element

Format/Length:	See <a href="#">SNOMED CT CODE</a>
National Codes:	
Default Codes:	

**Notes:**

[URGENT AND EMERGENCY CARE DISCHARGE DESTINATION \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

[URGENT AND 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 an [Urgent and Emergency Care Activity](#).

**SNOMED CT Refset:**

- [Refset FSN](#): [Emergency care discharge destination simple reference set \(foundation metadata concept\)](#)
- [Refset Id](#): [999003011000000105](#)

For further details relating to the [SNOMED CT Refset](#), see the [SNOMED CT Browser](#) at: [Emergency care discharge destination simple reference set \(foundation metadata concept\)](#).

**This data element is also known by these names:**

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

---

**URGENT AND EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT)**

---

Change to Data Element: New Data Element

**URGENT AND EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT)**

**Attribute:**

<u>CLINICAL TERMINOLOGY CODE</u>
----------------------------------

---

**URGENT AND EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT)**

---

Change to Data Element: New Data Element

Format/Length:	<u>See SNOMED CT CODE</u>
National Codes:	
Default Codes:	

**Notes:**

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

URGENT AND 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 Urgent and Emergency Care Activity.

SNOMED CT Refset:

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

For further details relating to the SNOMED CT Refset, see the SNOMED CT Browser at: Emergency care follow-up procedures simple reference set (foundation metadata concept).

**This data element is also known by these names:**

Context	Alias
snomedctrefsetname	

	Emergency care follow-up procedures simple reference set (foundation metadata concept)
plural	URGENT AND EMERGENCY CARE DISCHARGE FOLLOW UPS (SNOMED CT)
snomedctrefsetid	991441000000105

---

**URGENT AND EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT)**

---

Change to Data Element: New Data Element

## URGENT AND EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT)

**Attribute:**

CLINICAL TERMINOLOGY CODE
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---

**URGENT AND EMERGENCY CARE DISCHARGE INFORMATION GIVEN INDICATOR**

---

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	URGENT AND EMERGENCY CARE DISCHARGE INFORMATION GIVEN INDICATOR
Default Codes:	

**Notes:**

URGENT AND EMERGENCY CARE DISCHARGE INFORMATION GIVEN INDICATOR is the same as attribute URGENT AND EMERGENCY CARE DISCHARGE INFORMATION GIVEN INDICATOR.

**This data element is also known by these names:**

Context	Alias
plural	URGENT AND EMERGENCY CARE DISCHARGE INFORMATION GIVEN INDICATOR

---

**URGENT AND EMERGENCY CARE DISCHARGE INFORMATION GIVEN INDICATOR**

---

Change to Data Element: New Data Element

## URGENT AND EMERGENCY CARE DISCHARGE INFORMATION GIVEN INDICATOR

**Attribute:**

URGENT AND EMERGENCY CARE DISCHARGE INFORMATION GIVEN INDICATOR
-----------------------------------------------------------------

---

**URGENT AND EMERGENCY CARE DISCHARGE STATUS (SNOMED CT)**

---

Change to Data Element: New Data Element

Format/Length:	See <a href="#">SNOMED CT CODE</a>
National Codes:	
Default Codes:	

**Notes:**

[URGENT AND EMERGENCY CARE DISCHARGE STATUS \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

[URGENT AND 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 [Urgent and Emergency Care Activity](#).

**SNOMED CT Refset:**

- [Refset FSN](#): Emergency care discharge status simple reference set (foundation metadata concept)
- [Refset Id](#): 999003021000000104

For further details relating to the [SNOMED CT Refset](#), see the [SNOMED CT Browser](#) at: [Emergency care discharge status simple reference set \(foundation metadata concept\)](#).

**This data element is also known by these names:**

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

---

**URGENT AND EMERGENCY CARE DISCHARGE STATUS (SNOMED CT)**

---

Change to Data Element: New Data Element

**URGENT AND EMERGENCY CARE DISCHARGE STATUS (SNOMED CT)**

**Attribute:**

<a href="#">CLINICAL TERMINOLOGY CODE</a>
-------------------------------------------

---

**URGENT AND EMERGENCY CARE EXTENDED CARE EPISODE IDENTIFIER**

---

Change to Data Element: New Data Element

Format/Length:	min an1 max an20
National Codes:	

Default Codes:

**Notes:**

**URGENT AND EMERGENCY CARE EXTENDED CARE EPISODE IDENTIFIER** is the same as attribute **ACTIVITY IDENTIFIER**.

An **URGENT AND EMERGENCY CARE EXTENDED CARE EPISODE IDENTIFIER** is a system-generated **ACTIVITY IDENTIFIER** which uniquely identifies an **Urgent and Emergency Care Extended Care Episode** within a **Health Care Provider** and **ORGANISATION SITE IDENTIFIER (OF TREATMENT)**.

Usage in **Emergency Care Data Set Version 4**:

All **Emergency Care Attendances** and **Same Day Emergency Care Attendances**, either face to face or virtual, and either scheduled or unscheduled, that occurs during an **Urgent and Emergency Care Extended Care Episode** period, must be linked back to the **Urgent and Emergency Care Extended Care Episode**.

The **URGENT AND EMERGENCY CARE ACTIVITY IDENTIFIER** which identifies the open **Urgent and Emergency Care Extended Care Episode** must be linked in the **ELECTRONIC HEALTH RECORD** system, and submitted in the **Emergency Care Data Set Version 4** record relating to the **Emergency Care Attendance** or **Same Day Emergency Care Attendance**.

Therefore the **URGENT AND EMERGENCY CARE EXTENDED CARE EPISODE IDENTIFIER** data element must carry the unique identifier for the open **Urgent and Emergency Care Extended Care Episode**, whenever a scheduled or unscheduled **Emergency Care Attendance** or **Same Day Emergency Care Attendance** occurs within the open period.

**This data element is also known by these names:**

Context	Alias
plural	URGENT AND EMERGENCY CARE EXTENDED CARE EPISODE IDENTIFIERS

---

**URGENT AND EMERGENCY CARE EXTENDED CARE EPISODE IDENTIFIER**

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Change to Data Element: New Data Element

**URGENT AND EMERGENCY CARE EXTENDED CARE EPISODE IDENTIFIER**

**Attribute:**

<b>ACTIVITY IDENTIFIER</b>
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**URGENT AND EMERGENCY CARE INITIAL ASSESSMENT TIMESTAMP**

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Change to Data Element: New Data Element

Format/Length:	max an25
National Codes:	
Default Codes:	

**Notes:**

URGENT AND EMERGENCY CARE INITIAL ASSESSMENT TIMESTAMP is the same as attribute ACTIVITY DATE and ACTIVITY TIME for the 'Urgent and Emergency Care Initial Assessment Timestamp'.

A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time.

In most cases offset time is restricted to:

- +01:00
- +00:00
- -00:00

Examples of valid formats are:

- 2020-08-21T10:15:20+01:00 British Summer Time (GMT + 1 Hour)
- 2020-12-21T10:15:20+00:00 Greenwich Mean Time
- 2020-12-21T10:15:20-00:00 Greenwich Mean Time
- 2020-12-21T09:18:00Z Greenwich Mean Time.

**This data element is also known by these names:**

Context	Alias
plural	URGENT AND EMERGENCY CARE INITIAL ASSESSMENT TIMESTAMPS

---

**URGENT AND EMERGENCY CARE INITIAL ASSESSMENT TIMESTAMP**

---

Change to Data Element: [New Data Element](#)

**URGENT AND EMERGENCY CARE INITIAL ASSESSMENT TIMESTAMP**

**Attribute:**

<a href="#">ACTIVITY DATE</a>
<a href="#">ACTIVITY TIME</a>

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**URGENT AND EMERGENCY CARE PROCEDURE (SNOMED CT)**

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Change to Data Element: [New Data Element](#)

Format/Length:	See <a href="#">SNOMED CT CODE</a>
National Codes:	
Default Codes:	

**Notes:**

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

URGENT AND 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 Urgent and Emergency Care Service.

**SNOMED CT Refset:**

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

For further details relating to the SNOMED CT Refset, see the SNOMED CT Browser at: Emergency care treatments simple reference set (foundation metadata concept).

**This data element is also known by these names:**

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

**URGENT AND EMERGENCY CARE PROCEDURE (SNOMED CT)**

Change to Data Element: New Data Element

**URGENT AND EMERGENCY CARE PROCEDURE (SNOMED CT)**

**Attribute:**

CLINICAL TERMINOLOGY CODE

**URGENT AND EMERGENCY CARE TIMESTAMP SEEN FOR TREATMENT**

Change to Data Element: New Data Element

Format/Length:	max an25
National Codes:	
Default Codes:	

**Notes:**

URGENT AND EMERGENCY CARE TIMESTAMP SEEN FOR TREATMENT is the same as attribute ACTIVITY DATE and ACTIVITY TIME for the 'Urgent and Emergency Care Timestamp Seen For Treatment'.

A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time.

In most cases offset time is restricted to:

- +01:00
- +00:00
- -00:00

Examples of valid formats are:

- 2020-08-21T10:15:20+01:00 British Summer Time (GMT + 1 Hour)
- 2020-12-21T10:15:20+00:00 Greenwich Mean Time
- 2020-12-21T10:15:20-00:00 Greenwich Mean Time
- 2020-12-21T09:18:00Z Greenwich Mean Time.

This data element is also known by these names:

Context	Alias
plural	URGENT AND EMERGENCY CARE TIMESTAMPS SEEN FOR TREATMENT

---

URGENT AND EMERGENCY CARE TIMESTAMP SEEN FOR TREATMENT

---

Change to Data Element: New Data Element

## URGENT AND EMERGENCY CARE TIMESTAMP SEEN FOR TREATMENT

Attribute:

ACTIVITY DATE
ACTIVITY TIME

---

WITHHELD IDENTITY REASON

---

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See <a href="#">WITHHELD IDENTITY REASON</a>
Default Codes:	99 - Identity withheld but reason not known

Notes:

[WITHHELD IDENTITY REASON](#) is the same as attribute [WITHHELD IDENTITY REASON](#).

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EMERGENCY CARE DATA SET VERSION 4 XML SCHEMA CONSTRAINTS

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Change to XML Schema Constraint: New XML Schema Constraint

XML Schema Constraints applied to the:

- [Emergency Care Data Set Version 4 - Type 011](#)
- [ECDS V4 Type 001 - CDS Interchange Header](#)
- [ECDS V4 Type 002 - CDS Interchange Trailer](#)
- [ECDS V4 Type 003 - CDS Message Header](#)
- [ECDS V4 Type 004 - CDS Message Trailer](#)
- [ECDS V4 Type 005B - CDS Transaction Header Group - Bulk Update Protocol](#)
- [ECDS V4 Type 005N - CDS Transaction Header Group - Net Change Protocol](#)

### Key to XML Schema Constraint Column Headings:

Column Name	Column Meaning	Column Options		
XML Schema Format/Length	Indicates any differences between the Format/Length of the item in the NHS Data Model and Dictionary and the XML Schema representation	None = The Format/Length is the same as the NHS Data Model and Dictionary	Any other entry = The Format/Length is different in the XML Schema to the NHS Data Model and Dictionary	
Allowed Values	Indicates whether the NHS Data Model and Dictionary National Codes and Default Codes are present in the XML Schema	None = The NHS Data Model and Dictionary National and Default Codes are present in the XML Schema	Removed = The NHS Data Model and Dictionary National Codes and Default Codes are not present in the XML Schema	Any other entry = Shows the values present in the XML Schema which are a subset of those in the NHS Data Model and Dictionary
Range	Indicates whether a range value constraint has been applied in the XML Schema	None = There is no range value constraint applied in the XML Schema	Any other entry = Shows the range value constraint applied in the XML Schema	
Pattern Match	Indicates whether a data pattern, to which the data must conform, has been applied in the XML Schema	None = There is no data pattern, to which the data must conform, applied in the XML Schema	Any other entry = Shows the data pattern, to which the data must conform, applied in the XML Schema	

### XML Schema Constraints:

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	None	Removed	None	None	

					Default codes not enumerated in the XML Schema
<u>CDS BULK REPLACEMENT GROUP CODE</u>	None	160	None	None	ECDS V4 only allows submission of data relating to <u>CDS BULK REPLACEMENT GROUP CODE</u> 'Urgent and Emergency Care Activity'
<u>CDS INTERCHANGE TEST INDICATOR</u>	None	0,1	None	None	The ECDS V4 XML schema allows a null field to be submitted
<u>CDS MESSAGE VERSION NUMBER</u>	an6	ECDS04	None	None	Message version is hard coded in the XML Schema
<u>CDS TYPE CODE</u>	None	011	None	None	ECDS V4 only allows submission of data relating to <u>CDS TYPE CODE</u> 'Urgent and Emergency Care Activity'
<u>COMMISSIONER REFERENCE IDENTIFIER</u>	None	None	None	None	Default codes not enumerated in the XML Schema
<u>EMED3 FIT NOTE DURATION</u>	None	None	None	None	Default codes not enumerated in the XML Schema
<u>EMERGENCY CARE PLACE OF INJURY (LATITUDE)</u>	None	None	-90.000000-90.000000	None	Range applied to allow correct reporting of <u>EMERGENCY CARE PLACE OF INJURY (LATITUDE)</u>
<u>EMERGENCY CARE PLACE OF INJURY (LONGITUDE)</u>	None	None	-180.000000-180.000000	None	Range applied to allow correct reporting of <u>EMERGENCY CARE PLACE OF INJURY (LONGITUDE)</u>
<u>ETHNIC CATEGORY</u>	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 (PATIENT REGISTRATION)	None	Removed	None	None	Default codes not enumerated in the XML Schema
GENERAL MEDICAL PRACTITIONER (SPECIFIED)	None	Removed	None	None	Default codes not enumerated in the XML Schema
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE	None	Removed	None	None	National Codes and default codes not enumerated in the XML Schema
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION IDENTIFIER (CDS RECIPIENT)	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 URGENT AND EMERGENCY CARE)	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION SITE IDENTIFIER (URGENT AND 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
		None	None	None	

POSTCODE OF USUAL ADDRESS	min an2 max an8				Existing Format/Length states max an8 - XML Schema allows min an2 max an8
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER	min an1 max an32	None	None	None	Existing Format/Length states max an32 - XML Schema allows min an1 max an32
PROFESSIONAL REGISTRATION ISSUER CODE	None	None	None	None	National Codes not enumerated in the XML Schema
UNIT OF MEASUREMENT (UCUM)	max an20	None	None	None	The format/length of the UNIT OF MEASUREMENT (UCUM) is unconstrained in the NHS Data Model and Dictionary. ECDS V4 constrains the format/length to max an20

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

