NHS Data Model and Dictionary

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

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

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

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

Class Definitions

ACTIVITY	Changed Attributes
ACTIVITY GROUP	Changed Attributes
CARE CONTACT	Changed Attributes
CARE PROFESSIONAL	Changed Attributes
ORGANISATION	Changed Attributes

Attribute Definitions

CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR FOR URGENT AND EMERGENCY CARE	New Attribute
CARE PROFESSIONAL TIER FOR URGENT AND EMERGENCY CARE	New Attribute
CDS BULK REPLACEMENT GROUP CODE	Changed Description
CDS MESSAGE VERSION NUMBER	Changed Description
CDS TYPE CODE	Changed Description
CONSULTATION MECHANISM	Changed Description
EMERGENCY CARE DEPARTMENT TYPE	Changed Description
	New Attribute

EMERGENCY CARE DEPARTMENT TYPE FOR PATIENT LEVEL INFORMATION COSTING	
URGENT AND EMERGENCY CARE ACTIVITY TYPE	New Attribute
URGENT AND EMERGENCY CARE ATTENDANCE CATEGORY	New Attribute
URGENT AND EMERGENCY CARE DISCHARGE INFORMATION GIVEN INDICATOR	New Attribute

Data Elements

ACTIVITY SERVICE REQUEST TIMESTAMP (URGENT AND EMERGENCY CARE)	New Data Element
ASSAULT LOCATION DESCRIPTION	Changed Description
CARE PROFESSIONAL CLINICAL RESPONSIBILITY TIMESTAMP	Changed Description
CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR (URGENT AND EMERGENCY CARE)	New Data Element
CARE PROFESSIONAL TIER (URGENT AND EMERGENCY CARE)	New Data Element
CDS ACTIVITY DATE	Changed Description
CDS INTERCHANGE CONTROL REFERENCE	Changed Description
CDS RECORD IDENTIFIER	Changed Description
CLINICAL TRIAL IDENTIFIER	Changed Description
CODED FINDING TIMESTAMP	Changed Description
CODED OBSERVATION TIMESTAMP	Changed Description
CODED PROCEDURE TIMESTAMP (URGENT AND EMERGENCY CARE CLINICAL INVESTIGATION)	New Data Element
CODED PROCEDURE TIMESTAMP (URGENT AND EMERGENCY CARE PROCEDURE)	New Data Element
CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE)	New Data Element
DECIDED TO ADMIT DATE AND TIME	New Data Element
DISEASE OUTBREAK NOTIFICATION DESCRIPTION	Changed Description
EMED3 FIT NOTE CONDITION (SNOMED CT)	New Data Element
EMERGENCY CARE DEPARTMENT TYPE (PATIENT LEVEL INFORMATION COSTING)	Changed Description, linked Attribute
EMERGENCY CARE TREATMENT ALLOCATION TIMESTAMP	Changed Description
INJURY DATE AND TIME	New Data Element
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START TIMESTAMP	New Data Element
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION EXPIRY TIMESTAMP	New Data Element
ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE)	Changed Description
ORGANISATION SITE IDENTIFIER (DISCHARGE FROM URGENT AND EMERGENCY CARE)	New Data Element
ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE)	Changed Description
	New Data Element

ORGANISATION SITE IDENTIFIER (URGENT AND EMERGENCY CARE ATTENDANCE SOURCE)	
REFERRED TO SERVICE ASSESSMENT TIMESTAMP	New Data Element
SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP	Changed Description
URGENT AND EMERGENCY CARE ACTIVITY END TIMESTAMP	New Data Element
URGENT AND EMERGENCY CARE ACTIVITY IDENTIFIER	New Data Element
URGENT AND EMERGENCY CARE ACTIVITY START DATE AND TIME	New Data Element
URGENT AND EMERGENCY CARE ACTIVITY TYPE	New Data Element
URGENT AND EMERGENCY CARE ACUITY (SNOMED CT)	New Data Element
URGENT AND EMERGENCY CARE ARRIVAL MODE (SNOMED CT)	New Data Element
URGENT AND EMERGENCY CARE ATTENDANCE CATEGORY	New Data Element
URGENT AND EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT)	New Data Element
URGENT AND EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT)	New Data Element
URGENT AND EMERGENCY CARE CLINICAL INVESTIGATION (SNOMED CT)	New Data Element
URGENT AND EMERGENCY CARE CLINICALLY READY TO PROCEED TIMESTAMP	New Data Element
URGENT AND EMERGENCY CARE DIAGNOSIS (SNOMED CT)	New Data Element
URGENT AND EMERGENCY CARE DIAGNOSIS QUALIFIER (SNOMED CT)	New Data Element
URGENT AND EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT)	New Data Element
URGENT AND EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT)	New Data Element
URGENT AND EMERGENCY CARE DISCHARGE INFORMATION GIVEN INDICATOR	New Data Element
URGENT AND EMERGENCY CARE DISCHARGE STATUS (SNOMED CT)	New Data Element
URGENT AND EMERGENCY CARE EXTENDED CARE EPISODE IDENTIFIER	New Data Element
URGENT AND EMERGENCY CARE INITIAL ASSESSMENT TIMESTAMP	New Data Element
URGENT AND EMERGENCY CARE PROCEDURE (SNOMED CT)	New Data Element
URGENT AND EMERGENCY CARE TIMESTAMP SEEN FOR TREATMENT	New Data Element

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

ECDS V4 TYPE 002 - CDS INTERCHANGE TRAILER

Change to Data Set: New Data Set

Notation				DATA GROUP: ECDS V4 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER	
Group Status M	Group Repeats 1..1			FUNCTION: To carry the details of the mandatory identity and addressing information for the Commissioning Data Set submission.	

		One per Interchange submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

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

ECDS V4 TYPE 003 - CDS MESSAGE HEADER

Change to Data Set: New Data Set

Notation		**DATA GROUP: ECDS V4 TYPE 003 - COMMISSIONING DATA SET MESSAGE HEADER**
Group Status **M**	**Group Repeats** **1..1**	**FUNCTION: To carry the details of the mandatory identity controls for each Commissioning Data Set Message.** **One per Commissioning Data Set Message submitted to the** Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

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

ECDS V4 TYPE 004 - CDS MESSAGE TRAILER

Change to Data Set: New Data Set

Notation		**DATA GROUP: ECDS V4 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER**
Group Status **M**	**Group Repeats** **1..1**	**FUNCTION: To carry the details of the mandatory identity controls for each Commissioning Data Set Message.** **One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.**

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

		M	1..1	CDS MESSAGE REFERENCE	F

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

Change to Data Set: New Data Set

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

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

Change to Data Set: New Data Set

Notation	DATA GROUP: ECDS V4 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL

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

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

EMERGENCY CARE DATA SET VERSION 4

Change to Data Set: New Data Set

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

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

Notation		DATA GROUP: ECDS V4 TYPE 003 - COMMISSIONING DATA SET MESSAGE HEADER

Group Status	Group Repeats	FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.
M	1..1	DATA GROUP: ECDS V4 Type 003 - CDS Message Header One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange

ONE OF THE FOLLOWING TWO OPTIONS MUST BE USED

Notation		DATA GROUP: ECDS V4 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL
Group Status	Group Repeats	FUNCTION: To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of the Bulk Replacement Update Mechanism of the Commissioning Data Set Submission Protocol.
M	1..1	DATA GROUP: ECDS V4 Type 005B - CDS Transaction Header Group - Bulk Update Protocol One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

OR

Notation		DATA GROUP: ECDS V4 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL
Group Status	Group Repeats	FUNCTION: To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of the Net Change Update Mechanism of the Commissioning Data Set Submission Protocol.
M	1..1	DATA GROUP: ECDS V4 Type 005N - CDS Transaction Header Group - Net Change Protocol One per Commissioning Data Set record submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

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

One of the following DATA GROUPS must be used:

1..1	DATA GROUP: WITHHELD IDENTITY STRUCTURE Must be used where the Commissioning Data Set record has been anonymised

M	1..1	Data Element Components		Rules
	M	1..1	NHS NUMBER STATUS INDICATOR CODE	V
	R	0..1	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	F
	R	0..1	WITHHELD IDENTITY REASON	V

OR

1..1		

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

OR

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

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

Notation		DATA GROUP: PATIENT CHARACTERISTICS (URGENT AND EMERGENCY CARE)			
Group Status **R**	**Group Repeats** **0..1**	**FUNCTION:** **To carry the characteristics of the Patient for Urgent and Emergency Care Activity.**			
R	0..1	Data Element Components			**Rules**
		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

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

Notation		DATA GROUP: MENTAL HEALTH ACT LEGAL STATUS			
Group Status **R**	**Group Repeats** **0..***	**FUNCTION:** **To carry the Patient's Mental Health Act Legal Status.**			
R	0..1	**Data Element Components**			**Rules**
		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

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

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

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

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

Notation		**DATA GROUP: URGENT AND EMERGENCY CARE ACTIVITY CHARACTERISTICS**			
Group Status	**Group Repeats**	**FUNCTION:**			
M	**1..1**	**To carry the characteristics of the Urgent and Emergency Care Activity.**			
M	**1..1**	**Data Element Components**			**Rules**
		M	**1..1**	URGENT AND EMERGENCY CARE ACTIVITY IDENTIFIER	F

		R	0..1	CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE)	V
		R	0..1	URGENT AND EMERGENCY CARE ARRIVAL MODE (SNOMED CT)	F
		R	0..1	URGENT AND EMERGENCY CARE ATTENDANCE CATEGORY	V
		R	0..1	URGENT AND EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT)	F
		R	0..1	ORGANISATION SITE IDENTIFIER (URGENT AND EMERGENCY CARE ATTENDANCE SOURCE)	F
		M	**1..1**	URGENT AND EMERGENCY CARE ACTIVITY START DATE AND TIME	F S1 S13 S14
		M	**1..1**	AGE AT CDS ACTIVITY DATE	F S8
		R	0..1	URGENT AND EMERGENCY CARE INITIAL ASSESSMENT TIMESTAMP	F S13 S14
		R	0..1	URGENT AND EMERGENCY CARE ACUITY (SNOMED CT)	F
		R	0..1	URGENT AND EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT)	F
		R	0..1	URGENT AND EMERGENCY CARE TIMESTAMP SEEN FOR TREATMENT	F S13 S14
		R	0..1	URGENT AND EMERGENCY CARE EXTENDED CARE EPISODE IDENTIFIER	F

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

Notation		**DATA GROUP: OBSERVATION GROUP (SNOMED CT)**			
Group Status	**Group Repeats**	**FUNCTION:**			
R	**0..***	**To carry the details of the SNOMED CT coded Clinical Observations for the Patient.**			
R	0..*	**Data Element Components**			**Rules**
		M	**1..1**	CODED OBSERVATION (SNOMED CT)	F
		M	**1..1**	OBSERVATION VALUE	F
		R	0..1	UNIT OF MEASUREMENT (UCUM)	F
		M	**1..1**	CODED OBSERVATION TIMESTAMP	

					F S13 S14

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

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

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

Notation		DATA GROUP: SERVICE AGREEMENT DETAILS			
Group Status M	Group Repeats 1..1	FUNCTION: To carry the details of the Provider, Commissioners and Service Agreements.			
M	1..1	Data Element Components			Rules

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

Notation		**DATA GROUP: CARE PROFESSIONALS (URGENT AND EMERGENCY CARE)**			
Group Status	**Group Repeats**	**FUNCTION:**			
R	**0..***	**To carry the details of the Care Professionals active during the Urgent and Emergency Care Activity.**			
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:**			
R	**0..***	**To carry the details of SNOMED CT coded Clinical Diagnoses.**			
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

Notation		**DATA GROUP: URGENT AND EMERGENCY CARE INVESTIGATIONS (SNOMED CT)**			
Group Status	**Group Repeats**	**FUNCTION:**			
R	**0..***	**To carry the details of SNOMED CT coded Clinical Investigations.**			

R	0..1	Data Element Components			Rules
		M	**1..1**	URGENT AND EMERGENCY CARE CLINICAL INVESTIGATION (SNOMED CT)	F H4
		R	0..1	CODED PROCEDURE TIMESTAMP (URGENT AND EMERGENCY CARE CLINICAL INVESTIGATION)	F S13 S14

Notation		DATA GROUP: URGENT AND EMERGENCY CARE TREATMENTS (SNOMED CT)
Group Status R	Group Repeats 0..*	FUNCTION: To carry the details of SNOMED CT coded Procedures.

R	0..1	Data Element Components			Rules
		M	**1..1**	URGENT AND EMERGENCY CARE PROCEDURE (SNOMED CT)	F H4
		R	0..1	CODED PROCEDURE TIMESTAMP (URGENT AND EMERGENCY CARE PROCEDURE)	F S13 S14

Notation		DATA GROUP: REFERRALS TO OTHER SERVICES
Group Status R	Group Repeats 0..*	FUNCTION: To carry the details of referrals to other services.

R	0..1	Data Element Components			Rules
		R	0..1	REFERRED TO SERVICE (SNOMED CT)	F
		M	**1..1**	ACTIVITY SERVICE REQUEST TIMESTAMP (URGENT AND EMERGENCY CARE)	F S13 S14
		R	0..1	REFERRED TO SERVICE ASSESSMENT TIMESTAMP	F S13 S14

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

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

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

Notation		DATA GROUP: DISCHARGE FROM URGENT AND EMERGENCY CARE			
Group Status	**Group Repeats**	**FUNCTION:**			
R	**0..1**	**To carry the details of discharge from Urgent and Emergency Care.**			
R	0..1	**Data Element Components**			**Rules**
		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			
Group Status	**Group Repeats**	**FUNCTION:**			
R	**0..1**	**To carry details of any Research and/or Disease Outbreak Notifications.**			
R	0..1	Data Element Components			**Rules**
		O	0..1	CLINICAL TRIAL IDENTIFIER	F
		R *Or* R	0..1 0..1	DISEASE OUTBREAK NOTIFICATION DESCRIPTION *Or* DISEASE OUTBREAK NOTIFICATION (SNOMED CT)	F F

Notation		DATA GROUP: ECDS V4 CDS V6-3 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER
Group Status	**Group Repeats**	

		FUNCTION: **To define the mandatory identity and addressing information for a Commissioning Data Set submission.**
M	**1..1**	**DATA GROUP: ECDS V4 Type 004 - CDS Message Trailer** One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange

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

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CDS TYPE

Change to Supporting Information: Changed Description

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

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

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)
~~011 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

CLINICAL DATA SETS MENU

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

CLINICAL DATA SETS MESSAGE DOCUMENTATION

Change to Supporting Information: Changed Description

XML Schema Download:

- XML Schema TRUD Download

XML Schema Constraints:

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

CLINICAL DATA SETS MESSAGE DOCUMENTATION MENU

Change to Supporting Information: Changed Description

Clinical Data Sets Menu

XML Schema Download:

- XML Schema TRUD Download

XML Schema Constraints:

- Cancer Outcomes and Services
- Diagnostic Imaging
- 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

COMMISSIONING DATA SET BUSINESS RULES

Change to Supporting Information: Changed Description

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

Population Validation

All Data Elements are subject to **length** validation. Some Data Elements are also subject to **format** and **content** validation against a list of permitted values defined in the NHS Data Model and

Dictionary. The value lists are held on the Attribute which the Data Element is based on, plus default codes which are held on the Data Element itself.

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

Business Rules

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

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

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

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

PREFIX	BUSINESS RULES: N - NHS Data Standards and Policy Rules
N1	Psychiatric PATIENTS only (Retired January 2021).
N2	Not defined or approved by the Data Alliance Partnership Board or its predecessors the Data Coordination Board, Standardisation Committee for Care Information and Information Standards Board for Health and Social Care.
N3	The definition and value list for this data is under review.
N4	Up to 20 codes per daily activity occurrence may be recorded.
N5	This data should only flow in Commissioning Data Set version 6-1 for PATIENTS detained under the Mental Health Act prior to the Mental Health Act 2007 (Retired June 2015).
N6	This data should only flow in Commissioning Data Set version 6-2 for PATIENTS detained under the Mental Health Act 2007.
N7	From Commissioning Data Set version 6-0 onwards, the use of the DETAINED AND (OR) LONG TERM PSYCHIATRIC CENSUS DATE in the location group is **optional** as it **must** be carried in the Episode Characteristics.

PREFIX	BUSINESS RULES: S - Secondary Uses Service Business Rules
S1	This mandatory Commissioning Data Set date is used as the originating date to determine the mandatory CDS ACTIVITY DATE.
S2	The Secondary Uses Service **DOES NOT** support the use of the CDS TEST INDICATOR. Therefore this Data Element must not be used (Retired June 2015).
S3	See Security Issues and Patient Confidentiality, for further information.
S4	Used to ensure the correct sequencing of multiple and/or subsequent Commissioning Data Set submissions.
S5	These ORGANISATION CODES/ORGANISATION IDENTIFIERS must be present and registered with the Secondary Uses Service. The Commissioning Data Set Schema does not validate the content value of this data
S6	All CDS REPORT PERIOD START DATES and CDS REPORT PERIOD END DATES must be consistent in all Commissioning Data Set records contained in a BULK Interchange submission. The CDS REPORT PERIOD START DATE must be on or before the CDS REPORT PERIOD END DATE. The CDS ACTIVITY DATE is a mandatory data element and must fall within the period defined. See the Commissioning Data Set Submission Protocol.
S7	See the Commissioning Data Set Addressing Grid.
S8	These Data Elements are required for correct processing by the Secondary Uses Service. If omitted, the Secondary Uses Service will reject the Commissioning Data Set data.
S9	The CDS UNIQUE IDENTIFIER is a mandatory data item when using the Net Change Protocol. When using the Bulk Update Protocol this data item is optional but it is strongly advised that where it can be correctly generated and maintained it should be used. See the Commissioning Data Set Submission Protocol.
S10	For CDS V6-2 Type 170 - Admitted Patient Care - Detained and or Long Term Psychiatric Census Commissioning Data Set, the CDS ACTIVITY DATE contains the

	CDS CENSUS DATE which is also the DETAINED AND (OR) LONG TERM PSYCHIATRIC CENSUS DATE.
S11	For the following CDS Types, the CDS ACTIVITY DATE must contain the Date of the Elective Admission List Census which is usually the end of the Period being reported: CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set CDS V6-2 Type 040 - Elective Admission List - End of Period Census (Old) Commissioning Data Set CDS V6-2 Type 050 - Elective Admission List - End of Period Census (New) Commissioning Data Set
S12	These PERSON BIRTH DATE Data Elements must use dates between 01/01/1880 and 31/12/2999 in order to pass validation
S13	Data Elements reporting a date (which is not a PERSON BIRTH DATE Data Element) must use dates between 01/01/1900 and 31/12/2999 in order to pass validation
S14	For Data Elements reporting a time, the hour portion must be between 00 and 23 inclusive in order to pass validation

COMMISSIONING DATA SET MANDATED DATA FLOWS

Change to Supporting Information: Changed Description

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

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

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

CDS TYPE	DESCRIPTION	MIN FREQUENCY	DIRECTIVE	DATA FLOW
CDS010	Accident and Emergency (Retired 01 November 2020)			
~~CDS 011~~	~~Emergency Care~~	~~Weekly~~	~~Emergency Care Attendances for EMERGENCY CARE DEPARTMENT TYPE 01 and 02 were mandated to flow nationally from 1st October 2017. See SCCI0092-2062~~	~~Data is expected to flow on a daily basis where possible, but a weekly frequency is the minimum requirement.~~

			~~Emergency Care Attendances for EMERGENCY CARE DEPARTMENT TYPES 03 and 04 were mandated to flow from October 2018. See SCCI0092-2062~~	
CDS 011	Emergency Care	Weekly	Urgent and Emergency Care Activity for EMERGENCY CARE DEPARTMENT TYPES / URGENT AND EMERGENCY CARE ACTIVITY TYPES 01 and 02 were mandated to flow nationally from 1st October 2017. See SCCI0092-2062. Urgent and Emergency Care Activity for EMERGENCY CARE DEPARTMENT TYPES / URGENT AND EMERGENCY CARE ACTIVITY TYPE 03 was mandated to flow from October 2018. See SCCI0092-2062. Urgent and Emergency Care Activity for URGENT AND EMERGENCY CARE ACTIVITY TYPES 05 and 06 were enabled to flow from July 2023 and mandated to flow from July 2024. see DAPB0092-2062.	Data is expected to flow on a daily basis.
CDS 020	Out-Patient	Weekly	Out-Patient Attendance Commissioning Data Sets (including Ward	NHS Acute Health Care Providers must submit data weekly.

				Attenders) were mandated to be submitted to the Secondary Uses Service from 1st October 2001, see DSCN 05/2001. Out-Patient Attendance Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009. NURSE and MIDWIFE attendances and Attendances for nursing care were enabled to be carried in the Out-Patient Attendance Commissioning Data Set from 1 April 2005, DSCN 32/2004 Other Care Professional Attendances where an appropriate Treatment Function exists may also be submitted. Out-patient records where the activity relates to the Allied Health Professional Referral To Treatment Measurement standard must be submitted to the Secondary Uses Service (in accordance with ISN ISB0092 Amd 7/2013, and must include the PATIENT	NHS Community Health Care Providers, NHS Mental Health Care Providers and Independent Sector Healthcare Providers undertaking acute care, must submit data weekly as soon as possible and no later than 31 March 2021.

			PATHWAY data group data items. Note that this is only supported in Commissioning Data Set version 6-2 onwards, with the introduction of data element WAITING TIME MEASUREMENT TYPE.	
CDS 021	Future Out-Patients - **Commissioning Data Set version 6-2 only**	As Required for piloting	From 01/01/2008, submissions to support local activities and commissioning will be supported for piloting purposes only.	
CDS 030	Elective Admission List End of Period (Standard) - **Commissioning Data Set version 6-2 only**	Monthly if used	All Providers should endeavour to support this data flow. Elective Admission List End of Period Census (Standard) Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	All entries where at the end of the time period being reported and defined by the Commissioning Data Set Submission Protocol, the PATIENT remains on the ELECTIVE ADMISSION LIST. Optionally and by local agreement with commissioners, entries relating to the PATIENTS that have been removed from the ELECTIVE ADMISSION LIST may be included.
CDS 040	Elective Admission List End of Period (New) - **Commissioning Data Set version 6-2 only**	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
CDS 050	Elective Admission List End of Period (Old) - **Commissioning Data Set version 6-2 only**	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
CDS 060	Elective Admission List Event During Period (Add)	Monthly if used	Optional	May be submitted where an entry has

	Commissioning Data Set version 6-2 only		Elective Admission List Event During Period (Add) Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	been added to the ELECTIVE ADMISSION LIST during the time period reported.
CDS 070	Elective Admission List Event During Period (Remove)**Commissioning Data Set version 6-2 only**	Monthly if used	Optional Elective Admission List Event During Period (Remove) Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	May be submitted where an entry has been removed from the ELECTIVE ADMISSION LIST during the time period reported.
CDS 080	Elective Admission List Event During Period (Offer) **Commissioning Data Set version 6-2 only**	Monthly if used	Optional Elective Admission List Event During Period (Offer) CDS records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	May be submitted where an offer has been made during the time period reported.
			~~Optional~~	

~~CDS 090~~	~~Elective Admission List Event During Period (Available / Unavailable) - **Commissioning Data Set version 6-2 only**~~	~~Monthly if used~~		~~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) - **Commissioning Data Set version 6-2 only**	Monthly if used	Optional	May be submitted where a PATIENT becomes Available or Unavailable during the time period reported.
CDS 100	Elective Admission List Event During Period (Old Service Agreement) **Commissioning Data Set version 6-2 only**	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
CDS 110	Elective Admission List Event During Period (New Service Agreement) **Commissioning Data Set version 6-2 only**	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
CDS 120	Finished Birth Episode	Weekly	All finished Admitted Patient Care data must be submitted "at least monthly" (EL - Dec 1995). This includes Non-Contract Activity.	NHS Acute Health Care Providers must submit data weekly. NHS Community Health Care Providers, NHS Mental Health Care Providers and Independent Sector Healthcare Providers undertaking acute care, must submit data weekly as soon as possible and no later than 31 March 2021.
CDS 130	Finished General Episode	Weekly	All finished Admitted Patient Care data must be submitted "at least monthly" (EL - Dec 1995). This includes Non-Contract Activity.	NHS Acute Health Care Providers must submit data weekly. NHS Community Health Care Providers, NHS Mental Health Care Providers and Independent Sector

			Finished General Episode Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	Healthcare Providers undertaking acute care, must submit data weekly as soon as possible and no later than 31 March 2021.
CDS 140	Finished Delivery Episode	Weekly	All finished Admitted Patient Care data must be submitted "at least monthly" (EL - Dec 1995). This includes Non-Contract Activity.	NHS Acute Health Care Providers must submit data weekly. NHS Community Health Care Providers, NHS Mental Health Care Providers and Independent Sector Healthcare Providers undertaking acute care, must submit data weekly as soon as possible and no later than 31 March 2021.
CDS 150	Other Birth	Monthly	This includes Home Birth.	All Episodes that have finished relevant to the time period defined by the Commissioning Data Set Submission Protocol being used.
CDS 160	Other Delivery	Monthly	This includes Home Delivery.	All Episodes that have finished relevant to the time period defined by the Commissioning Data Set Submission Protocol being used.
CDS 170	The Detained and/or Long Term Psychiatric Census - **Commissioning Data Set version 6-2 only**	Annually	Required by the NHS Digital. May optionally be sent	Reflects data as at the 31st March each year. All Episodes that are relevant to the time

			more regularly, usually monthly.	period defined by the Commissioning Data Set Submission Protocol being used.
CDS 180	Unfinished Birth Episode	Annually	The Annual Census / Unfinished Census. Required by the NHS Digital. May optionally be sent more regularly, usually monthly.	Data relating to episodes that were unfinished as at midnight on 31st March and have not been included in the Detained and/or Long Term Psychiatric Census, and have not been submitted to the Secondary Uses Service in either Finished or Unfinished Commissioning Data Set data, must be submitted to the Secondary Uses Service.
CDS 190	Unfinished General Episode	Annually	The Annual Census / Unfinished Census. Required by the NHS Digital May optionally be sent more regularly, usually monthly. Unfinished General Episode Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	Data relating to episodes that were unfinished as at midnight on 31st March and have not been included in the Detained and/or Long Term Psychiatric Census, and have not been submitted to the Secondary Uses Service in either Finished or Unfinished Commissioning Data Set data, must be submitted to the Secondary Uses Service.
CDS 200	Unfinished Delivery Episode	Annually	The Annual Census / Unfinished Census. Required by the NHS Digital	Data relating to episodes that were unfinished as at midnight on 31st

			May optionally be sent more regularly, usually monthly.	March and have not been included in the Detained and/or Long Term Psychiatric Census, and have not been submitted to the Secondary Uses Service in either Finished or Unfinished Commissioning Data Set data, must be submitted to the Secondary Uses Service.

COMMISSIONING DATA SET NOTATION

Change to Supporting Information: Changed Description

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

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

Repeats Column Notation

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

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

Rules Column Notation

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

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

Notation Examples

The following are examples of some common scenarios:

EXAMPLE 1: **A MANDATORY Data Group with differing Sub-Groups and component data status conditions.**
The following example shows a **MANDATORY** Data Group - therefore the Data Group must be present for the CDS Type to be validated and accepted for processing by the Secondary Uses Service. When a Data Group is used: 1. All **MANDATORY** Sub Groups and/or Data Elements must be present 2. Any **REQUIRED** Sub Groups and/or Data Elements must be present if the data is available 3. Any **OPTIONAL** Sub Groups and/or Data Elements may be omitted The following data structure is one of three options when completing the Patient Identity Data Group:

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

EXPLANATION:

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

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

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

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

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

When the Data Group is used:

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

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

EXPLANATION:

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

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

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

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

EXAMPLE 3:
An OPTIONAL Data Group with differing component data status conditions.

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

When the Data Group is used:

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

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

EXPLANATION:

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

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

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

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

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

COMMISSIONING DATA SETS OVERVIEW

Change to Supporting Information: Changed Description

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

Commissioning Data Sets currently support the following ACTIVITIES:

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

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

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

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

COMMISSIONING DATA SET SUBMISSION PROTOCOL

Change to Supporting Information: Changed Description

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

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

Net Change:
~~Net Change processes are managed by specific data settings as defined in the CDS V6-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol / 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 he original CDS Type record, after the CDS

V6-2 Type 005N - CDS Transaction Header Group - Net Change Protocol/ CDS V6-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol. See the CDS V6-2 or CDS V6-3 XML Schema Release Notes which can be downloaded via the XML Schema TRUD Download page.

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

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

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.

ECDS V4 TYPE 001 - CDS INTERCHANGE HEADER OVERVIEW

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.

ECDS V4 TYPE 002 - CDS INTERCHANGE TRAILER OVERVIEW

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.

ECDS V4 TYPE 003 - CDS MESSAGE HEADER OVERVIEW

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.

ECDS V4 TYPE 004 - CDS MESSAGE TRAILER OVERVIEW

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.

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

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.

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

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.

EMERGENCY CARE ARRIVAL DATE

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.~~

EMERGENCY CARE ARRIVAL TIME

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.~~

EMERGENCY CARE ATTENDANCE

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

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.~~

EMERGENCY CARE ATTENDANCE CONCLUSION TIME

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.~~

EMERGENCY CARE DATA SET VERSION 4 OVERVIEW

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.

EMERGENCY CARE DATE SEEN FOR TREATMENT

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.~~

EMERGENCY CARE DEPARTMENT

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.

EMERGENCY CARE DEPARTURE DATE

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.~~

EMERGENCY CARE DEPARTURE TIME

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.~~

EMERGENCY CARE EPISODE (RETIRED) renamed from EMERGENCY CARE EPISODE

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

~~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 with "NHS Data Model and Dictionary - Archive Request" in the email subject line.**

~~The Emergency Care Episode may result in a DECISION TO ADMIT.~~

EMERGENCY CARE EPISODE (RETIRED) renamed from EMERGENCY CARE EPISODE

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

- Changed 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

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EMERGENCY CARE INITIAL ASSESSMENT DATE

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.~~

EMERGENCY CARE INITIAL ASSESSMENT TIME

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

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.~~

HES DATA DICTIONARY

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.

HOSPITAL EPISODE STATISTICS

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.

SAME DAY EMERGENCY CARE

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
shortname	SDEC

SAME DAY EMERGENCY CARE ATTENDANCE

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

URGENT AND EMERGENCY CARE ACTIVITY

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

URGENT AND EMERGENCY CARE ACTIVITY END TIMESTAMP

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.

URGENT AND EMERGENCY CARE ACTIVITY START DATE AND TIME

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

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

URGENT AND EMERGENCY CARE EXTENDED CARE EPISODE

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 that 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

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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

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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

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 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~~	~~Emergency Care Attendance~~
160	Urgent and Emergency Care Activity

CDS MESSAGE VERSION NUMBER

Change to Attribute: Changed Description

The version number of the Commissioning Data Set XML Schema in use.

The Commissioning Data Set message version numbers are updated as required during the on-going message development processes.

National Codes:

NHS003	The 2000 / 2001 Specification
NHS004	The 2004 / 2005 CDS XML Specification
NHS005	The 2005 / 2006 CDS XML Specification: For implementation of XML messaging in the Secondary Uses Service
CDS006	The 2007 CDS-XML Specification (CDS V6-0/6-1/6-1-1): Note the change to the prefix **CDS**
CDS062	The 2012 CDS XML Specification (V6-2/6-2-1/6-2-2/6-2-3/6-2-0): Note the change to the format which represents the sub-version identifier (version 6-2)
CDS063	The 2022 CDS XML Specification (V6-3)
ECDS04	The 2023 ECDS XML Specification (ECDS V4)

CDS TYPE CODE

Change to Attribute: Changed Description

A code to identify the specific type of Commissioning Data Set data.

Note:

- ~~National Code 011 '*Emergency Care Attendance*' is **only** valid for:~~
  - ~~CDS V6-2-2 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)
~~011~~	~~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

CONSULTATION MECHANISM

Change to Attribute: Changed 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.

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)

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:

URGENT AND EMERGENCY CARE ACTIVITY TYPE

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

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

ASSAULT LOCATION DESCRIPTION

Change to Data Element: Changed 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.

CARE PROFESSIONAL CLINICAL RESPONSIBILITY TIMESTAMP

Change to Data Element: Changed 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 CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR FOR URGENT AND EMERGENCY CARE
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 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:

CDS TYPE	DESCRIPTION	CDS ORIGINATING DATE (used to populate the CDS ACTIVITY DATE)
010	Accident and Emergency Attendance (Retired 1 November 2020)	
~~011~~	~~Emergency Care Attendance~~	~~EMERGENCY CARE ARRIVAL DATE, EMERGENCY CARE ARRIVAL TIME~~
011	Urgent and Emergency Care Activity	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)
020	Outpatient (known in the Schema as Care Activity)	APPOINTMENT DATE
021	Future Outpatient (known in the Schema as Future Care Activity)	APPOINTMENT DATE
030	EAL End Of Period Census - STANDARD	DECIDED TO ADMIT DATE
040	EAL End Of Period Census - OLD	NHS SERVICE AGREEMENT CHANGE DATE
050	EAL End Of Period Census - NEW	NHS SERVICE AGREEMENT CHANGE DATE
060	EAL Event During Period - ADD	DECIDED TO ADMIT DATE
070	EAL Event During Period - REMOVE	ELECTIVE ADMISSION LIST REMOVAL DATE
080	EAL Event During Period - OFFER	OFFERED FOR ADMISSION DATE
090	EAL Event During Period - AVAILABLE / UNAVAILABLE	SUSPENSION START DATE
100	EAL Event During Period - OLD SERVICE AGREEMENT	NHS SERVICE AGREEMENT CHANGE DATE
110	EAL Event During Period - NEW SERVICE AGREEMENT	NHS SERVICE AGREEMENT CHANGE DATE
120	Finished Birth Episode	END DATE (EPISODE)
130	Finished General Episode	END DATE (EPISODE)

140	Finished Delivery Episode	END DATE (EPISODE)
150	Other Birth	DELIVERY DATE (CDS V6-2) / DELIVERY TIMESTAMP (CDS V6-3)
160	Other Delivery	DELIVERY DATE (VDS V6-2) / DELIVERY TIMESTAMP (CDS V6-3)
170	Detained and/or Long-Term Psychiatric Census	DETAINED AND (OR) LONG TERM PSYCHIATRIC CENSUS DATE
180	Unfinished Birth Episode	START DATE (EPISODE)
190	Unfinished General Episode	START DATE (EPISODE)
200	Unfinished Delivery Episode	START DATE (EPISODE)

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

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

CDS INTERCHANGE CONTROL REFERENCE

Change to Data Element: Changed Description

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

Notes:
CDS INTERCHANGE CONTROL REFERENCE is the same as attribute CDS INTERCHANGE CONTROL REFERENCE.

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

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

For Commissioning Data Sets 6-2, 6-2-2 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.

CDS RECORD IDENTIFIER

Change to Data Element: Changed Description

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

Notes:
CDS RECORD IDENTIFIER is the same as attribute RECORD IDENTIFIER.

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

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

The CDS RECORD IDENTIFIER consists of the following components:

REF	RID COMPONENT	FORMAT	CODES / VALUES
~~1~~	~~CDS SENDER IDENTITY/ORGANISATION IDENTIFIER (CDS SENDER)~~	~~an5~~	~~As generated in the CDS V6-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol or the CDS V6-2 Type 005N - CDS Transaction Header Group - Net Change Protocol~~ ~~*Or*~~ ~~As generated in the CDS V6-2-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol or the CDS V6-2-2 Type 005N - CDS Transaction Header Group - Net Change Protocol~~ ~~*Or*~~ ~~As generated in the CDS V6-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol or CDS V6-3 Type 005N -~~

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

CLINICAL TRIAL IDENTIFIER

Change to Data Element: Changed 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 FINDING TIMESTAMP

Change to Data Element: Changed 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 TIMESTAMP

Change to Data Element: Changed 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:

ACTIVITY DATE
ACTIVITY TIME

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:

CONSULTATION MECHANISM

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	DECIDED TO ADMIT DATES AND TIMES

DECIDED TO ADMIT DATE AND TIME

Change to Data Element: New Data Element

DECIDED TO ADMIT DATE AND TIME

Attribute:

DECIDED TO ADMIT DATE
DECIDED TO ADMIT TIME

DISEASE OUTBREAK NOTIFICATION DESCRIPTION

Change to Data Element: Changed 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 CONDITION (SNOMED CT)

Change to Data Element: New Data Element

Format/Length:	See SNOMED CT CODE
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	EMED3 FIT NOTE CONDITIONS (SNOMED CT)

EMED3 FIT NOTE CONDITION (SNOMED CT)

Change to Data Element: New Data Element

EMED3 FIT NOTE CONDITION (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

EMERGENCY CARE DEPARTMENT TYPE (PATIENT LEVEL INFORMATION COSTING)

Change to Data Element: Changed Description, linked Attribute

Format/Length:	an2
~~National Codes:~~	
National Codes:	See EMERGENCY CARE DEPARTMENT TYPE FOR PATIENT LEVEL INFORMATION COSTING
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 Description, linked Attribute

EMERGENCY CARE DEPARTMENT TYPE (PATIENT LEVEL INFORMATION COSTING)

Attribute:

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

EMERGENCY CARE TREATMENT ALLOCATION TIMESTAMP

Change to Data Element: Changed 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.

INJURY DATE AND TIME

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	INJURY DATES AND TIMES

INJURY DATE AND TIME

Change to Data Element: New Data Element

INJURY DATE AND TIME

Attribute:

PERSON PROPERTY EFFECTIVE START DATE
PERSON PROPERTY EFFECTIVE START TIME

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

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:

ACTIVITY DATE
ACTIVITY TIME

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:

PERSON PROPERTY EFFECTIVE END DATE
PERSON PROPERTY EFFECTIVE END TIME

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 ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER 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 ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER 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	ORGANISATION SITE IDENTIFIERS (DISCHARGE FROM URGENT AND EMERGENCY CARE)

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:

ORGANISATION SITE IDENTIFIER

ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
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 (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 ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER 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

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:

ACTIVITY DATE
ACTIVITY TIME

SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP

Change to Data Element: Changed 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.

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:

ACTIVITY DATE
ACTIVITY TIME

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:

ACTIVITY IDENTIFIER

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:

ACTIVITY DATE
ACTIVITY TIME

URGENT AND EMERGENCY CARE ACTIVITY TYPE

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See URGENT AND EMERGENCY CARE ACTIVITY TYPE
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	URGENT AND EMERGENCY CARE ACTIVITY TYPES

URGENT AND EMERGENCY CARE ACTIVITY TYPE

Change to Data Element: New Data Element

URGENT AND EMERGENCY CARE ACTIVITY TYPE

Attribute:

URGENT AND EMERGENCY CARE ACTIVITY TYPE

URGENT AND EMERGENCY CARE ACUITY (SNOMED CT)

Change to Data Element: New Data Element

Format/Length:	See SNOMED CT CODE

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 SNOMED CT CODE
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

Change to Data Element: New Data Element

URGENT AND EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

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:

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

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

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

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:	See SNOMED CT CODE
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:

CLINICAL TERMINOLOGY CODE

URGENT AND EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT)

Change to Data Element: New Data Element

Format/Length:	See SNOMED CT CODE
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:

CLINICAL TERMINOLOGY CODE

URGENT AND EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:
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

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 SNOMED CT CODE
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:

CLINICAL TERMINOLOGY CODE

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

Change to Data Element: New Data Element

URGENT AND EMERGENCY CARE EXTENDED CARE EPISODE IDENTIFIER

Attribute:

ACTIVITY IDENTIFIER

URGENT AND EMERGENCY CARE INITIAL ASSESSMENT TIMESTAMP

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:

ACTIVITY DATE
ACTIVITY TIME

URGENT AND EMERGENCY CARE PROCEDURE (SNOMED CT)

Change to Data Element: New Data Element

Format/Length:	See SNOMED CT CODE
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

EMERGENCY CARE DATA SET VERSION 4 XML SCHEMA CONSTRAINTS

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	None = There is no data pattern, to which the data	Any other entry = Shows the data pattern, to which the	

	conform, has been applied in the XML Schema	must conform, applied in the XML Schema	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
CDS BULK REPLACEMENT GROUP CODE	None	160	None	None	ECDS V4 only allows submission of data relating to CDS BULK REPLACEMENT GROUP CODE *'Urgent and Emergency Care Activity'*
CDS INTERCHANGE TEST INDICATOR	None	0,1	None	None	The ECDS V4 XML schema allows a null field to be submitted
CDS MESSAGE VERSION NUMBER	an6	ECDS04	None	None	Message version is hard coded in the XML Schema
CDS TYPE CODE	None	011	None	None	ECDS V4 only allows submission of data relating to CDS TYPE CODE *'Urgent and Emergency Care Activity'*
COMMISSIONER REFERENCE IDENTIFIER	None	None	None	None	Default codes not enumerated in the XML Schema
EMED3 FIT NOTE DURATION	None	None	None	None	Default codes not enumerated in the XML Schema

EMERGENCY CARE PLACE OF INJURY (LATITUDE)	None	None	-90.000000-90.000000	None	Range applied to allow correct reporting of EMERGENCY CARE PLACE OF INJURY (LATITUDE)
EMERGENCY CARE PLACE OF INJURY (LONGITUDE)	None	None	-180.000000-180.000000	None	Range applied to allow correct reporting of EMERGENCY CARE PLACE OF INJURY (LONGITUDE)
ETHNIC CATEGORY	max an2	None	None	None	Existing Format/Length means fixed length which is incorrect. Unable to change this as it is used in other data sets. Second character can be for local use. Format/Length amended to max an2
GENERAL MEDICAL PRACTICE (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	None	Removed	None	None	

(DISCHARGE FROM URGENT AND EMERGENCY CARE)					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
POSTCODE OF USUAL ADDRESS	min an2 max an8	None	None	None	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