

Type:	Change Request
Reference:	1740
Version No:	1.0
Subject:	Update to Commissioning Data Set Type 011 Emergency Care
Effective Date:	1 April 2021
Reason for Change:	Change to Information Standards
Publication Date:	8 September 2020

Background:

Commissioning Data Set V6-2-2 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, Commissioning Data Set V6-2-3 Type 011 Emergency Care.

A number of changes have been identified since the last version, and the Commissioning Data Set V6-2-3 Type 011 Emergency Care includes:

Introduction of Data Elements:

- AMBULANCE CALL IDENTIFIER
- CARE CONTACT IDENTIFIER (CONVEYING AMBULANCE TRUST)
- EMERGENCY CARE EXPECTED DATE AND TIMESTAMP OF TREATMENT
- EMERGENCY CARE TREATMENT ALLOCATION TIMESTAMP
- CODED ASSESSMENT TOOL TYPE (SNOMED CT)
- PERSON SCORE
- ASSESSMENT TOOL VALIDATION TIMESTAMP
- CODED OBSERVATION (SNOMED CT)
- OBSERVATION VALUE
- UCUM UNIT OF MEASUREMENT
- CODED OBSERVATION TIMESTAMP
- CODED FINDING (SNOMED CT)
- CODED FINDING TIMESTAMP
- CARE PROFESSIONAL CLINICAL RESPONSIBILITY TIMESTAMP
- EMERGENCY CARE CLINICALLY READY TO PROCEED TIMESTAMP
- DISEASE OUTBREAK NOTIFICATION (SNOMED CT)
- DISEASE OUTBREAK NOTIFICATION DESCRIPTION
- Pilot item ETHNIC CATEGORY 2021
- Pilot item ASSAULT LOCATION DESCRIPTION

Removal of Data Elements:

- EMERGENCY CARE ATTENDANCE CONCLUSION DATE
- EMERGENCY CARE ATTENDANCE CONCLUSION TIME
- AMBULANCE INCIDENT NUMBER
- DISEASE OUTBREAK NOTIFICATION

Addition and amendment of National Codes in:

- PROFESSIONAL REGISTRATION ISSUER CODE
- EMERGENCY CARE DEPARTMENT TYPE

Commissioning Data Set V6-2 Type 010 - Accident and Emergency CDS has been retired. Note that submission of the Commissioning Data Set V6-2 Type 010 - Accident and Emergency CDS will not be accepted by the Secondary Uses Service from 01 November 2020.

A new Commissioning Data Set version 6-2-3 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). Changes have been made to the Organisation Code identifiers to comply with [DCB0090: Health and Social Care Organisation Reference Data](#). The following new data items are being introduced:

- ORGANISATION IDENTIFIER (CDS SENDER) to replace CDS SENDER IDENTITY
- ORGANISATION IDENTIFIER (CDS RECIPIENT) to replace CDS PRIME RECIPIENT IDENTITY and CDS COPY RECIPIENT IDENTITY

Note that the usage of the new ORGANISATION IDENTIFIER fields within the Commissioning Data Set headers remains the same as before.

The existing Commissioning Data Sets and CDS-XML Schema release versions 6-2 and 6-2-1 and 6-2-2 remain valid until future notification.

This Change Request adds CDS V6-2-3 Type 011 Emergency Care Commissioning Data Set to the NHS Data Model and Dictionary to support the Information Standard.

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

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

Summary of changes:

Data Set

CDS V6-2-3 TYPE 001 - CDS INTERCHANGE HEADER	New Data Set
CDS V6-2-3 TYPE 002 - CDS INTERCHANGE TRAILER	New Data Set
CDS V6-2-3 TYPE 003 - CDS MESSAGE HEADER	New Data Set
CDS V6-2-3 TYPE 004 - CDS MESSAGE TRAILER	New Data Set
CDS V6-2-3 TYPE 005B - CDS TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL	New Data Set
CDS V6-2-3 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL	New Data Set
CDS V6-2-3 TYPE 011 - EMERGENCY CARE CDS	New Data Set
CDS V6-2 TYPE 001 - CDS INTERCHANGE HEADER	Changed Dataset
CDS V6-2 TYPE 002 - CDS INTERCHANGE TRAILER	Changed Dataset
CDS V6-2 TYPE 003 - CDS MESSAGE HEADER	Changed Dataset
CDS V6-2 TYPE 004 - CDS MESSAGE TRAILER	Changed Dataset
CDS V6-2 TYPE 005B - CDS TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL	Changed Dataset
CDS V6-2 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL	Changed Dataset
CDS V6-2 TYPE 010 - ACCIDENT AND EMERGENCY CDS (RETIRED) renamed from CDS V6-2 TYPE 010 - ACCIDENT AND EMERGENCY CDS	Changed Description, Name, status to Retired

Supporting Information

ACCIDENT AND EMERGENCY ATTENDANCE (RETIRED) renamed from ACCIDENT AND EMERGENCY ATTENDANCE	Changed Description, Name, status to Retired
ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE (RETIRED) renamed from ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE	Changed Description, Name, status to Retired
ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION TIME (RETIRED) renamed from ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION TIME	Changed Description, Name, status to Retired
ACCIDENT AND EMERGENCY CODING TABLES (RETIRED) renamed from ACCIDENT AND EMERGENCY CODING TABLES	Changed Description, Name, status to Retired
ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT (RETIRED) renamed from ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT	Changed Description, Name, status to Retired
ACCIDENT AND EMERGENCY DEPARTMENT (RETIRED) renamed from ACCIDENT AND EMERGENCY DEPARTMENT	Changed Description, Name, status to Retired
ACCIDENT AND EMERGENCY DEPARTURE DATE (RETIRED) renamed from ACCIDENT AND EMERGENCY DEPARTURE DATE	Changed Description, Name, status to Retired
ACCIDENT AND EMERGENCY DEPARTURE TIME (RETIRED) renamed from ACCIDENT AND EMERGENCY DEPARTURE TIME	Changed Description, Name, status to Retired
ACCIDENT AND EMERGENCY DIAGNOSIS TABLES (RETIRED) renamed from ACCIDENT AND EMERGENCY DIAGNOSIS TABLES	Changed Description, Name, status to Retired
ACCIDENT AND EMERGENCY EPISODE (RETIRED) renamed from ACCIDENT AND EMERGENCY EPISODE	Changed Description, Name, status to Retired
ACCIDENT AND EMERGENCY INITIAL ASSESSMENT DATE (RETIRED) renamed from ACCIDENT AND EMERGENCY INITIAL ASSESSMENT DATE	Changed Description, Name, status to Retired
ACCIDENT AND EMERGENCY INITIAL ASSESSMENT TIME (RETIRED) renamed from ACCIDENT AND EMERGENCY INITIAL ASSESSMENT TIME	Changed Description, Name, status to Retired
ACCIDENT AND EMERGENCY INVESTIGATION TABLE (RETIRED) renamed from ACCIDENT AND EMERGENCY INVESTIGATION TABLE	Changed Description, Name, status to Retired

ACCIDENT AND EMERGENCY TIME SEEN FOR TREATMENT (RETIRED) renamed from ACCIDENT AND EMERGENCY TIME SEEN FOR TREATMENT	Changed Description, Name, status to Retired
ACCIDENT AND EMERGENCY TREATMENT TABLES (RETIRED) renamed from ACCIDENT AND EMERGENCY TREATMENT TABLES	Changed Description, Name, status to Retired
ARRIVAL DATE AT ACCIDENT AND EMERGENCY DEPARTMENT (RETIRED) renamed from ARRIVAL DATE AT ACCIDENT AND EMERGENCY DEPARTMENT	Changed Description, Name, status to Retired
ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT (RETIRED) renamed from ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT	Changed Description, Name, status to Retired
ASSESSMENT TOOL VALIDATION TIMESTAMP	New Supporting Information
CANCER PATHWAY	Changed Description
CARE PROFESSIONAL CLINICAL RESPONSIBILITY TIMESTAMP	New Supporting Information
CDS TYPE	Changed Description
CDS V6-2-3 TYPE 001 - CDS INTERCHANGE HEADER OVERVIEW	New Supporting Information
CDS V6-2-3 TYPE 002 - CDS INTERCHANGE TRAILER OVERVIEW	New Supporting Information
CDS V6-2-3 TYPE 003 - CDS MESSAGE HEADER OVERVIEW	New Supporting Information
CDS V6-2-3 TYPE 004 - CDS MESSAGE TRAILER OVERVIEW	New Supporting Information
CDS V6-2-3 TYPE 005B - CDS TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL OVERVIEW	New Supporting Information
CDS V6-2-3 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL OVERVIEW	New Supporting Information
CDS V6-2-3 TYPE 011 - EMERGENCY CARE CDS OVERVIEW	New Supporting Information
CDS V6-2 TYPE 010 - ACCIDENT AND EMERGENCY CDS OVERVIEW (RETIRED) renamed from CDS V6-2 TYPE 010 - ACCIDENT AND EMERGENCY CDS OVERVIEW	Changed Description, Name, status to Retired
CDS VERSION 6-2 MENU	Changed Description
CLINICAL CODING INTRODUCTION	Changed Description
CODING AND CLASSIFICATIONS MENU	Changed Description
COMMISSIONING DATA SET BUSINESS RULES	Changed Dataset
COMMISSIONING DATA SET DATA DUPLICATION	Changed Description
COMMISSIONING DATA SET MANDATED DATA FLOWS	Changed Description
COMMISSIONING DATA SET NOTATION	Changed Description, Dataset
COMMISSIONING DATA SETS MENU	Changed Description
COMMISSIONING DATA SETS OVERVIEW	Changed Description
COMMISSIONING DATA SET SUBMISSION AND ORGANISATION MERGERS	Changed Description
COMMISSIONING DATA SET SUBMISSION PROTOCOL	Changed Description
COMMISSIONING DATA SET VERSION 6-2 TYPE LIST	Changed Description
COMMISSIONING DATA SET VERSIONS	Changed Description
DIAGNOSTIC IMAGING DATA SET OVERVIEW	Changed Description
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 CLINICALLY READY TO PROCEED TIMESTAMP	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	New Supporting Information
EMERGENCY CARE EXPECTED DATE AND TIMESTAMP OF TREATMENT	New Supporting Information
EMERGENCY CARE INITIAL ASSESSMENT DATE	Changed Description
EMERGENCY CARE INITIAL ASSESSMENT TIME	Changed Description
EMERGENCY CARE TIME SEEN FOR TREATMENT	Changed Description
FEMALE GENITAL MUTILATION DATA SET OVERVIEW	Changed Description
ORGANISATION MERGERS	Changed Description
REFERRAL TO TREATMENT CLOCK STOP ADMINISTRATIVE EVENT	Changed Description
SECONDARY USES SERVICE	Changed Dataset
URGENT TREATMENT CENTRE	Changed Description
XML SCHEMA TRUD DOWNLOAD	Changed Description

Class Definitions

[ACTIVITY GROUP](#)

[ADDRESS STRUCTURED](#)

[ADDRESS UNSTRUCTURED](#)

[CARE CONTACT](#)

[CARE PROFESSIONAL ORGANISATION](#)

[CLINICAL INTERVENTION](#)

[CRITICAL CARE PERIOD](#)

[LOCATION](#)

[LODGED PATIENT](#)

[PATIENT DIAGNOSIS](#)

[PERSON NAME STRUCTURED](#)

[PERSON NAME UNSTRUCTURED](#)

[PERSON PROPERTY QUALIFIER](#)

[PLANNED ACTIVITY DATE TIME](#)

[REFERRAL REQUEST](#)

Changed Attributes

Changed Dataset

Changed Dataset

Changed Attributes

Changed Attributes

Changed Attributes

Changed Description

Changed Attributes

Changed Description

Changed Attributes

Changed Dataset

Changed Dataset

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Changed Attributes

Changed Attributes

Attribute Definitions

[A AND E ATTENDANCE CATEGORY \(RETIRED\)](#) renamed from [A AND E ATTENDANCE CATEGORY](#)

Changed Description, Dataset, Name, status to Retired

[A AND E INITIAL ASSESSMENT TRIAGE CATEGORY \(RETIRED\)](#) renamed from [A AND E INITIAL ASSESSMENT TRIAGE CATEGORY](#)

Changed Description, Name, status to Retired

[A AND E PATIENT GROUP \(RETIRED\)](#) renamed from [A AND E PATIENT GROUP](#)

Changed Description, Dataset, Name, status to Retired

[A AND E STREAM \(RETIRED\)](#) renamed from [A AND E STREAM](#)

Changed Description, Name, status to Retired

[ACCIDENT AND EMERGENCY ARRIVAL MODE \(RETIRED\)](#) renamed from [ACCIDENT AND EMERGENCY ARRIVAL MODE](#)

Changed Description, Dataset, Name, status to Retired

[ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL \(RETIRED\)](#) renamed from [ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL](#)

Changed Description, Dataset, Name, status to Retired

[ACCIDENT AND EMERGENCY DEPARTMENT TYPE \(RETIRED\)](#) renamed from [ACCIDENT AND EMERGENCY DEPARTMENT TYPE](#)

Changed Description, Dataset, Name, status to Retired

[ACCIDENT AND EMERGENCY DIAGNOSIS \(RETIRED\)](#) renamed from [ACCIDENT AND EMERGENCY DIAGNOSIS](#)

Changed Description, Dataset, Name, status to Retired

[ACCIDENT AND EMERGENCY INCIDENT LOCATION TYPE \(RETIRED\)](#) renamed from [ACCIDENT AND EMERGENCY INCIDENT LOCATION TYPE](#)

Changed Description, Dataset, Name, status to Retired

[ACCIDENT AND EMERGENCY INVESTIGATION \(RETIRED\)](#) renamed from [ACCIDENT AND EMERGENCY INVESTIGATION](#)

Changed Description, Dataset, Name, status to Retired

[ACCIDENT AND EMERGENCY TREATMENT \(RETIRED\)](#) renamed from [ACCIDENT AND EMERGENCY TREATMENT](#)

Changed Description, Dataset, Name, status to Retired

[ACTIVITY DATE](#)

Changed Dataset

[ACTIVITY DATE AND TIME TYPE](#)

Changed Description

[ACTIVITY DATE TYPE](#)

Changed Description

[ACTIVITY GROUP TYPE](#)

Changed Description

[ACTIVITY IDENTIFIER](#)

Changed Dataset

[ACTIVITY SERVICE REQUEST DATE](#)

Changed Dataset

[ACTIVITY SERVICE REQUEST TIME](#)

Changed Dataset

[ACTIVITY TIME](#)

Changed Description, Dataset

[ACTIVITY TIME TYPE](#)

Changed Description

[ADDRESS](#)

Changed Dataset

ADMISSION METHOD	Changed Description
AMBULANCE CALL IDENTIFIER	Changed Dataset
ANATOMICAL AREA (RETIRED) renamed from ANATOMICAL AREA	Changed Description, Name, status to Retired
CANCER SURGICAL ADMISSION TYPE	Changed Description
CARE CONTACT TYPE	Changed Description
CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR FOR EMERGENCY CARE	Changed Dataset
CARE PROFESSIONAL TIER FOR EMERGENCY CARE	Changed Dataset
CARER SUPPORT INDICATOR	Changed Dataset
CDS BULK REPLACEMENT GROUP CODE	Changed Description, Dataset
CDS INTERCHANGE APPLICATION REFERENCE	Changed Dataset
CDS INTERCHANGE CONTROL COUNT	Changed Dataset
CDS INTERCHANGE CONTROL REFERENCE	Changed Dataset
CDS INTERCHANGE RECEIVER IDENTITY	Changed Dataset
CDS INTERCHANGE SENDER IDENTITY	Changed Dataset
CDS INTERCHANGE TEST INDICATOR	Changed Dataset
CDS MESSAGE REFERENCE	Changed Dataset
CDS MESSAGE TYPE	Changed Dataset
CDS MESSAGE VERSION NUMBER	Changed Description, Dataset
CDS PROTOCOL IDENTIFIER CODE	Changed Dataset
CDS TYPE CODE	Changed Description, Dataset
CDS UPDATE TYPE	Changed Dataset
CLINICAL CLASSIFICATION CODE	Changed Dataset
CLINICAL TERMINOLOGY CODE	Changed Dataset
CLINICAL TRIAL IDENTIFIER	Changed Dataset
CODED CLINICAL ENTRY SEQUENCE NUMBER	Changed Dataset
COMMISSIONER REFERENCE NUMBER	Changed Dataset
DECIDED TO ADMIT DATE	Changed Dataset
DECIDED TO ADMIT TIME	Changed Dataset
DIAGNOSIS SCHEME IN USE	Changed Description, Dataset
EMERGENCY CARE ATTENDANCE CATEGORY	Changed Dataset
EMERGENCY CARE DEPARTMENT TYPE	Changed Description, Dataset
ETHNIC CATEGORY 2021	Changed Dataset
ETHNIC CATEGORY CODE 2001	Changed Dataset
EVENT DATE	Changed Dataset
EVENT TIME	Changed Description, Dataset
GENERAL MEDICAL PRACTITIONER PPD CODE	Changed Dataset
GEOGRAPHIC CO-ORDINATE	Changed Dataset
INITIAL DIAGNOSIS CARE SETTING OR SERVICE FOR HIV	Changed Description
INVESTIGATION SCHEME IN USE (RETIRED) renamed from INVESTIGATION SCHEME IN USE	Changed Description, Dataset, Name, status to Retired
LOCAL CARE PROFESSIONAL IDENTIFIER (RETIRED) renamed from LOCAL CARE PROFESSIONAL IDENTIFIER	Changed Description, Dataset, Name, status to Retired
LOCAL PATIENT IDENTIFIER	Changed Dataset
LODGING END TIME	Changed Description
LODGING START TIME	Changed Description
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE	Changed Dataset
NHS NUMBER	Changed Description, Dataset
NHS NUMBER STATUS INDICATOR CODE	Changed Dataset
NHS SERVICE AGREEMENT LINE NUMBER	Changed Dataset

NHS SERVICE AGREEMENT NUMBER	Changed Dataset
OBSERVATION VALUE	Changed Dataset
ORGANISATION CODE	Changed Dataset
ORGANISATION IDENTIFIER	Changed Dataset
ORGANISATION SITE CODE	Changed Dataset
ORGANISATION SITE IDENTIFIER	Changed Dataset
OVERSEAS VISITOR CHARGING CATEGORY	Changed Dataset
OVERSEAS VISITOR STATUS CLASSIFICATION	Changed Dataset
PATIENT PATHWAY IDENTIFIER	Changed Dataset
PATIENT SOURCE SETTING TYPE FOR DIAGNOSTIC IMAGING	Changed Description
PERSON AGE	Changed Dataset
PERSON BIRTH DATE	Changed Dataset
PERSON GENDER CODE	Changed Dataset
PERSON NAME WORD TEXT	Changed Dataset
PERSON OBSERVATION TEXT STRING	Changed Dataset
PERSON PROPERTY EFFECTIVE END DATE	Changed Dataset
PERSON PROPERTY EFFECTIVE END TIME	Changed Dataset
PERSON PROPERTY EFFECTIVE START DATE	Changed Dataset
PERSON PROPERTY EFFECTIVE START TIME	Changed Dataset
PERSON PROPERTY RECORDED DATE	Changed Dataset
PERSON PROPERTY RECORDED TIME	Changed Description, Dataset
PERSON SCORE	Changed Dataset
PERSON STATED GENDER CODE	Changed Dataset
PLANNED ACTIVITY DATE	Changed Dataset
PLANNED ACTIVITY DATE AND TIME TYPE	New Attribute
PLANNED ACTIVITY TIME	New Attribute
POSTCODE	Changed Dataset
PRESENT ON ADMISSION INDICATOR	Changed Dataset
PROCEDURE SCHEME IN USE	Changed Dataset
PROFESSIONAL REGISTRATION BODY CODE	Changed Dataset
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER	Changed Dataset
PROVIDER REFERENCE NUMBER	Changed Dataset
RECORD IDENTIFIER	Changed Dataset
REFERRAL TO TREATMENT PERIOD END DATE	Changed Dataset
REFERRAL TO TREATMENT PERIOD START DATE	Changed Description, Dataset
REFERRAL TO TREATMENT PERIOD STATUS	Changed Dataset
SAFEGUARDING VULNERABILITY FACTORS TYPE	Changed Description
SOURCE OF ADMISSION	Changed Description
SOURCE OF REFERRAL FOR A AND E (RETIRED) renamed from SOURCE OF REFERRAL FOR A AND E	Changed Description, Dataset, Name, status to Retired
SOURCE OF REFERRAL FOR COMMUNITY	Changed Description
SOURCE OF REFERRAL FOR MATERNITY	Changed Description
SOURCE OF REFERRAL FOR MENTAL HEALTH	Changed Description
SOURCE OF REFERRAL FOR OUT-PATIENTS	Changed Description
TREATMENT FUNCTION CODE	Changed Dataset
UCUM UNIT OF MEASUREMENT	Changed Dataset
UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	Changed Dataset
WAITING TIME MEASUREMENT TYPE	Changed Dataset
WITHHELD IDENTITY REASON	Changed Dataset
Data Elements	
A AND E ATTENDANCE CONCLUSION TIME (RETIRED) renamed from A AND E ATTENDANCE CONCLUSION TIME	Changed Description, linked Attribute, Dataset, Name, status to Retired
A AND E ATTENDANCE NUMBER (RETIRED) renamed from A AND E ATTENDANCE NUMBER	

[A AND E DEPARTMENT TYPE \(RETIRED\)](#) renamed from [A AND E DEPARTMENT TYPE](#)

[A AND E DEPARTURE TIME \(RETIRED\)](#) renamed from [A AND E DEPARTURE TIME](#)

[A AND E INCIDENT LOCATION TYPE \(RETIRED\)](#) renamed from [A AND E INCIDENT LOCATION TYPE](#)

[A AND E INITIAL ASSESSMENT TIME \(RETIRED\)](#) renamed from [A AND E INITIAL ASSESSMENT TIME](#)

[A AND E PATIENT GROUP \(RETIRED\)](#) renamed from [A AND E PATIENT GROUP](#)

[A AND E STAFF MEMBER CODE \(RETIRED\)](#) renamed from [A AND E STAFF MEMBER CODE](#)

[A AND E TIME SEEN FOR TREATMENT \(RETIRED\)](#) renamed from [A AND E TIME SEEN FOR TREATMENT](#)

[ACCESSIBLE INFORMATION PROFESSIONAL REQUIRED CODE \(SNOMED CT\)](#)

[ACCIDENT AND EMERGENCY ARRIVAL MODE CODE \(RETIRED\)](#) renamed from [ACCIDENT AND EMERGENCY ARRIVAL MODE CODE](#)

[ACCIDENT AND EMERGENCY ATTENDANCE CATEGORY CODE \(RETIRED\)](#) renamed from [ACCIDENT AND EMERGENCY ATTENDANCE CATEGORY CODE](#)

[ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE \(RETIRED\)](#) renamed from [ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE](#)

[ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL CODE \(RETIRED\)](#) renamed from [ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL CODE](#)

[ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT \(RETIRED\)](#) renamed from [ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT](#)

[ACCIDENT AND EMERGENCY DEPARTURE DATE \(RETIRED\)](#) renamed from [ACCIDENT AND EMERGENCY DEPARTURE DATE](#)

[ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST \(RETIRED\)](#) renamed from [ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST](#)

[ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND \(RETIRED\)](#) renamed from [ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND](#)

[ACCIDENT AND EMERGENCY INITIAL ASSESSMENT DATE \(RETIRED\)](#) renamed from [ACCIDENT AND EMERGENCY INITIAL ASSESSMENT DATE](#)

[ACCIDENT AND EMERGENCY INVESTIGATION - FIRST \(RETIRED\)](#) renamed from [ACCIDENT AND EMERGENCY INVESTIGATION - FIRST](#)

[ACCIDENT AND EMERGENCY INVESTIGATION - SECOND \(RETIRED\)](#) renamed from [ACCIDENT AND EMERGENCY INVESTIGATION - SECOND](#)

[ACCIDENT AND EMERGENCY TREATMENT - FIRST \(RETIRED\)](#) renamed from [ACCIDENT AND EMERGENCY TREATMENT - FIRST](#)

[ACCIDENT AND EMERGENCY TREATMENT - SECOND \(RETIRED\)](#) renamed from [ACCIDENT AND EMERGENCY TREATMENT - SECOND](#)

Changed Description, linked Attribute, Dataset, Name, status to Retired

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Changed Dataset

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Changed Description, linked Attribute, Dataset, Name, status to Retired

Changed Description, linked Attribute, Dataset, Name, status to Retired

Changed Description, linked Attribute, Dataset, Name, status to Retired

ACCOMMODATION STATUS (SNOMED CT)	Changed Dataset
ACTIVITY SERVICE REQUEST DATE (EMERGENCY CARE)	Changed Dataset
ACTIVITY SERVICE REQUEST TIME (EMERGENCY CARE)	Changed Dataset
ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT)	Changed Dataset
AGE AT CDS ACTIVITY DATE	Changed Dataset
AMBULANCE CALL IDENTIFIER	Changed Dataset
AMBULANCE INCIDENT NUMBER	Changed Description, Dataset
ARRIVAL DATE (RETIRED) renamed from ARRIVAL DATE	Changed Description, linked Attribute, Dataset, Name, status to Retired
ARRIVAL DATE AND TIME AT ACCIDENT AND EMERGENCY DEPARTMENT (RETIRED)	Changed Description
ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT (RETIRED) renamed from ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT	Changed Description, linked Attribute, Dataset, Name, status to Retired
ASSAULT LOCATION DESCRIPTION	Changed Description, Dataset
ASSESSMENT TOOL VALIDATION TIMESTAMP	New Data Element
ATTENDANCE DATE	Changed Description
CARE CONTACT IDENTIFIER (AMBULANCE SERVICE)	Changed Dataset
CARE PROFESSIONAL CLINICAL RESPONSIBILITY TIMESTAMP	New Data Element
CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR (EMERGENCY CARE)	Changed Dataset
CARE PROFESSIONAL TIER (EMERGENCY CARE)	Changed Dataset
CARER SUPPORT INDICATOR	Changed Dataset
CDS ACTIVITY DATE	Changed Description, Dataset
CDS APPLICABLE DATE	Changed Dataset
CDS APPLICABLE TIME	Changed Dataset
CDS BULK REPLACEMENT GROUP CODE	Changed Dataset
CDS COPY RECIPIENT IDENTITY	Changed Dataset
CDS EXTRACT DATE	Changed Dataset
CDS EXTRACT TIME	Changed Dataset
CDS INTERCHANGE APPLICATION REFERENCE	Changed Dataset
CDS INTERCHANGE CONTROL COUNT	Changed Dataset
CDS INTERCHANGE CONTROL REFERENCE	Changed Dataset
CDS INTERCHANGE DATE OF PREPARATION	Changed Dataset
CDS INTERCHANGE RECEIVER IDENTITY	Changed Dataset
CDS INTERCHANGE SENDER IDENTITY	Changed Dataset
CDS INTERCHANGE TEST INDICATOR	Changed Dataset
CDS INTERCHANGE TIME OF PREPARATION	Changed Dataset
CDS MESSAGE REFERENCE	Changed Dataset
CDS MESSAGE TYPE	Changed Dataset
CDS MESSAGE VERSION NUMBER	Changed Dataset
CDS PRIME RECIPIENT IDENTITY	Changed Dataset
CDS PROTOCOL IDENTIFIER CODE	Changed Dataset
CDS RECORD IDENTIFIER	Changed Description, Dataset
CDS REPORT PERIOD END DATE	Changed Dataset
CDS REPORT PERIOD START DATE	Changed Dataset
CDS SENDER IDENTITY	Changed Description, Dataset
CDS TYPE CODE	Changed Dataset
CDS UNIQUE IDENTIFIER	Changed Dataset
CDS UPDATE TYPE	Changed Dataset
CLINICAL TRIAL IDENTIFIER	Changed Description, Dataset
CODED ASSESSMENT TOOL TYPE (SNOMED CT)	Changed Dataset
CODED CLINICAL ENTRY SEQUENCE NUMBER	Changed Dataset
CODED FINDING (SNOMED CT)	New Data Element

CODED FINDING TIMESTAMP	New Data Element
CODED OBSERVATION (SNOMED CT)	Changed Dataset
CODED OBSERVATION TIMESTAMP	New Data Element
COMMISSIONER REFERENCE NUMBER	Changed Dataset
COMMISSIONING SERIAL NUMBER	Changed Dataset
COMORBIDITY (SNOMED CT)	Changed Dataset
DATE FIRST SEEN	Changed Description
DECIDED TO ADMIT DATE	Changed Dataset
DECIDED TO ADMIT TIME	Changed Dataset
DIAGNOSIS SCHEME IN USE	Changed Dataset
DISEASE OUTBREAK NOTIFICATION	Changed Description
DISEASE OUTBREAK NOTIFICATION (SNOMED CT)	New Data Element
DISEASE OUTBREAK NOTIFICATION DESCRIPTION	New Data Element
EMERGENCY CARE ACUITY (SNOMED CT)	Changed Dataset
EMERGENCY CARE ARRIVAL DATE	Changed Dataset
EMERGENCY CARE ARRIVAL MODE (SNOMED CT)	Changed Dataset
EMERGENCY CARE ARRIVAL TIME	Changed Dataset
EMERGENCY CARE ATTENDANCE CATEGORY	Changed Dataset
EMERGENCY CARE ATTENDANCE IDENTIFIER	Changed Dataset
EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT)	Changed Dataset
EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT)	Changed Dataset
EMERGENCY CARE CLINICAL INVESTIGATION (SNOMED CT)	Changed Dataset
EMERGENCY CARE CLINICALLY READY TO PROCEED TIMESTAMP	New Data Element
EMERGENCY CARE DATE SEEN FOR TREATMENT	Changed Dataset
EMERGENCY CARE DEPARTMENT TYPE	Changed Description, Dataset
EMERGENCY CARE DEPARTURE DATE	Changed Dataset
EMERGENCY CARE DEPARTURE TIME	Changed Dataset
EMERGENCY CARE DIAGNOSIS (SNOMED CT)	Changed Dataset
EMERGENCY CARE DIAGNOSIS QUALIFIER (SNOMED CT)	Changed Dataset
EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT)	Changed Dataset
EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT)	Changed Dataset
EMERGENCY CARE DISCHARGE INFORMATION GIVEN (SNOMED CT)	Changed Dataset
EMERGENCY CARE DISCHARGE STATUS (SNOMED CT)	Changed Dataset
EMERGENCY CARE EXPECTED DATE AND TIMESTAMP OF TREATMENT	New Data Element
EMERGENCY CARE INITIAL ASSESSMENT DATE	Changed Dataset
EMERGENCY CARE INITIAL ASSESSMENT TIME	Changed Dataset
EMERGENCY CARE INJURY ACTIVITY STATUS (SNOMED CT)	Changed Dataset
EMERGENCY CARE INJURY ACTIVITY TYPE (SNOMED CT)	Changed Dataset
EMERGENCY CARE INJURY ALCOHOL OR DRUG INVOLVEMENT (SNOMED CT)	Changed Dataset
EMERGENCY CARE INJURY INTENT (SNOMED CT)	Changed Dataset
EMERGENCY CARE INJURY MECHANISM (SNOMED CT)	Changed Dataset
EMERGENCY CARE PLACE OF INJURY (LATITUDE)	Changed Dataset
EMERGENCY CARE PLACE OF INJURY (LONGITUDE)	Changed Dataset
EMERGENCY CARE PLACE OF INJURY (SNOMED CT)	Changed Dataset
EMERGENCY CARE PROCEDURE (SNOMED CT)	Changed Dataset
EMERGENCY CARE TIME SEEN FOR TREATMENT	Changed Dataset
EMERGENCY CARE TREATMENT ALLOCATION TIMESTAMP	New Data Element
ETHNIC CATEGORY	Changed Dataset
ETHNIC CATEGORY 2021	Changed Dataset
EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	Changed Dataset
EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	Changed Dataset
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	Changed Dataset
GENERAL MEDICAL PRACTITIONER (SPECIFIED)	Changed Dataset
INJURY DATE	Changed Dataset
INJURY TIME	Changed Dataset
INTERPRETER LANGUAGE (SNOMED CT)	Changed Dataset

INVESTIGATION SCHEME IN USE (RETIRED)	renamed from INVESTIGATION SCHEME IN USE	Changed Description, linked Attribute, Dataset, Name, status to Retired
LOCAL PATIENT IDENTIFIER		Changed Dataset
LOCAL PATIENT IDENTIFIER (EXTENDED)		Changed Dataset
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE		Changed Dataset
NHS NUMBER		Changed Dataset
NHS NUMBER STATUS INDICATOR CODE		Changed Dataset
NHS SERVICE AGREEMENT LINE NUMBER		Changed Dataset
OBSERVATION VALUE		Changed Dataset
ORGANISATION CODE (CODE OF COMMISSIONER)		Changed Dataset
ORGANISATION CODE (CODE OF PROVIDER)		Changed Dataset
ORGANISATION CODE (CONVEYING AMBULANCE TRUST)		Changed Dataset
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)		Changed Dataset
ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)		Changed Dataset
ORGANISATION CODE (RESIDENCE RESPONSIBILITY)		Changed Dataset
ORGANISATION IDENTIFIER (CDS RECIPIENT)		Changed Dataset
ORGANISATION IDENTIFIER (CDS SENDER)		Changed Dataset
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)		Changed Dataset
ORGANISATION IDENTIFIER (CODE OF PROVIDER)		Changed Dataset
ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST)		Changed Dataset
ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)		Changed Dataset
ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)		Changed Dataset
ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)		Changed Dataset
ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE)		Changed Dataset
ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE)		Changed Dataset
ORGANISATION SITE IDENTIFIER (OF PROVIDER FIRST SEEN)		Changed Description
ORGANISATION SITE IDENTIFIER (OF TREATMENT)		Changed Dataset
OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE		Changed Dataset
OVERSEAS VISITOR STATUS CLASSIFICATION AT CDS ACTIVITY DATE		Changed Dataset
PATIENT NAME		Changed Dataset
PATIENT PATHWAY IDENTIFIER		Changed Dataset
PATIENT USUAL ADDRESS		Changed Dataset
PERSON BIRTH DATE		Changed Dataset
PERSON GENDER CODE CURRENT		Changed Dataset
PERSON SCORE		Changed Dataset
PERSON STATED GENDER CODE		Changed Dataset
POSTCODE OF USUAL ADDRESS		Changed Dataset
PREFERRED SPOKEN LANGUAGE (SNOMED CT)		Changed Dataset
PRESENT ON ADMISSION INDICATOR		Changed Dataset
PRIMARY DIAGNOSIS (ICD)		Changed Dataset
PRIMARY DIAGNOSIS (READ)		Changed Dataset
PRIMARY PROCEDURE (OPCS)		Changed Dataset
PRIMARY PROCEDURE (READ)		Changed Dataset
PROCEDURE (OPCS)		Changed Dataset
PROCEDURE (READ)		Changed Dataset
PROCEDURE DATE		Changed Dataset
PROCEDURE DATE (EMERGENCY CARE CLINICAL INVESTIGATION)		Changed Dataset
PROCEDURE DATE (EMERGENCY CARE PROCEDURE)		Changed Dataset
PROCEDURE SCHEME IN USE		Changed Dataset
PROCEDURE TIME (EMERGENCY CARE CLINICAL INVESTIGATION)		Changed Dataset
PROCEDURE TIME (EMERGENCY CARE PROCEDURE)		Changed Dataset
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER		Changed Dataset
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)		Changed Dataset
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)		Changed Dataset
PROFESSIONAL REGISTRATION ISSUER CODE		Changed Description, Dataset
PROVIDER REFERENCE NUMBER		Changed Dataset

REFERRAL TO TREATMENT PERIOD END DATE	Changed Dataset
REFERRAL TO TREATMENT PERIOD START DATE	Changed Dataset
REFERRAL TO TREATMENT PERIOD STATUS	Changed Dataset
REFERRED TO SERVICE (SNOMED CT)	Changed Dataset
REFERRED TO SERVICE ASSESSMENT DATE	Changed Dataset
REFERRED TO SERVICE ASSESSMENT TIME	Changed Dataset
SAFEGUARDING CONCERN (SNOMED CT)	Changed Dataset
SECONDARY DIAGNOSIS (ICD)	Changed Dataset
SECONDARY DIAGNOSIS (READ)	Changed Dataset
SITE CODE (OF TREATMENT)	Changed Dataset
SOURCE OF REFERRAL FOR A AND E (RETIRED) renamed from SOURCE OF REFERRAL FOR A AND E	Changed Description, linked Attribute, Dataset, Name, status to Retired
START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	Changed Dataset
START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	Changed Dataset
UCUM UNIT OF MEASUREMENT	Changed Dataset
UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	Changed Dataset
WAITING TIME MEASUREMENT TYPE	Changed Dataset
WITHHELD IDENTITY REASON	Changed Dataset

XML Schema Constraint

COMMISSIONING DATA SET VERSION 6-2-2 XML SCHEMA CONSTRAINTS	Changed Description
COMMISSIONING DATA SET VERSION 6-2-3 XML SCHEMA CONSTRAINTS	New XML Schema Constraint
COMMISSIONING DATA SET VERSION 6-2 XML SCHEMA CONSTRAINTS	Changed Description

Date: 8 September 2020

Sponsor: Marc Thomas, Director of Policy for Emergency and Elective Care, NHS England and NHS Improvement

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

CDS V6-2-3 TYPE 001 - CDS INTERCHANGE HEADER

Change to Data Set: New Data Set

Notation		DATA GROUP: CDS V6-2-3 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER	
Group Status	Group Repeats	FUNCTION:	
M	1..1	To carry the details of the mandatory identity and addressing information for the Commissioning Data Set submission.	
		One per Interchange submitted to the Secondary Uses Service.	
		Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.	
M	1..1	Data Element Components	Rules
M	1..1	CDS INTERCHANGE SENDER IDENTITY	F S8
M	1..1	CDS INTERCHANGE RECEIVER IDENTITY	F S8
M	1..1	CDS INTERCHANGE CONTROL REFERENCE	F S8
M	1..1	CDS INTERCHANGE DATE OF PREPARATION	F S8 S13
M	1..1	CDS INTERCHANGE TIME OF PREPARATION	F S8 S14
M	1..1	CDS INTERCHANGE APPLICATION REFERENCE	F S8
O	0..1	CDS INTERCHANGE TEST INDICATOR	F

CDS V6-2-3 TYPE 002 - CDS INTERCHANGE TRAILER

Change to Data Set: New Data Set

Notation		DATA GROUP: CDS V6-2-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER	
Group	Group	FUNCTION:	
Status	Repeats	To carry the details of the mandatory identity and addressing information for the Commissioning Data Set submission.	
M	1..1	One per Interchange submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.	
M	1..1	Data Element Components	Rules
M	1..1	CDS INTERCHANGE CONTROL REFERENCE	F S8
M	1..1	CDS INTERCHANGE CONTROL COUNT	F S8
O	0..1	CDS INTERCHANGE SENDER IDENTITY	F
O	0..1	CDS INTERCHANGE RECEIVER IDENTITY	F

CDS V6-2-3 TYPE 003 - CDS MESSAGE HEADER

Change to Data Set: New Data Set

Notation		DATA GROUP: CDS V6-2-3 TYPE 003 - COMMISSIONING DATA SET MESSAGE HEADER	
Group	Group	FUNCTION:	
Status	Repeats	To carry the details of the mandatory identity controls for each Commissioning Data Set Message.	
M	1..1	One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.	
M	1..1	Data Element Components	Rules
M	1..1	CDS MESSAGE TYPE	V
M	1..1	CDS MESSAGE VERSION NUMBER	F
M	1..1	CDS MESSAGE REFERENCE	F
O	0..1	CDS RECORD IDENTIFIER	F

CDS V6-2-3 TYPE 004 - CDS MESSAGE TRAILER

Change to Data Set: New Data Set

Notation		DATA GROUP: CDS V6-2-3 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER	
Group	Group	FUNCTION:	
Status	Repeats	To carry the details of the mandatory identity controls for each Commissioning Data Set Message.	
M	1..1	One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.	
M	1..1	Data Element Components	Rules
M	1..1	CDS MESSAGE REFERENCE	F

CDS V6-2-3 TYPE 005B - CDS TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL

Change to Data Set: New Data Set

Notation		DATA GROUP: CDS V6-2-3 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL	
Group	Group	FUNCTION:	
Status	Repeats	To carry the details of the mandatory Commissioning Data Set Submission Protocol controls for when using the Bulk Update mechanism.	
M	1..1	One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.	

M	1..1	Data Element Components	Rules
M	1..1	CDS TYPE CODE	V
M	1..1	CDS PROTOCOL IDENTIFIER CODE	V
O	0..1	CDS UNIQUE IDENTIFIER	F S9
M	1..1	CDS BULK REPLACEMENT GROUP CODE	V
M	1..1	CDS EXTRACT DATE	F S13
M	1..1	CDS EXTRACT TIME	F S14
M	1..1	CDS REPORT PERIOD START DATE	F S6 S13
M	1..1	CDS REPORT PERIOD END DATE	F S6 S13
M	1..1	CDS ACTIVITY DATE	F S6 S10 S11 S13
M	1..1	ORGANISATION IDENTIFIER (CDS SENDER)	F S5
O	0..7	ORGANISATION IDENTIFIER (CDS RECIPIENT)	F S5

CDS V6-2-3 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL

Change to Data Set: New Data Set

Notation		DATA GROUP: CDS V6-2-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL	
Group	Group	FUNCTION:	
Status	Repeats	To carry the details of the mandatory Commissioning Data Set Submission Protocol controls for when using the Net Change mechanism.	
M	1..1	One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.	
M	1..1	Data Element Components	Rules
M	1..1	CDS TYPE CODE	V
M	1..1	CDS PROTOCOL IDENTIFIER CODE	V
M	1..1	CDS UNIQUE IDENTIFIER	F S9
M	1..1	CDS UPDATE TYPE	V
M	1..1	CDS APPLICABLE DATE	F S8 S13
M	1..1	CDS APPLICABLE TIME	F S8 S14
M	1..1	CDS ACTIVITY DATE	F S6 S10 S11 S13
M	1..1	ORGANISATION IDENTIFIER (CDS SENDER)	F S5
O	0..7	ORGANISATION IDENTIFIER (CDS RECIPIENT)	F S5

Change to Data Set: New Data Set

CDS V6-2-3 TYPE 011 - EMERGENCY CARE COMMISSIONING DATA SET
FUNCTION: To support the details of an Emergency Care Attendance.

Notation		DATA GROUP: CDS V6-2-3 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER
Group	Group	FUNCTION:
Status	Repeats	To define the mandatory identity and addressing information for a Commissioning Data Set submission.
M	1..1	DATA GROUP: CDS V6-2-3 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: CDS V6-2-3 TYPE 003 - COMMISSIONING DATA SET MESSAGE HEADER
Group	Group	FUNCTION:
Status	Repeats	To define the mandatory identity and addressing information for a Commissioning Data Set submission.
M	1..1	DATA GROUP: CDS V6-2-3 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: CDS V6-2-3 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL
Group	Group	FUNCTION:
Status	Repeats	To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of the Bulk Replacement Update Mechanism of the Commissioning Data Set Submission Protocol.
M	1..1	DATA GROUP: CDS V6-2-3 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: CDS V6-2-3 TYPE 005N - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL
Group	Group	FUNCTION:
Status	Repeats	To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of the Net Change Update Mechanism of the Commissioning Data Set Submission Protocol.
M	1..1	DATA GROUP: CDS V6-2-3 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 PATHWAY
Group	Group	FUNCTION:
Status	Repeats	To carry the details of the Patient Pathway.
O	0..1	
M	1..1	DATA GROUP: PATIENT PATHWAY IDENTITY
M	1..1	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)
Or		
M	1..1	PATIENT PATHWAY IDENTIFIER
M	1..1	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)
M	1..1	DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS
M	1..1	REFERRAL TO TREATMENT PERIOD STATUS
M	1..1	WAITING TIME MEASUREMENT TYPE
O	0..1	REFERRAL TO TREATMENT PERIOD START DATE
O	0..1	REFERRAL TO TREATMENT PERIOD END DATE

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

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	<u>NHS NUMBER STATUS INDICATOR CODE</u>	V
		R	0..1	<u>ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)</u>	F
		R	0..1	<u>WITHHELD IDENTITY REASON</u>	V

OR

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

OR

1..1	DATA GROUP: UNVERIFIED IDENTITY STRUCTURE Must be used for all other values of the <u>NHS NUMBER STATUS INDICATOR CODE</u> NOT included in the above				
R	0..1	DATA GROUP: LOCAL IDENTIFIER STRUCTURE		Rules	
		M	1..1	<u>LOCAL PATIENT IDENTIFIER (EXTENDED)</u>	F S3
		M	1..1	<u>ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)</u>	F
M	1..1	Data Element Components		Rules	
		R	0..1	<u>NHS NUMBER</u>	F
		M	1..1	<u>NHS NUMBER STATUS INDICATOR CODE</u>	V
		O	0..1	<u>PATIENT NAME - PERSON NAME STRUCTURED</u> Or <u>PATIENT NAME - PERSON NAME UNSTRUCTURED</u>	F S3
		O	0..1	<u>PATIENT USUAL ADDRESS - ADDRESS STRUCTURED (Label format Postal Address)</u> Or <u>PATIENT USUAL ADDRESS - ADDRESS UNSTRUCTURED (Character string)</u>	F S3
R	0..1	Data Element Components		Rules	
		R	0..1	<u>POSTCODE OF USUAL ADDRESS</u>	F S3
		R	0..1	<u>ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)</u>	F
		R	0..1	<u>PERSON BIRTH DATE</u>	F S3 S12

Notation		DATA GROUP: PATIENT CHARACTERISTICS (EMERGENCY CARE)		
Group	Group	FUNCTION:		
Status	Repeats	To carry the characteristics of the Patient for an Emergency Care Attendance.		
R	0..1			
R	0..1	Data Element Components		Rules
		R	0..1	<u>PERSON STATED GENDER CODE</u>

	R	0..1	ETHNIC CATEGORY	V
	X	0..1	ETHNIC CATEGORY 2021	F
	R	0..1	ACCOMMODATION STATUS (SNOMED CT)	F
	R	0..1	PREFERRED SPOKEN LANGUAGE (SNOMED CT)	F
	R	0..1	ACCESSIBLE INFORMATION PROFESSIONAL REQUIRED CODE (SNOMED CT)	F
	R	0..1	INTERPRETER LANGUAGE (SNOMED CT)	F
	R	0..1	OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE	V

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

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

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

Notation		DATA GROUP: AMBULANCE DETAILS		
Group Status	Group Repeats	FUNCTION: To carry ambulance details relating to the patients arrival at Emergency Care.		
R	0..1			
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: To carry the expected date and time of treatment given to the patient.		
R	0..*			
R	0..*	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

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

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

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

Notation		DATA GROUP: CODED CLINICAL FINDINGS			
Group	Group	FUNCTION:			
Status	Repeats	To carry the details of the SNOMED CT coded clinical findings.			
R	0..*				
R	0..*	Data Element Components			Rules
		M	1..1	CODED FINDING (SNOMED CT)	F
		M	1..1	CODED FINDING TIMESTAMP	F

Notation		DATA GROUP: INJURY CHARACTERISTICS		
Group	Group	FUNCTION:		
Status	Repeats	To carry the details of injuries.		
R	0..1			

R	0..1	Data Element Components		Rules	
		M	1..1	INJURY DATE	F S13
		M	1..1	INJURY TIME	F S14
		R	0..1	EMERGENCY CARE PLACE OF INJURY (SNOMED CT)	F
		O	0..1	EMERGENCY CARE PLACE OF INJURY (LATITUDE)	F
		O	0..1	EMERGENCY CARE PLACE OF INJURY (LONGITUDE)	F
		R	0..1	EMERGENCY CARE INJURY INTENT (SNOMED CT)	F
		R	0..1	EMERGENCY CARE INJURY ACTIVITY STATUS (SNOMED CT)	F
		R	0..1	EMERGENCY CARE INJURY ACTIVITY TYPE (SNOMED CT)	F
		R	0..1	EMERGENCY CARE INJURY MECHANISM (SNOMED CT)	F
		R	0..*	EMERGENCY CARE INJURY ALCOHOL OR DRUG INVOLVEMENT (SNOMED CT)	F
		X	0..1	ASSAULT LOCATION DESCRIPTION	F

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

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

Notation		DATA GROUP: 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	EMERGENCY CARE DIAGNOSIS (SNOMED CT)	F H4	
M	1..1	CODED CLINICAL ENTRY SEQUENCE NUMBER	F	
M	1..1	EMERGENCY CARE DIAGNOSIS QUALIFIER (SNOMED CT)	F	

Notation		DATA GROUP: EMERGENCY CARE INVESTIGATIONS (SNOMED CT)			
Group Status	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	EMERGENCY CARE CLINICAL INVESTIGATION (SNOMED CT)	F H4
		R	0..1	PROCEDURE DATE (EMERGENCY CARE CLINICAL INVESTIGATION)	F S13
		R	0..1	PROCEDURE TIME (EMERGENCY CARE CLINICAL INVESTIGATION)	F S14

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

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

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

	R	0..1	EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT)	F
	R	0..1	EMERGENCY CARE DISCHARGE INFORMATION GIVEN (SNOMED CT)	F

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

Notation		DATA GROUP: CDS V6-2-3 TYPE 004 - COMMISSIONING DATA SET MESSAGE TRAILER		
Group	Group	FUNCTION:		
Status	Repeats	To define the mandatory identity and addressing information for a Commissioning Data Set submission.		
M	1..1	DATA GROUP: CDS V6-2-3 Type 004 - CDS Message Trailer		
		One per Commissioning Data Set Message submitted to the <u>Secondary Uses Service</u> . Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange		

Notation		DATA GROUP: CDS V6-2-3 TYPE 002 - COMMISSIONING DATA SET INTERCHANGE TRAILER		
Group	Group	FUNCTION:		
Status	Repeats	To define the mandatory identity and addressing information for a Commissioning Data Set submission.		
M	1..1	DATA GROUP: CDS V6-2-3 Type 002 - CDS Interchange Trailer		
		One per Interchange submitted to the <u>Secondary Uses Service</u> . Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange		

CDS V6-2 TYPE 001 - CDS INTERCHANGE HEADER

Change to Data Set: Changed Dataset

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

CDS V6-2 TYPE 002 - CDS INTERCHANGE TRAILER

Change to Data Set: Changed Dataset

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

CDS V6-2 TYPE 003 - CDS MESSAGE HEADER

Change to Data Set: Changed Dataset

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

CDS V6-2 TYPE 004 - CDS MESSAGE TRAILER

Change to Data Set: Changed Dataset

Notation	DATA GROUP: CDS V6-2 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

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

Change to Data Set: Changed Dataset

Notation	DATA GROUP: CDS V6-2 TYPE 005B - COMMISSIONING DATA SET TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL			
Group Status M	Group Repeats 1..1	FUNCTION: To carry the details of the mandatory Commissioning Data Set Submission Protocol controls for when using the Bulk Update mechanism. One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.		
M	1..1	Data Element Components	Rules	
		M 1..1	CDS TYPE CODE	V
		M 1..1	CDS PROTOCOL IDENTIFIER CODE	V
		O 0..1	CDS UNIQUE IDENTIFIER	F S9
		M 1..1	CDS BULK REPLACEMENT GROUP CODE	V
		M 1..1	CDS EXTRACT DATE	F S13
		M 1..1	CDS EXTRACT TIME	F S14

M	1..1	CDS REPORT PERIOD START DATE	F S6 S13
M	1..1	CDS REPORT PERIOD END DATE	F S6 S13
M	1..1	CDS ACTIVITY DATE	F S6 S10 S11 S13
M	1..1	CDS SENDER IDENTITY	F S5
M	1..1	CDS PRIME RECIPIENT IDENTITY	F S5 S7
O	1..7	CDS COPY RECIPIENT IDENTITY	F S5 S7

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

Change to Data Set: Changed Dataset

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

CDS V6-2 TYPE 010 - ACCIDENT AND EMERGENCY CDS (RETIRED), renamed from CDS V6-2 TYPE 010 - ACCIDENT AND EMERGENCY CDS

Change to Data Set: Changed Description, Name, status to Retired

CDS V6-2 TYPE 010 – ACCIDENT AND EMERGENCY COMMISSIONING DATA SET

FUNCTION: To support the details of an Accident And Emergency Attendance.

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

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

ONE OF THE FOLLOWING TWO OPTIONS MUST BE USED

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

OR

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

Notation		DATA GROUP: PATIENT PATHWAY			
Group Status	Group Repeats	FUNCTION: To carry the details of the Patient Pathway.			
0	0..4				
M	1..1	DATA GROUP: PATIENT PATHWAY IDENTITY			
		M	1..1	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	F
		Or			
		M	1..1	PATIENT PATHWAY IDENTIFIER	F I2
M	1..1	ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	F I2		
M	1..1	DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS			
		M	1..1	REFERRAL TO TREATMENT PERIOD STATUS	V
		M	1..1	WAITING TIME MEASUREMENT TYPE	V
		0	0..1	REFERRAL TO TREATMENT PERIOD START DATE	F S13
		0	0..1	REFERRAL TO TREATMENT PERIOD END DATE	F S13

Notation		DATA GROUP: PATIENT IDENTITY	
Group Status	Group Repeats	FUNCTION: To carry the Identity of the Patient.	
M	1..4	See Note: S3 in Commissioning Data Set Business Rules.	

One of the following DATA GROUPS must be used:

1..4	DATA GROUP: WITHHELD IDENTITY STRUCTURE Must be used where the Commissioning Data Set record has been anonymised				
M	1..4	Data Element Components		Rules	
		M	1..4	NHS NUMBER STATUS INDICATOR CODE	√
		R	0..4	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	F
		R	0..4	WITHHELD IDENTITY REASON	√

OR

1..4	DATA GROUP: VERIFIED IDENTITY STRUCTURE Must be used where the NHS NUMBER STATUS INDICATOR CODE National Code = 01 (Number present and verified)				
R	0..4	DATA GROUP: LOCAL IDENTIFIER STRUCTURE		Rules	
		M	1..4	LOCAL PATIENT IDENTIFIER	F S3
		M	1..4	ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	F
M	1..4	Data Element Components		Rules	
		M	1..4	NHS NUMBER	F S3
		M	1..4	NHS NUMBER STATUS INDICATOR CODE	√
		M	1..4	POSTCODE OF USUAL ADDRESS	F S3
		R	0..4	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	F
		R	0..4	PERSON BIRTH DATE	F S3 S12

OR

1..4	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..4	DATA GROUP: LOCAL IDENTIFIER STRUCTURE		Rules	
		M	1..4	LOCAL PATIENT IDENTIFIER	F S3
		M	1..4	ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	F
M	1..4	Data Element Components		Rules	
		R	0..4	NHS NUMBER	F
		M	1..4	NHS NUMBER STATUS INDICATOR CODE	√
		⊖	0..4	PATIENT NAME – PERSON NAME STRUCTURED Or PATIENT NAME – PERSON NAME UNSTRUCTURED	F S3
		⊖	0..4	PATIENT USUAL ADDRESS – ADDRESS STRUCTURED (Label format Postal Address) Or PATIENT USUAL ADDRESS – ADDRESS UNSTRUCTURED (Character string)	F S3
R	0..4	Data Element Components		Rules	
		R	0..4	POSTCODE OF USUAL ADDRESS	F S3
		R	0..4	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	F
		R	0..4	PERSON BIRTH DATE	F S3 S12

Notation		DATA GROUP: PATIENT CHARACTERISTICS (A AND E)			
Group Status	Group Repeats	FUNCTION: To carry the characteristics of the Patient for an Accident and Emergency Attendance.			
R	0..4				
R	1..4	Data Element Components		Rules	
		R	0..4	PERSON GENDER CODE CURRENT	√
		⊖	0..4	CARER SUPPORT INDICATOR	√
		R	0..4	ETHNIC CATEGORY	√

Notation		DATA GROUP: GP REGISTRATION		
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Group Status	Group Repeats	FUNCTION: To carry the Patient's General Medical Practitioner and the General Practice details.	
R	0..1		
Notation	DATA GROUP: LOCATION GROUP—ATTENDANCE		
Group Status	Group Repeats	FUNCTION: To carry the details of the Accident and Emergency Attendance location.	
R	0..1		
M	1..1	Data Element Components	
		GENERAL MEDICAL PRACTITIONER (SPECIFIED)	F
		GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	F

Notation	DATA GROUP: ATTENDANCE OCCURRENCE—ACTIVITY CHARACTERISTICS		
Group Status	Group Repeats	FUNCTION: To carry the characteristics of the Accident and Emergency Attendance.	
M	1..1		
M	1..1	Data Element Components	Rules
		SITE CODE (OF TREATMENT)	F

Notation	DATA GROUP: SERVICE AGREEMENT DETAILS		
Group Status	Group Repeats	FUNCTION: To carry the details of the Service Agreement.	
M	1..1		
M	1..1	Data Element Components	Rules
		A and E ATTENDANCE NUMBER	F
		ACCIDENT AND EMERGENCY ARRIVAL MODE CODE	V
		ACCIDENT AND EMERGENCY ATTENDANCE CATEGORY CODE	V
		ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL CODE	V
		A and E INCIDENT LOCATION TYPE	V
		A and E PATIENT GROUP	V
		SOURCE OF REFERRAL FOR A and E	V
		A and E DEPARTMENT TYPE	V
		ARRIVAL DATE	F S4 S13
		ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT	F S14
		AGE AT CDS ACTIVITY DATE	F S8
		OVERSEAS VISITOR STATUS CLASSIFICATION AT CDS ACTIVITY DATE	V
		ACCIDENT AND EMERGENCY INITIAL ASSESSMENT DATE	F S13
		A and E INITIAL ASSESSMENT TIME	F S14
		ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT	F S13
		A and E TIME SEEN FOR TREATMENT	F S14
		ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE	F S13
		A and E ATTENDANCE CONCLUSION TIME	F S14
		ACCIDENT AND EMERGENCY DEPARTURE DATE	F S13
		A and E DEPARTURE TIME	F S14
		AMBULANCE INCIDENT NUMBER	F
		ORGANISATION CODE (CONVEYING AMBULANCE TRUST)	F

Notation	DATA GROUP: SERVICE AGREEMENT DETAILS	
Group Status	Group Repeats	FUNCTION: To carry the details of the Service Agreement.
M	1..1	

M	1..1	Data Element Components		Rules	
		R	0..1	COMMISSIONING SERIAL NUMBER	F
		0	0..1	NHS SERVICE AGREEMENT LINE NUMBER	F
		0	0..1	PROVIDER REFERENCE NUMBER	F
		0	0..1	COMMISSIONER REFERENCE NUMBER	F
		M	1..1	ORGANISATION CODE (CODE OF PROVIDER)	F H4
M	1..1	ORGANISATION CODE (CODE OF COMMISSIONER)	F		

Notation		DATA GROUP: ATTENDANCE OCCURRENCE – PERSON GROUP (A AND E CONSULTANT)		
Group Status	Group Repeats	FUNCTION: To carry the details of the Responsible Clinician.		
R	0..1			
R	0..1	Data Element Components	Rules	
R	0..1	A and E STAFF MEMBER CODE	F	

Notation		DATA GROUP: CLINICAL DIAGNOSIS GROUP (ICD)		
Group Status	Group Repeats	FUNCTION: To carry the details of the ICD-coded Clinical Diagnoses.		
0	0..1			
M	1..1	Data Element Components	Rules	
M	1..1	DIAGNOSIS SCHEME IN USE	√	
M	1..1	DATA GROUP: PRIMARY DIAGNOSIS	Rules	
M	1..1	PRIMARY DIAGNOSIS (ICD)	F	
0	0..1	PRESENT ON ADMISSION INDICATOR	√	
0	0..*	DATA GROUP: SECONDARY DIAGNOSES	Rules	
M	1..1	SECONDARY DIAGNOSIS (ICD)	F	
0	0..1	PRESENT ON ADMISSION INDICATOR	√	

Notation		DATA GROUP: CLINICAL DIAGNOSIS GROUP (READ)		
Group Status	Group Repeats	FUNCTION: To carry the details of the READ coded Clinical Diagnoses.		
0	0..1			
M	1..1	Data Element Components	Rules	
M	1..1	DIAGNOSIS SCHEME IN USE	√	
M	1..1	DATA GROUP: PRIMARY DIAGNOSIS	Rules	
M	1..1	PRIMARY DIAGNOSIS (READ)	F	
0	0..*	DATA GROUP: SECONDARY DIAGNOSES	Rules	
M	1..1	SECONDARY DIAGNOSIS (READ)	F	

Notation		DATA GROUP: CLINICAL DIAGNOSIS GROUP (A AND E)		
Group Status	Group Repeats	FUNCTION: To carry the details of the Accident and Emergency-coded Clinical Diagnoses.		
R	0..1			
M	1..1	Data Element Components	Rules	
M	1..1	DIAGNOSIS SCHEME IN USE	√	
M	1..1	DATA GROUP: PRIMARY DIAGNOSIS	Rules	
M	1..1	ACCIDENT AND EMERGENCY DIAGNOSIS – FIRST	F	
0	0..*	DATA GROUP: SECONDARY DIAGNOSES	Rules	
M	1..1	ACCIDENT AND EMERGENCY DIAGNOSIS – SECOND	F	

Notation		DATA GROUP: ATTENDANCE OCCURRENCE – CLINICAL INVESTIGATION GROUP (A AND E)		
Group Status	Group Repeats	FUNCTION: To carry the details of the Accident and Emergency-coded Investigations undertaken.		
R	0..1			
M	1..1	Data Element Components	Rules	

		M	1..1	INVESTIGATION SCHEME IN USE	√
M	1..1	DATA GROUP: PRIMARY INVESTIGATION			Rules
		M	1..1	ACCIDENT AND EMERGENCY INVESTIGATION - FIRST	F H4
0	0..*	DATA GROUP: SECONDARY INVESTIGATION			Rules
		M	1..1	ACCIDENT AND EMERGENCY INVESTIGATION - SECOND	F H4

Notation		DATA GROUP: ATTENDANCE OCCURRENCE - CLINICAL ACTIVITY GROUP (OPCS)			
Group Status	Group Repeats	FUNCTION: To carry the details of the OPCS coded Clinical Activities and Treatments undertaken.			
0	0..4				
M	1..1	Data Element Components			Rules
		M	1..1	PROCEDURE SCHEME IN USE	√
M	1..1	DATA GROUP: PRIMARY PROCEDURE			Rules
		M	1..1	PRIMARY PROCEDURE (OPCS)	F
		R	1..1	PROCEDURE DATE	F S13
0	0..1	DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL			Rules
		M	1..1	PROFESSIONAL REGISTRATION ISSUER CODE	√
		M	1..1	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)	F
0	0..1	DATA GROUP: RESPONSIBLE ANAESTHETIST			Rules
		M	1..1	PROFESSIONAL REGISTRATION ISSUER CODE	√
		M	1..1	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)	F
R	0..*	DATA GROUP: SECONDARY PROCEDURES			Rules
		M	1..1	PROCEDURE (OPCS)	F
		R	0..1	PROCEDURE DATE	F S13
0	0..1	DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL			Rules
		M	1..1	PROFESSIONAL REGISTRATION ISSUER CODE	√
		M	1..1	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)	F
0	0..1	DATA GROUP: RESPONSIBLE ANAESTHETIST			Rules
		M	1..1	PROFESSIONAL REGISTRATION ISSUER CODE	√
		M	1..1	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)	F

Notation		DATA GROUP: ATTENDANCE OCCURRENCE - CLINICAL ACTIVITY GROUP (READ)			
Group Status	Group Repeats	FUNCTION: To carry the details of the READ coded Clinical Activities and Treatments undertaken.			
0	0..4				
M	1..1	Data Element Components			Rules
		M	1..1	PROCEDURE SCHEME IN USE	√
M	1..1	DATA GROUP: PRIMARY PROCEDURE			Rules
		M	1..1	PRIMARY PROCEDURE (READ)	F
		R	0..1	PROCEDURE DATE	F S13
0	0..*	DATA GROUP: SECONDARY PROCEDURES			Rules
		M	1..1	PROCEDURE (READ)	F
		R	0..1	PROCEDURE DATE	F S13

Notation		DATA GROUP: ATTENDANCE OCCURRENCE - CLINICAL TREATMENT GROUP (A AND E)			
Group Status	Group Repeats	FUNCTION: To carry the details of the Accident and Emergency coded Clinical Activities and Treatments undertaken.			
R	0..1				
M	1..1	Data Element Components			Rules
		M	1..1	PROCEDURE SCHEME IN USE	√
M	1..1	DATA GROUP: PRIMARY PROCEDURE			Rules

		M	1..1	ACCIDENT AND EMERGENCY TREATMENT - FIRST	F H4
		R	0..1	PROCEDURE DATE	F S13
Q	0..*	DATA GROUP: SECONDARY PROCEDURES			Rules
		M	1..1	ACCIDENT AND EMERGENCY TREATMENT - SECOND	F H4
		R	1..1	PROCEDURE DATE	F S13

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

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

This item has been retired from the NHS Data Model and Dictionary.

The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

CDS V6-2 TYPE 010 - ACCIDENT AND EMERGENCY CDS (RETIRED), renamed from CDS V6-2 TYPE 010 - ACCIDENT AND EMERGENCY CDS

Change to Data Set: Changed Description, Name, status to Retired

- Changed Description
- Changed Name from Data_Dictionary.Messages.CDS_V6-2.Data_Sets.CDS_V6-2_Type_010_-_Accident_and_Emergency_CDS to Retired.Data_Dictionary.Messages.CDS_V6-2.CDS_V6-2_Type_010_-_Accident_and_Emergency_CDS
- Retired CDS V6-2 Type 010 - Accident and Emergency CDS

ACCIDENT AND EMERGENCY ATTENDANCE (RETIRED), renamed from ACCIDENT AND EMERGENCY ATTENDANCE

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

An [Accident and Emergency Attendance](#) is a [CARE CONTACT](#). This item has been retired from the NHS Data Model and Dictionary.

An [Accident and Emergency Attendance](#) is an individual visit by one [PATIENT](#) to an [Accident and Emergency Department](#) to receive treatment from the accident and emergency service. The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Note that the accident and emergency service may be provided by staff from other [MAIN SPECIALTY](#). 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.

During an [Accident and Emergency Attendance](#) the [PATIENT](#) may temporarily leave the [Accident and Emergency Department](#), e.g. for an X-ray, whilst still under the responsibility of the [Accident and Emergency Department](#).

An [Accident and Emergency Attendance](#) may be as a result of a request from a [GENERAL PRACTITIONER](#) for help with a diagnosis or treatment.

Attendances at [Out Patient Clinic](#) run in the [Accident and Emergency Department](#) should not be recorded as [Accident and Emergency Attendance](#) but should be recorded as [Out Patient Attendance Consultant](#) or [Clinic Attendance Non Consultant](#) depending upon the type of [Out Patient Clinic](#) attended.

Any facility set up to receive and treat emergency cases is regarded as an [Accident and Emergency Department](#) for this purpose.

[Accident and Emergency Attendances](#) include both first and follow up attendances. A follow up attendance is any subsequent [Accident and Emergency Attendance](#) at the same [Accident and Emergency Department](#) for the same incident. All attendances for the same incident will constitute an [Accident and Emergency Episode](#).

Each [Accident and Emergency Attendance](#), which is a first attendance or an unplanned follow up attendance, should be assigned an [A AND E STREAM](#).

Any [PATIENT](#) diagnoses and interventions should be recorded using the A & E specific codes, see [ACCIDENT AND EMERGENCY DIAGNOSIS](#), [ACCIDENT AND EMERGENCY INVESTIGATION](#) and [ACCIDENT AND EMERGENCY TREATMENT](#).

ACCIDENT AND EMERGENCY ATTENDANCE (RETIRED), renamed from ACCIDENT AND EMERGENCY ATTENDANCE

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

- Changed Description
- Changed Name from Data_Dictionary.NHS_Business_Definitions.A.Accident_and_Emergency_Attendance to Retired.Data_Dictionary.NHS_Business_Definitions.A.Accident_and_Emergency_Attendance
- Retired Accident and Emergency Attendance

ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE (RETIRED), renamed from ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE

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

An [Accident and Emergency Attendance Conclusion Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

An [Accident and Emergency Attendance Conclusion Date](#) is the date. The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

- that a [PATIENT](#)'s [Accident and Emergency Attendance](#) concludes or
- when treatment in the [Accident and Emergency Department](#) is completed (whichever is the later).

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

ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE (RETIRED), renamed from ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE

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

- Changed Description
- Changed Name from Data_Dictionary.NHS_Business_Definitions.A.Accident_and_Emergency_Attendance_Conclusion_Date to Retired.Data_Dictionary.NHS_Business_Definitions.A.Accident_and_Emergency_Attendance_Conclusion_Date
- Retired Accident and Emergency Attendance Conclusion Date

ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION TIME (RETIRED), renamed from ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION TIME

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

An [Accident and Emergency Attendance Conclusion Time](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

An [Accident and Emergency Attendance Conclusion Time](#) is the time, recorded using a 24 hour clock. The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

- that a [PATIENT](#)'s [Accident and Emergency Attendance](#) concludes or
- when treatment in an [Accident and Emergency Department](#) is completed (whichever is the later).

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

ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION TIME (RETIRED), renamed from ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION TIME

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

- Changed Description
- Changed Name from Data_Dictionary.NHS_Business_Definitions.A.Accident_and_Emergency_Attendance_Conclusion_Time to Retired.Data_Dictionary.NHS_Business_Definitions.A.Accident_and_Emergency_Attendance_Conclusion_Time
- Retired Accident and Emergency Attendance Conclusion Time

ACCIDENT AND EMERGENCY CODING TABLES (RETIRED), renamed from ACCIDENT AND EMERGENCY CODING TABLES

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

The Accident and Emergency Commissioning Data Set identified the need for a national set of codes to be used in [Accident and Emergency Departments](#) to reflect [ACTIVITY](#) relating to Diagnosis, Investigation and Treatment. This item has been retired from the NHS Data Model and Dictionary.

These are presented in the following tables: The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

- [Accident and Emergency Diagnosis Tables](#)
- [Accident and Emergency Investigation Table](#)
- [Accident and Emergency Treatment Tables](#)

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.

ACCIDENT AND EMERGENCY CODING TABLES (RETIRED), renamed from ACCIDENT AND EMERGENCY CODING TABLES

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

- Changed Description
- Changed Name from Web_Site_Content.Supporting_Information.Clinical_Coding.Accident_and_Emergency_Coding_Tables to Retired.Web_Site_Content.Supporting_Information.Accident_and_Emergency_Coding_Tables
- Retired Accident and Emergency Coding Tables

ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT (RETIRED), renamed from ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT

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

An [Accident and Emergency Date Seen For Treatment](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

[Accident and Emergency Date Seen For Treatment](#) is the date, that the [PATIENT](#) is seen by a clinical decision maker (someone who can define the management plan and discharge the [PATIENT](#)) to diagnose the problem and arrange or start definite treatment as necessary. The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

For guidance on the use of this data item in the Accident and Emergency Clinical Quality Indicators, further information is available on the [Department of Health and Social Care National Archives](#) at: [A&E clinical quality indicators: Implementation guidance and data definitions](#). 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.

ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT (RETIRED), renamed from ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT

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

- Changed Description

- Changed Name from Data_Dictionary.NHS_Business_Definitions.A.Accident_and_Emergency_Date_Seen_For_Treatment to Retired.Data_Dictionary.NHS_Business_Definitions.A.Accident_and_Emergency_Date_Seen_For_Treatment
- Retired Accident and Emergency Date Seen For Treatment

ACCIDENT AND EMERGENCY DEPARTMENT (RETIRED), renamed from **ACCIDENT AND EMERGENCY DEPARTMENT**

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

An ~~Accident and Emergency Department~~ is a ~~Department~~. **This item has been retired from the NHS Data Model and Dictionary.**

~~Accident and Emergency 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 small units commonly called casualty departments, in which services are often only available for limited hours and which may not deal with emergency ambulance cases. **The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.**

A casualty 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~~. **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.**

~~Hospital Beds~~ either within or adjacent to a department will be counted as a ~~WARD~~ or part of a ~~WARD~~. Work apart from the accident and emergency service should be recorded in the appropriate data system.

An accident and emergency service offers care to ~~PATIENTS~~ who arrive with urgent problems and who have not usually been seen previously by a ~~GENERAL PRACTITIONER~~.

In the case of serious illness or accident, the treatment provided will be vital resuscitation only before the ~~PATIENT~~ is admitted to hospital.

ACCIDENT AND EMERGENCY DEPARTMENT (RETIRED), renamed from **ACCIDENT AND EMERGENCY DEPARTMENT**

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

- Changed Description
- Changed Name from Data_Dictionary.NHS_Business_Definitions.A.Accident_and_Emergency_Department to Retired.Data_Dictionary.NHS_Business_Definitions.A.Accident_and_Emergency_Department
- Retired Accident and Emergency Department

ACCIDENT AND EMERGENCY DEPARTURE DATE (RETIRED), renamed from **ACCIDENT AND EMERGENCY DEPARTURE DATE**

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

An ~~Accident and Emergency Departure Date~~ is an ~~ACTIVITY DATE TIME~~. **This item has been retired from the NHS Data Model and Dictionary.**

An ~~Accident and Emergency Departure Date~~ is the date that a ~~PATIENT~~ leaves an ~~Accident and Emergency Department~~ after an ~~Accident and Emergency Attendance~~ has concluded. **The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.**

Notes: 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.

- This date may be different from the ~~Accident and Emergency Attendance Conclusion Date~~ for ~~PATIENTS~~ who wait for patient transport or who are ~~LODGED PATIENTS~~ prior to admission to a ~~WARD~~.
- For ~~PATIENTS~~ who die in an ~~Accident and Emergency Department~~ the ~~Accident and Emergency Departure Date~~ is the date the body was removed from the ~~Accident and Emergency Department~~.
- The ~~PATIENT~~ may leave the ~~Accident and Emergency Department~~ temporarily during an ~~Accident and Emergency Attendance~~, for example, for an X-ray but they remain under the care of an Accident and Emergency ~~CONSULTANT~~.

For guidance on the use of this data item in the Accident and Emergency Clinical Quality Indicators, further information is available on the ~~Department of Health and Social Care~~ National Archives at: [A&E clinical quality indicators: Implementation guidance and data definitions](#).

ACCIDENT AND EMERGENCY DEPARTURE DATE (RETIRED), renamed from ACCIDENT AND EMERGENCY DEPARTURE DATE

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

- Changed Description
- Changed Name from Data_Dictionary.NHS_Business_Definitions.A.Accident_and_Emergency_Departure_Date to Retired.Data_Dictionary.NHS_Business_Definitions.A.Accident_and_Emergency_Departure_Date
- Retired Accident and Emergency Departure Date

ACCIDENT AND EMERGENCY DEPARTURE TIME (RETIRED), renamed from ACCIDENT AND EMERGENCY DEPARTURE TIME

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

An [Accident and Emergency Departure Time](#) is an [ACTIVITY_DATE_TIME](#). This item has been retired from the NHS Data Model and Dictionary.

An [Accident and Emergency Departure Time](#) is the time recorded using a 24 hour clock that a [PATIENT](#) leaves an [Accident and Emergency Department](#) after an [Accident and Emergency Attendance](#) has concluded. The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Notes:

- This time will be different from the [Accident and Emergency Attendance Conclusion Time](#) for [PATIENTS](#) who wait for patient transport or who are [LODGED PATIENTS](#) prior to admission to a [WARD](#).
- For [PATIENTS](#) who die in an [Accident and Emergency Department](#) the [Accident and Emergency Departure Time](#) is the time the body was removed from the [Accident and Emergency Department](#).
- The [PATIENT](#) may leave the [Accident and Emergency Department](#) temporarily during an [Accident and Emergency Attendance](#), for example, for an X-ray but they remain under the care of an Accident and Emergency [CONSULTANT](#).

For guidance on the use of this data item in the Accident and Emergency Clinical Quality Indicators, further information is available on the [Department of Health and Social Care National Archives](#) at: [A&E clinical quality indicators: Implementation guidance and data definitions](#). 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.

ACCIDENT AND EMERGENCY DEPARTURE TIME (RETIRED), renamed from ACCIDENT AND EMERGENCY DEPARTURE TIME

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

- Changed Description
- Changed Name from Data_Dictionary.NHS_Business_Definitions.A.Accident_and_Emergency_Departure_Time to Retired.Data_Dictionary.NHS_Business_Definitions.A.Accident_and_Emergency_Departure_Time
- Retired Accident and Emergency Departure Time

ACCIDENT AND EMERGENCY DIAGNOSIS TABLES (RETIRED), renamed from ACCIDENT AND EMERGENCY DIAGNOSIS TABLES

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

- A broad classification of types of diagnoses which may be made as a result of [Accident and Emergency Attendance](#). The full description is made up of codes from three tables – [ACCIDENT AND EMERGENCY DIAGNOSIS](#), [Accident and Emergency Attendance: ANATOMICAL AREAS](#) and [Accident and Emergency Attendance: ANATOMICAL SIDE, ANATOMICAL AREA](#) (a classification of parts of the human body) and [ANATOMICAL SIDE](#) (an indication of the side of the human body) together give the Anatomical Site of clinical problems presented at an [Accident and Emergency Attendance](#).
- Certain items are sub-analysed to specify the diagnosis, investigation or treatment more precisely. These are marked with an asterisk. The diagnosis sub-analysis list follows the main diagnosis list, and the treatment sub-analysis list follows the main treatment list.
- It is recommended that computerised systems provide a minimum of six character fields for each category in order to accommodate more detailed information if necessary. Where fewer than six characters are required for coding, such as for investigations and treatments, it is recommended that the codes are left justified and the unused fields left blank.
- [ACCIDENT AND EMERGENCY DIAGNOSIS](#) is a six character code, comprising:

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

Accident and Emergency Diagnosis – Diagnosis Condition

Diagnosis Condition	Code
Laceration	01
Contusion/abrasion*	02
Soft tissue inflammation	03
Head injury*	04
Dislocation/fracture/joint injury/amputation*	05
Sprain/ligament injury	06
Muscle/tendon injury	07
Nerve injury	08
Vascular injury	09
Burns and scalds*	10
Electric shock	11
Foreign body	12
Bites/stings	13
Poisoning* (including overdose)	14
Near drowning	15
Visceral injury	16
Infectious disease*	17
Local infection	18
Septicaemia	19
Cardiac conditions*	20
Cerebro-vascular conditions	21
Other vascular conditions	22
Haematological conditions	23
Central Nervous System conditions* (excluding strokes)	24
Respiratory conditions*	25
Gastrointestinal conditions*	26
Urological conditions (including cystitis)	27
Obstetric conditions	28
Gynaecological conditions	29
Diabetes and other endocrinological conditions*	30
Dermatological conditions	31
Allergy (including anaphylaxis)	32
Facio-maxillary conditions	33
ENT conditions	34
Psychiatric conditions	35
Ophthalmological conditions	36
Social problem (includes chronic alcoholism and homelessness)	37
Diagnosis not classifiable	38
Nothing abnormal detected	39

*Item sub-analysed

Accident and Emergency Diagnosis – Sub-analysis

Sub-analysis	Code	
Contusion/abrasion	-contusion	1
	-abrasion	2
Head Injury	-concussion	1
	-other head injury	2
Dislocation/fracture/joint injury/amputation	-dislocation	1
	-open fracture	2

	- closed fracture	3
	- joint injury	4
	- amputation	5
Burns and scalds	- electric	1
	- thermal	2
	- chemical	3
	- radiation	4
Poisoning	- prescriptive drugs	1
	- proprietary drugs	2
	- controlled drugs	3
	- other, including alcohol	4
Infectious disease	- notifiable disease	1
	- non-notifiable disease	2
Cardiac conditions	- myocardial ischaemia & infarction	1
	- other non-ischaemia	2
Respiratory conditions	- bronchial asthma	1
	- other non-asthma	2
Central Nervous System conditions	- epilepsy	1
	- other non-epilepsy	2
Gastrointestinal conditions	- haemorrhage	1
	- acute abdominal pain	2
	- other	3
Diabetes and other endocrinological conditions	- diabetic	1
	- other non-diabetic	2

Anatomical Site

Accident And Emergency Anatomical Area – Area

Anatomical Area	Code
Head and Neck	
Brain	01
Head	02
Face	03
Eye	04
Ear	05
Nose	06
Mouth, Jaw, Teeth	07
Throat	08
Neck	09
Upper Limb	
Shoulder	10
Axilla	11
Upper Arm	12
Elbow	13
Forearm	14
Wrist	15
Hand	16
Digit	17
Trunk	
Cervical spine	18
Thoracic	19
Lumbosacral spine	20
Pelvis	21
Chest	22
Breast	23
Abdomen	24
Back/buttocks	25

Ano/rectal	26
Genitalia	27
Lower-Limb	
Hip	28
Groin	29
Thigh	30
Knee	31
Lower leg	32
Ankle	33
Foot	34
Toe	35
Multiple Site	36
Accident and Emergency Anatomical Side	
Left	L
Right	R
Bilateral	B
Not applicable	8

This item has been retired from the NHS Data Model and Dictionary.

The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ACCIDENT AND EMERGENCY DIAGNOSIS TABLES (RETIRED), renamed from ACCIDENT AND EMERGENCY DIAGNOSIS TABLES

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

- Changed Description
- Changed Name from Web_Site_Content.Supporting_Information.Clinical_Coding.Accident_and_Emergency_Diagnosis_Tables to Retired.Web_Site_Content.Supporting_Information.Accident_and_Emergency_Diagnosis_Tables
- Retired Accident and Emergency Diagnosis Tables

ACCIDENT AND EMERGENCY EPISODE (RETIRED), renamed from ACCIDENT AND EMERGENCY EPISODE

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

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

An [Accident and Emergency Episode](#) involves visits to an [Accident and Emergency Department](#) of one [PATIENT](#) for a particular incident. The [PATIENT](#) may receive treatment during the [Accident and Emergency Episode](#) from the accident and emergency service and from other [MAIN SPECIALTIES](#). The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Each [Accident and Emergency Episode](#) takes place at a single [Accident and Emergency Department](#) and consists of one or more [Accident and Emergency Attendance](#). 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 [Accident and Emergency Episode](#) may give rise to a [DECISION TO ADMIT](#).

ACCIDENT AND EMERGENCY EPISODE (RETIRED), renamed from ACCIDENT AND EMERGENCY EPISODE

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

- Changed Description
- Changed Name from Data_Dictionary.NHS_Business_Definitions.A.Accident_and_Emergency_Episode to Retired.Data_Dictionary.NHS_Business_Definitions.A.Accident_and_Emergency_Episode
- Retired Accident and Emergency Episode

ACCIDENT AND EMERGENCY INITIAL ASSESSMENT DATE (RETIRED), renamed from ACCIDENT AND EMERGENCY INITIAL ASSESSMENT DATE

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

An [Accident and Emergency Initial Assessment Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

An [Accident and Emergency Initial Assessment Date](#) is the date that the [PATIENT](#) is first assessed in the [Accident and Emergency Department](#). The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

An Initial Assessment would include: 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 taking of a brief [PATIENT](#) medical history
- pain assessment
- early warning scores (including vital signs)

The assessment should be conducted by medical or nursing staff who have received appropriate training.

For guidance on the use of this data item in the Accident and Emergency Clinical Quality Indicators, further information is available on the [Department of Health and Social Care](#) National Archives at: [A&E clinical quality indicators: Implementation guidance and data definitions](#).

ACCIDENT AND EMERGENCY INITIAL ASSESSMENT DATE (RETIRED), renamed from ACCIDENT AND EMERGENCY INITIAL ASSESSMENT DATE

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

- Changed Description
- Changed Name from Data_Dictionary.NHS_Business_Definitions.A.Accident_and_Emergency_Initial_Assessment_Date to Retired.Data_Dictionary.NHS_Business_Definitions.A.Accident_and_Emergency_Initial_Assessment_Date
- Retired Accident and Emergency Initial Assessment Date

ACCIDENT AND EMERGENCY INITIAL ASSESSMENT TIME (RETIRED), renamed from ACCIDENT AND EMERGENCY INITIAL ASSESSMENT TIME

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

An [Accident and Emergency Initial Assessment Time](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

An [Accident and Emergency Initial Assessment Time](#) is the time, recorded using the 24 hour clock, that the [PATIENT](#) is first assessed in the [Accident and Emergency Department](#) for first attendances and unplanned follow-up attendances. The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

An Initial Assessment would include: 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 taking of a brief [PATIENT](#) medical history
- pain assessment
- early warning scores (including vital signs)

The assessment should be conducted by medical or nursing staff who have received appropriate training.

For guidance on the use of this data item in the Accident and Emergency Clinical Quality Indicators, further information is available on the [Department of Health and Social Care](#) National Archives at: [A&E clinical quality indicators: Implementation guidance and data definitions](#).

ACCIDENT AND EMERGENCY INITIAL ASSESSMENT TIME (RETIRED), renamed from ACCIDENT AND EMERGENCY INITIAL ASSESSMENT TIME

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

- Changed Description
 - Changed Name from Data_Dictionary.NHS_Business_Definitions.A.Accident_and_Emergency_Initial_Assessment_Time to Retired.Data_Dictionary.NHS_Business_Definitions.A.Accident_and_Emergency_Initial_Assessment_Time
 - Retired Accident and Emergency Initial Assessment Time
-

ACCIDENT AND EMERGENCY INVESTIGATION TABLE (RETIRED) renamed from ACCIDENT AND EMERGENCY INVESTIGATION TABLE

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

- A broad classification of types of investigation which may be requested to assist with diagnosis as a result of [Accident and Emergency Attendance](#).
- Certain items are sub-analysed to specify the diagnosis, investigation or treatment more precisely. These are marked with an asterisk. The diagnosis sub-analysis list follows the main diagnosis list, and the treatment sub-analysis list follows the main treatment list.
- It is recommended that computerised systems provide a minimum of six character fields for each category in order to accommodate more detailed information if necessary. Where fewer than six characters are required for coding, such as for investigations and treatments, it is recommended that the codes are left justified and the unused fields left blank.
- [ACCIDENT AND EMERGENCY INVESTIGATION](#) is a six character code, comprising:

Investigation	n2 (see Table below)
Local sub-Analysis	up to an4

Accident And Emergency Investigation Table This item has been retired from the NHS Data Model and Dictionary.

Investigation	Code
X-ray plain film	01
Electrocardiogram	02
Haematology	03
Cross match blood/group and save serum for later cross match	04
Biochemistry	05
Urinalysis	06
Bacteriology	07
Histology	08
Computerised Tomography - Retired 2006-04-04	09
Ultrasound	10
Magnetic Resonance Imaging	11
Computerised Tomography (excludes genitourinary contrast examination/tomography)	12
Genitourinary contrast examination/tomography	13
Clotting studies	14
Immunology	15
Cardiac enzymes	16
Arterial/capillary blood gas	17
Toxicology	18
Blood culture	19
Serology	20
Pregnancy test	21
Dental investigation	22
Refraction, orthoptic tests and computerised visual fields	23
None	24
Other	99

Items expected to be sub-analysed at discretion of individual [Accident and Emergency Departments](#). The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ACCIDENT AND EMERGENCY INVESTIGATION TABLE (RETIRED) renamed from ACCIDENT AND EMERGENCY INVESTIGATION TABLE

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

- Changed Description

- Changed Name from Web_Site_Content.Supporting_Information.Clinical_Coding.Accident_and_Emergency_Investigation_Table to Retired.Web_Site_Content.Supporting_Information.Accident_and_Emergency_Investigation_Table
- Retired Accident and Emergency Investigation Table

ACCIDENT AND EMERGENCY TIME SEEN FOR TREATMENT (RETIRED), renamed from **ACCIDENT AND EMERGENCY TIME SEEN FOR TREATMENT**

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

An [Accident and Emergency Time Seen For Treatment](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

An [Accident and Emergency Time Seen For Treatment](#) is the time, recorded using the 24 hour clock, that the [PATIENT](#) is seen by a clinical decision maker (someone who can define the management plan and discharge the [PATIENT](#)) to diagnose the problem and arrange or start definite treatment as necessary. The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

For guidance on the use of this data item in the Accident and Emergency Clinical Quality Indicators, further information is available on the [Department of Health and Social Care National Archives](#) at: [A&E clinical quality indicators: Implementation guidance and data definitions](#). 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.

ACCIDENT AND EMERGENCY TIME SEEN FOR TREATMENT (RETIRED), renamed from **ACCIDENT AND EMERGENCY TIME SEEN FOR TREATMENT**

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

- Changed Description
- Changed Name from Data_Dictionary.NHS_Business_Definitions.A.Accident_and_Emergency_Time_Seen_For_Treatment to Retired.Data_Dictionary.NHS_Business_Definitions.A.Accident_and_Emergency_Time_Seen_For_Treatment
- Retired Accident and Emergency Time Seen For Treatment

ACCIDENT AND EMERGENCY TREATMENT TABLES (RETIRED), renamed from **ACCIDENT AND EMERGENCY TREATMENT TABLES**

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

- A broad classification of types of treatment or guidance which may be provided to a [PATIENT](#) as a result of [Accident and Emergency Attendance](#).
- Certain items are sub-analysed to specify the diagnosis, investigation or treatment more precisely. These are marked with an asterisk. The diagnosis sub-analysis list follows the main diagnosis list, and the treatment sub-analysis list follows the main treatment list.
- It is recommended that computerised systems provide a minimum of six character fields for each category in order to accommodate more detailed information if necessary. Where fewer than six characters are required for coding, such as for investigations and treatments, it is recommended that the codes are left justified and the unused fields left blank.
- [ACCIDENT AND EMERGENCY TREATMENT](#) is a six character code, comprising:

Condition	n2 (see Treatment Table below)
Sub-Analysis	n1 (see Sub-analysis Table below)
Local use	up to an3

~~Accident and Emergency Treatment – Treatment~~ This item has been retired from the NHS Data Model and Dictionary.

Treatment	Code
Dressing*	01
Bandage/support	02
Sutures*	03
Wound closure (excluding sutures)*	04
Plaster of Paris*	05
Splint	06
Prescription – Retired 2006-04-01	07
Removal foreign body	08
Physiotherapy*	09

Manipulation*	10
Incision & drainage	11
Intravenous cannula	12
Central line	13
Lavage/emesis/charcoal/eye irrigation	14
Intubation & Endotracheal tubes/laryngeal mask airways/rapid sequence induction	15
Chest drain	16
Urinary catheter/suprapubic	17
Defibrillation/pacing*	18
Resuscitation/cardiopulmonary resuscitation	19
Minor surgery	20
Observation/electrocardiogram, pulse oximetry/head injury/trends	21
Guidance/advice only*	22
Anaesthesia*	23
Tetanus*	24
Nebuliser/spacer	25
Parenteral thrombolysis*	28
Other Parenteral drugs*	29
Recording vital signs	30
Burns review	31
Recall/x ray review	32
Fracture review	33
Wound cleaning	34
Dressing/wound review	35
Sling/collar cuff/broad arm sling	36
Epistaxis control	37
Nasal airway	38
Oral airway	39
Supplemental oxygen	40
Continuous positive airways pressure/nasal intermittent positive pressure ventilation/bag valve mask	41
Arterial line	42
Infusion fluids	43
Blood product transfusion	44
Pericardiocentesis	45
Lumbar puncture	46
Joint aspiration	47
Minor plastic procedure/split skin graft	48
Active rewarming of the hypothermic patient	49
Cooling—control body temperature	50
Medication administered*	51
Occupational Therapy*	52
Lean of walking aid (crutches)	53
Social work intervention	54
Eye*	55
Dental treatment	56
Prescription/medicines prepared to take away	57
Other (consider alternatives)	27
None (consider guidance/advice option)	99

Items sub-analysed in Table below. The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Accident and Emergency Treatment — Sub-analysis 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.

Sub-analysis Treatment		Code
Dressing	-dressing minor wound/burn/eye	1
	-dressing major wound/burn	2
Sutures	-primary sutures	1
	-secondary/complex suture	2
	-removal of sutures/clips	3
Wound closure (excluding sutures)	-steristrips	1
	-wound glue	2
	-other (e.g. clips)	3
Plaster of Paris	-application Plaster of Paris	1
	-removal Plaster of Paris	2
Physiotherapy	-strapping, ultra-sound treatment, short wave diathermy, manipulation	1
	-gait re-education, falls prevention	2
Manipulation	-manipulation of upper limb fracture	1
	-manipulation of lower limb fracture	2
	-manipulation of dislocation	3
Defibrillation/pacing	-defibrillation	1
	-external pacing	2
Guidance/advice only	-written	1
	-verbal	2
Anaesthesia	-general anaesthetic	1
	-local anaesthetic	2
	-regional block	3
	-entonox	4
	-sedation	5
	-other	6
Tetanus	-immune	1
	-tetanus toxoid course	2
	-tetanus toxoid booster	3
	-human immunoglobulin	4
	-combined tetanus/diphtheria course	5
	-combined tetanus/diphtheria booster	6
Parenteral thrombolysis	-streptokinase parenteral thrombolysis	1
	-recombinant plasminogen activator	2
Other Parenteral drugs	-intravenous drug, e.g. stat/bolus	1
	-intravenous infusion	2
Medication administered	-oral	1
	-intra-muscular	2
	-subcutaneous	3
	-per rectum	4
	-sublingual	5
	-intra-nasal	6
	-eye drops	7
	-ear drops	8
	-topical skin cream	9
Occupational Therapy	-OT functional assessment	1
	-OT activities of daily living equipment provision	2
Eye	-orthoptic exercises	1
	-laser of retina/iris or posterior capsule	2
	-retrobulbar injection	3
	-epilation of lashes	4
	-subconjunctival injection	5

ACCIDENT AND EMERGENCY TREATMENT TABLES (RETIRED) renamed from ACCIDENT AND EMERGENCY TREATMENT TABLES

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

- Changed Description
- Changed Name from `Web_Site_Content.Supporting_Information.Clinical_Coding.Accident_and_Emergency_Treatment_Tables` to `Retired.Web_Site_Content.Supporting_Information.Accident_and_Emergency_Treatment_Tables`

- Retired Accident and Emergency Treatment Tables

ARRIVAL DATE AT ACCIDENT AND EMERGENCY DEPARTMENT (RETIRED), renamed from ARRIVAL DATE AT ACCIDENT AND EMERGENCY DEPARTMENT

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

An [Arrival Date At Accident and Emergency Department](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

An [Arrival Date At Accident and Emergency Department](#) is the date the [PATIENT](#). The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

- self presented at the [Accident and Emergency Department](#) or
- arrived in an [Ambulance](#) at the [Accident and Emergency Department](#).

For the Accident and Emergency Clinical Quality Indicators, for [PATIENTS](#) arriving by [Emergency Ambulance](#), the [Arrival Time At Accident and Emergency Department](#) is when handover occurs, or 15 minutes after the [Emergency Ambulance](#) arrives at the [Accident and Emergency Department](#), whichever is the sooner. 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.

Further guidance is available on the [Department of Health and Social Care](#) National Archives at: [A&E clinical quality indicators: Implementation guidance and data definitions](#).

ARRIVAL DATE AT ACCIDENT AND EMERGENCY DEPARTMENT (RETIRED), renamed from ARRIVAL DATE AT ACCIDENT AND EMERGENCY DEPARTMENT

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

- Changed Description
- Changed Name from Data_Dictionary.NHS_Business_Definitions.A.Arrival_Date_At_Accident_and_Emergency_Department to Retired.Data_Dictionary.NHS_Business_Definitions.A.Arrival_Date_At_Accident_and_Emergency_Department
- Retired Arrival Date At Accident and Emergency Department

ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT (RETIRED), renamed from ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT

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

An [Arrival Time At Accident and Emergency Department](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

An [Arrival Time At Accident and Emergency Department](#) is the time the [PATIENT](#). The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

- self presented at the [Accident and Emergency Department](#) or
- arrived in an [Ambulance](#) at the [Accident and Emergency Department](#).

The time should be recorded using the 24 hour clock. 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.

For the Accident and Emergency Clinical Quality Indicators, for [PATIENTS](#) arriving by [Emergency Ambulance](#), the [Arrival Time At Accident and Emergency Department](#) is when handover occurs, or 15 minutes after the [Emergency Ambulance](#) arrives at the [Accident and Emergency Department](#), whichever is the sooner.

Further guidance is available on the [Department of Health and Social Care](#) National Archives at: [A&E clinical quality indicators: Implementation guidance and data definitions](#).

ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT (RETIRED), renamed from ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT

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

- Changed Description
- Changed Name from Data_Dictionary.NHS_Business_Definitions.A.Arrival_Time_At_Accident_and_Emergency_Department to Retired.Data_Dictionary.NHS_Business_Definitions.A.Arrival_Time_At_Accident_and_Emergency_Department

- Retired Arrival Time At Accident and Emergency Department

ASSESSMENT TOOL VALIDATION TIMESTAMP

Change to Supporting Information: New Supporting Information

An **Assessment Tool Validation Timestamp** is an **ACTIVITY DATE TIME** and time zone.

The **Assessment Tool Validation Timestamp** is the date, time and time zone that the **CODED ASSESSMENT TOOL TYPE (SNOMED CT)** was validated by the **CARE PROFESSIONAL**.

This supporting information is also known by these names:

Context	Alias
plural	Assessment Tool Validation Timestamps

CANCER PATHWAY

Change to Supporting Information: Changed Description

A **Cancer Pathway** is a **PATIENT PATHWAY**.

A **Cancer Pathway** is the **PATIENT**'s journey from the initial suspicion of cancer through **Clinical Investigations**, **PATIENT DIAGNOSIS** and treatment.

This could be by:

- Initial referral to a hospital specialist by the **PATIENT**'s **GENERAL PRACTITIONER**
- **Assessment in an Accident and Emergency Department**
- **Assessment in an Emergency Care Department**
- Assessment when the **PATIENT** is already in the hospital system with an acute illness or an earlier **PATIENT DIAGNOSIS**
- Identification through one of the **Screening Programmes**.

For the following data sets, types of **Cancer Pathway** include:

- **Cancer Outcomes and Services Data Set:**
 - **Primary Cancer Pathway**
 - **Non Primary Cancer Pathway**
- **National Cancer Waiting Times Monitoring Data Set:**
 - **Cancer Faster Diagnosis Pathway**

CARE PROFESSIONAL CLINICAL RESPONSIBILITY TIMESTAMP

Change to Supporting Information: New Supporting Information

A **Care Professional Clinical Responsibility Timestamp** is an **ACTIVITY DATE TIME** and time zone.

A **Care Professional Clinical Responsibility Timestamp** is the date, time and time zone when the **CARE PROFESSIONAL** first became clinically responsible for the **PATIENT**.

This supporting information is also known by these names:

Context	Alias
plural	Care Professional Clinical Responsibility Timestamps

CDS TYPE

Change to Supporting Information: Changed Description

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

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

Note:

- [CDS Type 010 'Accident and Emergency Attendance'](#) will no longer be accepted for submission to the [Secondary Uses Service](#) from 01 November 2020.

The [CDS Types](#) are:

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

CDS V6-2-3 TYPE 001 - CDS INTERCHANGE HEADER OVERVIEW

Change to Supporting Information: New Supporting Information

Introduction

The [CDS V6-2-3 Type 001 - Commissioning Data Set Interchange Header](#) carries mandatory controls for a Commissioning Data Set Interchange and is only used by inclusion in other [CDS Types](#).

Note that the [CDS V6-2-3 Type 001 - Commissioning Data Set Interchange Header](#) should only be used when submitting the [CDS V6-2-3 Type 011 - Emergency Care CDS](#).

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

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

- [CDS V6-2-3 Type 001 - Commissioning Data Set Interchange Header](#) - Mandatory - One per Commissioning Data Set Interchange
- [CDS V6-2-3 Type 003 - Commissioning Data Set Message Header](#) - Mandatory - One per Commissioning Data Set Message

Dependent upon the [Commissioning Data Set Submission Protocol](#) being used, one of the following must be used:

- [CDS V6-2-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#) - Mandatory, one per [CDS Type](#)
- [CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#) - Mandatory, one per [CDS Type](#)

Followed by:

- [The CDS Type](#) - As required to carry the specific Commissioning Data Set data records

Each Commissioning Data Set message ends with:

- [CDS V6-2-3 Type 004 - Commissioning Data Set Message Trailer](#) - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- [CDS V6-2-3 Type 002 - Commissioning Data Set Interchange Trailer](#) - Mandatory - One per Commissioning Data Set Interchange

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

Data Group Overview

A high-level view of the Data Groups is shown below.

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

Notation		DATA GROUP OVERVIEW: CDS V6-2-3 TYPE 001 - COMMISSIONING DATA SET INTERCHANGE HEADER
Group Status	Group Repeats	FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set Interchange submission.
M	1..1	DATA GROUP: CDS V6-2-3 Type 001 - Commissioning Data Set Interchange Header One per Commissioning Data Set Interchange submitted to the Secondary Uses Service . Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

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 [Commissioning Data Set Version 6-2-3 XML Schema Constraints](#).

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

CDS V6-2-3 TYPE 002 - CDS INTERCHANGE TRAILER OVERVIEW

Change to Supporting Information: New Supporting Information

Introduction

The [CDS V6-2-3 Type 002 - Commissioning Data Set Interchange Trailer](#) carries mandatory controls for a Commissioning Data Set Interchange and is only used by inclusion in other CDS Types.

Note that the [CDS V6-2-3 Type 002 - Commissioning Data Set Interchange Trailer](#) should only be used when submitting the [CDS V6-2-3 Type 011 - Emergency Care CDS](#).

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

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

- [CDS V6-2-3 Type 001 - Commissioning Data Set Interchange Header](#) - Mandatory - One per Commissioning Data Set Interchange
- [CDS V6-2-3 Type 003 - Commissioning Data Set Message Header](#) - Mandatory - One per Commissioning Data Set Message

Dependent upon the [Commissioning Data Set Submission Protocol](#) being used, one of the following must be used:

- [CDS V6-2-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#) - Mandatory, one per CDS Type
- [CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#) - Mandatory, one per CDS Type

Followed by:

- The [CDS Type](#) - As required to carry the specific Commissioning Data Set data records

Each Commissioning Data Set message ends with:

- [CDS V6-2-3 Type 004 - Commissioning Data Set Message Trailer](#) - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- [CDS V6-2-3 Type 002 - Commissioning Data Set Interchange Trailer](#) - Mandatory - One per Commissioning Data Set Interchange

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

Data Group Overview

A high-level view of the Data Groups is shown below.

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

Notation		DATA GROUP OVERVIEW: CDS V6-2-3 TYPE 002 - CDS INTERCHANGE TRAILER
Group Status	Group Repeats	FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.
M	1..1	DATA GROUP: CDS V6-2-3 Type 002 - Commissioning Data Set Interchange Trailer One per Interchange submitted to the Secondary Uses Service . Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

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 [Commissioning Data Set Version 6-2-3 XML Schema Constraints](#).

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

CDS V6-2-3 TYPE 003 - CDS MESSAGE HEADER OVERVIEW

Change to Supporting Information: New Supporting Information

Introduction

The [CDS V6-2-3 Type 003 - Commissioning Data Set Message Header](#) carries mandatory controls for a Commissioning Data Set Message and is only used by inclusion in other [CDS Types](#).

Note that the [CDS V6-2-3 Type 003 - Commissioning Data Set Message Header](#) should only be used when submitting the [CDS V6-2-3 Type 011 - Emergency Care CDS](#).

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

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

- [CDS V6-2-3 Type 001 - Commissioning Data Set Interchange Header](#) - Mandatory - One per Commissioning Data Set Interchange
- [CDS V6-2-3 Type 003 - Commissioning Data Set Message Header](#) - Mandatory - One per Commissioning Data Set Message

Dependent upon the [Commissioning Data Set Submission Protocol](#) being used, one of the following must be used:

- [CDS V6-2-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#) - Mandatory, one per [CDS Type](#)
- [CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#) - Mandatory, one per [CDS Type](#)

Followed by:

- The [CDS Type](#) - As required to carry the specific Commissioning Data Set data records

Each Commissioning Data Set message ends with:

- [CDS V6-2-3 Type 004 - Commissioning Data Set Message Trailer](#) - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- [CDS V6-2-3 Type 002 - Commissioning Data Set Interchange Trailer](#) - Mandatory - One per Commissioning Data Set Interchange

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

Data Group Overview

A high-level view of the Data Groups carried is shown below.

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

Notation		DATA GROUP OVERVIEW: CDS V6-2-3 TYPE 003 - CDS MESSAGE HEADER
Group Status	Group Repeats	FUNCTION: To define the mandatory identity and addressing information for a Commissioning Data Set submission.
M	1..*	DATA GROUP: CDS V6-2-3 Type 003 - Commissioning Data Set Message Header One per Commissioning Data Set Message submitted to the Secondary Uses Service . Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

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 [Commissioning Data Set Version 6-2-3 XML Schema Constraints](#).

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

CDS V6-2-3 TYPE 004 - CDS MESSAGE TRAILER OVERVIEW

Change to Supporting Information: New Supporting Information

Introduction

The [CDS V6-2-3 Type 004 - Commissioning Data Set Message Trailer](#) carries mandatory controls for a Commissioning Data Set Message and is only used by inclusion in other [CDS Types](#).

Note that the [CDS V6-2-3 Type 004 - Commissioning Data Set Message Trailer](#) should only be used when submitting the [CDS V6-2-3 Type 011 - Emergency Care CDS](#).

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

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

- [CDS V6-2-3 Type 001 - Commissioning Data Set Interchange Header](#) - Mandatory - One per Commissioning Data Set Interchange
- [CDS V6-2-3 Type 003 - Commissioning Data Set Message Header](#) - Mandatory - One per Commissioning Data Set Message

Dependent upon the [Commissioning Data Set Submission Protocol](#) being used, one of the following must be used:

- [CDS V6-2-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#) - Mandatory, one per [CDS Type](#)
- [CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#) - Mandatory, one per [CDS Type](#)

Followed by:

- The [CDS Type](#) - As required to carry the specific Commissioning Data Set data records

Each Commissioning Data Set message ends with:

- [CDS V6-2-3 Type 004 - Commissioning Data Set Message Trailer](#) - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- [CDS V6-2-3 Type 002 - Commissioning Data Set Interchange Trailer](#) - Mandatory - One per Commissioning Data Set Interchange

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

Data Group Overview

A high-level view of the Data Groups carried is shown below.

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

Notation		DATA GROUP OVERVIEW: CDS V6-2-3 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..*	DATA GROUP: CDS V6-2-3 Type 004 - Commissioning Data Set Message Trailer One per Commissioning Data Set Message submitted to the Secondary Uses Service . Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

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 [Commissioning Data Set Version 6-2-3 XML Schema Constraints](#).

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

CDS V6-2-3 TYPE 005B - CDS TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL OVERVIEW

Change to Supporting Information: New Supporting Information

Introduction

The [CDS V6-2-3 Type 005B - CDS Transaction Header Group - Bulk Update Protocol](#) carries mandatory controls for a Commissioning Data Set Type and is only used by inclusion in other [CDS Types](#).

Note that the [CDS V6-2-3 Type 005B - CDS Transaction Header Group - Bulk Update Protocol](#) should only be used when submitting the [CDS V6-2-3 Type 011 - Emergency Care CDS](#).

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

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

- [CDS V6-2-3 Type 001 - Commissioning Data Set Interchange Header](#) - Mandatory - One per Commissioning Data Set Interchange
- [CDS V6-2-3 Type 003 - Commissioning Data Set Message Header](#) - Mandatory - One per Commissioning Data Set Message

Dependent upon the [Commissioning Data Set Submission Protocol](#) being used, one of the following must be used:

- [CDS V6-2-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#) - Mandatory, one per [CDS Type](#)
- [CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#) - Mandatory, one per [CDS Type](#)

Followed by:

- The [CDS Type](#) - As required to carry the specific Commissioning Data Set data records

Each Commissioning Data Set message ends with:

- [CDS V6-2-3 Type 004 - Commissioning Data Set Message Trailer](#) - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- [CDS V6-2-3 Type 002 - Commissioning Data Set Interchange Trailer](#) - Mandatory - One per Commissioning Data Set Interchange

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

Data Group Overview

A high-level view of the Data Groups carried is shown below.

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

Notation		DATA GROUP OVERVIEW: CDS V6-2-3 TYPE 005B - TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL
Group Status	Group Repeats	FUNCTION: To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of one of the Update Mechanisms of the Commissioning Data Set Submission Protocol.
M	1..1	DATA GROUP: CDS V6-2-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol One per Commissioning Data Set record submitted to the Secondary Uses Service . Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

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 [Commissioning Data Set Version 6-2-3 XML Schema Constraints](#).

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

CDS V6-2-3 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL OVERVIEW

Change to Supporting Information: New Supporting Information

Introduction

The [CDS V6-2-3 Type 005N - CDS Transaction Header Group - Net Change Protocol](#) carries mandatory controls for a Commissioning Data Set Type and is only used by inclusion in other [CDS Types](#).

Note that the [CDS V6-2-3 Type 005N - CDS Transaction Header Group - Net Change Protocol](#) should only be used when submitting the [CDS V6-2-3 Type 011 - Emergency Care CDS](#).

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

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

- [CDS V6-2-3 Type 001 - Commissioning Data Set Interchange Header](#) - Mandatory - One per Commissioning Data Set Interchange
- [CDS V6-2-3 Type 003 - Commissioning Data Set Message Header](#) - Mandatory - One per Commissioning Data Set Message

Dependent upon the [Commissioning Data Set Submission Protocol](#) being used, one of the following must be used:

- [CDS V6-2-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#) - Mandatory, one per [CDS Type](#)
- [CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#) - Mandatory, one per [CDS Type](#)

Followed by:

- The [CDS Type](#) - As required to carry the specific Commissioning Data Set data records

Each Commissioning Data Set message ends with:

- [CDS V6-2-3 Type 004 - Commissioning Data Set Message Trailer](#) - Mandatory - One per Commissioning Data Set Message

Each Commissioning Data Set Interchange ends with:

- [CDS V6-2-3 Type 002 - Commissioning Data Set Interchange Trailer](#) - Mandatory - One per Commissioning Data Set Interchange

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

Data Group Overview

A high-level view of the Data Groups carried is shown below.

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

Notation		DATA GROUP OVERVIEW: CDS V6-2-3 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL
Group Status	Group Repeats	FUNCTION:
		To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of one of the Update Mechanisms of the Commissioning Data Set Submission Protocol.
M	1..1	DATA GROUP: CDS V6-2-3 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.

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 [Commissioning Data Set Version 6-2-3 XML Schema Constraints](#).

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

CDS V6-2-3 TYPE 011 - EMERGENCY CARE CDS OVERVIEW

Change to Supporting Information: New Supporting Information

Introduction

CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set carries the data for an [Emergency Care Attendance](#).

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

Data Group Overview

A high-level view of the Data Groups carried is shown below.

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

Notation		DATA GROUP OVERVIEW: CDS V6-2-3 TYPE 011 - EMERGENCY CARE COMMISSIONING DATA SET
Group Status	Group Repeats	FUNCTION:
		To support the details of an Emergency Care Attendance.
M	1..1	DATA GROUP: CDS V6-2-3 Type 001 - Commissioning Data Set Interchange Header One per Interchange submitted to the Secondary Uses Service . Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.
M	1..*	DATA GROUP: CDS V6-2-3 Type 003 - Commissioning Data Set Message Header One per Commissioning Data Set Message submitted to the Secondary Uses Service .
M	1..1	DATA GROUP: COMMISSIONING DATA SET TRANSACTION HEADER GROUP Dependent upon the Commissioning Data Set Submission Protocol being used, one of the following must be used per

		Commissioning Data Set Message submitted to the Secondary Uses Service : CDS V6-2-3 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol Or CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol
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O	0..1	DATA GROUP: PATIENT PATHWAY
M	1..1	DATA GROUP: PATIENT IDENTITY
R	0..1	DATA GROUP: PATIENT CHARACTERISTICS (EMERGENCY CARE)
R	0..*	DATA GROUP: MENTAL HEALTH ACT LEGAL STATUS
R	0..1	DATA GROUP: GP REGISTRATION
R	0..1	DATA GROUP: EMERGENCY CARE ATTENDANCE LOCATION
R	0..1	DATA GROUP: AMBULANCE DETAILS
R	0..*	DATA GROUP: EXPECTED DATE AND TIME OF TREATMENT
M	1..1	DATA GROUP: EMERGENCY CARE ATTENDANCE ACTIVITY CHARACTERISTICS
R	0..*	DATA GROUP: CODED SCORED ASSESSMENT
R	0..*	DATA GROUP: CODED CLINICAL OBSERVATION
R	0..1	DATA GROUP: INJURY CHARACTERISTICS
R	0..1	DATA GROUP: PATIENT CLINICAL HISTORY
M	1..1	DATA GROUP: SERVICE AGREEMENT DETAILS
R	0..*	DATA GROUP: CARE PROFESSIONALS (EMERGENCY CARE)
R	0..*	DATA GROUP: EMERGENCY CARE DIAGNOSES
R	0..*	DATA GROUP: EMERGENCY CARE INVESTIGATIONS
R	0..*	DATA GROUP: EMERGENCY CARE TREATMENTS
R	0..*	DATA GROUP: REFERRALS TO OTHER SERVICES
R	0..1	DATA GROUP: DISCHARGE FROM EMERGENCY CARE
O	0..1	DATA GROUP: RESEARCH AND DISEASE OUTBREAK NOTIFICATION

M	1..*	DATA GROUP: CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol One per Commissioning Data Set Message submitted to the Secondary Uses Service . Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.
M	1..1	DATA GROUP: CDS V6-2-3 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol One per Interchange submitted to the Secondary Uses Service . Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

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 [Commissioning Data Set Version 6-2-3 XML Schema Constraints](#).

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

CDS V6-2 TYPE 010 - ACCIDENT AND EMERGENCY CDS OVERVIEW (RETIRED)_renamed from CDS V6-2 TYPE 010 - ACCIDENT AND EMERGENCY CDS OVERVIEW

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

Introduction This item has been retired from the NHS Data Model and Dictionary.

[CDS V6-2 Type 010 - Accident and Emergency Commissioning Data Set](#) carries the data for an [Accident and Emergency Attendance](#). The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

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

Data-Group-Overview

A high-level view of the Data Groups carried is shown below.

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

Notation		DATA GROUP OVERVIEW: CDS V6 2 TYPE 010 – ACCIDENT AND EMERGENCY COMMISSIONING DATA SET
Group Status	Group Repeats	FUNCTION: To support the details of an Accident and Emergency Attendance.

M	1..1	DATA GROUP: CDS V6 2 Type 001 – Commissioning Data Set Interchange Header One per Interchange submitted to the Secondary Uses Service . Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.
M	1..*	DATA GROUP: CDS V6 2 Type 003 – Commissioning Data Set Message Header One per Commissioning Data Set Message submitted to the Secondary Uses Service .
M	1..1	DATA GROUP: COMMISSIONING DATA SET TRANSACTION HEADER GROUP Dependent upon the Commissioning Data Set Submission Protocol being used, one of the following must be used per Commissioning Data Set Message submitted to the Secondary Uses Service : CDS V6 2 Type 005B – Commissioning Data Set Transaction Header Group – Bulk Update Protocol Or CDS V6 2 Type 005N – Commissioning Data Set Transaction Header Group – Net Change Protocol

0	0..1	DATA GROUP: PATIENT PATHWAY
M	1..1	DATA GROUP: PERSON GROUP (PATIENT)
		M 1..1 DATA GROUP: PATIENT IDENTITY
		R 0..1 DATA GROUP: PATIENT CHARACTERISTICS (A AND E)
R	0..1	DATA GROUP: GP REGISTRATION
R	0..1	DATA GROUP: LOCATION GROUP – ATTENDANCE
M	1..1	DATA GROUP: ATTENDANCE OCCURRENCE
		M 1..1 DATA GROUP: ACTIVITY CHARACTERISTICS
		M 1..1 DATA GROUP: SERVICE AGREEMENT DETAILS
		R 0..1 DATA GROUP: PERSON GROUP (A AND E CONSULTANT)
		0 0..1 DATA GROUP: CLINICAL DIAGNOSIS GROUP (ICD)
		0 0..1 DATA GROUP: CLINICAL DIAGNOSIS GROUP (READ)
		R 0..1 DATA GROUP: CLINICAL DIAGNOSIS GROUP (A AND E)
		R 0..1 DATA GROUP: CLINICAL INVESTIGATION GROUP (A AND E)
		0 0..1 DATA GROUP: CLINICAL ACTIVITY GROUP (OPCS)
		0 0..1 DATA GROUP: CLINICAL ACTIVITY GROUP (READ)
		R 0..1 DATA GROUP: CLINICAL TREATMENT GROUP (A AND E)

M	1..*	DATA GROUP: CDS V6 2 Type 004 – Commissioning Data Set Message Trailer One per Commissioning Data Set Message submitted to the Secondary Uses Service . Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.
M	1..1	DATA GROUP: CDS V6 2 Type 002 – Commissioning Data Set Interchange Trailer One per Interchange submitted to the Secondary Uses Service . Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.

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 [Commissioning Data Set Version 6 2 XML Schema Constraints](#).

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

CDS V6-2 TYPE 010 - ACCIDENT AND EMERGENCY CDS OVERVIEW (RETIRED)_renamed from CDS V6-2 TYPE 010 - ACCIDENT AND EMERGENCY CDS OVERVIEW

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

- Changed Description
- Changed Name from Data_Dictionary.Messages.CDS_V6-2.Overviews.CDS_V6-2_Type_010_-_Accident_and_Emergency_CDS_Overview to Retired.Data_Dictionary.Messages.CDS_V6-2.CDS_V6-2_Type_010_-_Accident_and_Emergency_CDS_Overview
- Retired CDS V6-2 Type 010 - Accident and Emergency CDS Overview

CDS VERSION 6-2 MENU

Change to Supporting Information: Changed Description

[Commissioning Data Set Business Rules](#)
[Commissioning Data Set Notation](#)

CDS Data Flow Controls - (Mandatory for every CDS Interchange):

- [CDS V6-2 Type 001 - CDS Interchange Header](#)
- [CDS V6-2 Type 002 - CDS Interchange Trailer](#)
- [CDS V6-2 Type 003 - CDS Message Header](#)
- [CDS V6-2 Type 004 - CDS Message Trailer](#)
- [CDS V6-2-1 Type 001 - CDS Interchange Header](#)
- [CDS V6-2-1 Type 002 - CDS Interchange Trailer](#)
- [CDS V6-2-1 Type 003 - CDS Message Header](#)
- [CDS V6-2-1 Type 004 - CDS Message Trailer](#)
- [CDS V6-2-2 Type 001 - CDS Interchange Header](#)
- [CDS V6-2-2 Type 002 - CDS Interchange Trailer](#)
- [CDS V6-2-2 Type 003 - CDS Message Header](#)
- [CDS V6-2-2 Type 004 - CDS Message Trailer](#)
- [CDS V6-2-3 Type 001 - CDS Interchange Header](#)
- [CDS V6-2-3 Type 002 - CDS Interchange Trailer](#)
- [CDS V6-2-3 Type 003 - CDS Message Header](#)
- [CDS V6-2-3 Type 004 - CDS Message Trailer](#)

CDS Transaction Header Group - (Mandatory for every CDS TYPE):

- [CDS V6-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol](#) or
- [CDS V6-2 Type 005N - CDS Transaction Header Group - Net Change Protocol](#)
- [CDS V6-2-1 Type 005B - CDS Transaction Header Group - Bulk Update Protocol](#) or
- [CDS V6-2-1 Type 005N - CDS Transaction Header Group - Net Change Protocol](#)
- [CDS V6-2-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol](#) or
- [CDS V6-2-2 Type 005N - CDS Transaction Header Group - Net Change Protocol](#)
- [CDS V6-2-3 Type 005B - CDS Transaction Header Group - Bulk Update Protocol](#) or
- [CDS V6-2-3 Type 005N - CDS Transaction Header Group - Net Change Protocol](#)

CDS TYPES:

Emergency Care:

- [CDS V6-2 Type 010 - Accident and Emergency CDS](#)
- [CDS V6-2-1 Type 011 - Emergency Care CDS](#)
- [CDS V6-2-2 Type 011 - Emergency Care CDS](#)
- [CDS V6-2-3 Type 011 - Emergency Care CDS](#)

Outpatient Care:

- [CDS V6-2 Type 020 - Outpatient CDS](#)
- [CDS V6-2 Type 021 - Future Outpatient CDS](#)

Admitted Patient Care:

- [CDS V6-2 Type 120 - Admitted Patient Care - Finished Birth Episode CDS](#)
- [CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode CDS](#)
- [CDS V6-2 Type 140 - Admitted Patient Care - Finished Delivery Episode CDS](#)
- [CDS V6-2 Type 150 - Admitted Patient Care - Other Birth Event CDS](#)
- [CDS V6-2 Type 160 - Admitted Patient Care - Other Delivery Event CDS](#)
- [CDS V6-2 Type 170 - Admitted Patient Care - Detained and/or Long Term Psychiatric Census CDS](#)
- [CDS V6-2 Type 180 - Admitted Patient Care - Unfinished Birth Episode CDS](#)

[CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode CDS](#)
[CDS V6-2 Type 200 - Admitted Patient Care - Unfinished Delivery Episode CDS](#)

Elective Admission List - End Of Period Census Types:

[CDS V6-2 Type 030 - Elective Admission List - End of Period Census \(Standard\) CDS](#)
[CDS V6-2 Type 040 - Elective Admission List - End of Period Census \(Old\) CDS](#)
[CDS V6-2 Type 050 - Elective Admission List - End of Period Census \(New\) CDS](#)

Elective Admission List - Event During Period Types:

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

CLINICAL CODING INTRODUCTION

Change to Supporting Information: Changed Description

- [Accident and Emergency Coding Tables](#)
 - [International Classification of Diseases \(ICD\)](#)
 - [International Classification of Diseases for Oncology \(ICD-O\)](#)
 - [National Interim Clinical Imaging Procedure Code Set \(NICIP Code Set\)](#)
 - [NHS dictionary of medicines and devices \(dm+d\)](#)
 - [OPCS Classification of Interventions and Procedures](#)
 - [Read Coded Clinical Terms](#)
 - [SNOMED CT®](#)
 - [SNOMED CT Refset](#)

Requests for Change:

- Change requests for [CLINICAL TERMINOLOGY CODES](#) and [CLINICAL CLASSIFICATION CODES](#) released by [NHS Digital](#) should be made through the Request Submission Portal on the [NHS Digital](#) website at: [Welcome to the Request Submission Portal](#).
- Requests for medicines or devices terminologies should be made via the Service Desk at: information.standards@nhs.net.

CODING AND CLASSIFICATIONS MENU

Change to Supporting Information: Changed Description

- [Clinical Coding Introduction](#)

- [International Classification of Diseases](#)
- [International Classification of Diseases for Oncology](#)
- [National Interim Clinical Imaging Procedure Code Set](#)
- [NHS dictionary of medicines and devices](#)
- [OPCS Classification of Interventions and Procedures](#)
- [Read Coded Clinical Terms](#)
- [SNOMED CT®](#)
- [SNOMED CT Refset](#)

~~Accident and Emergency Coding Tables~~

- [Accident and Emergency Diagnosis Tables](#)
- [Accident and Emergency Investigation Table](#)
- [Accident and Emergency Treatment Tables](#)

Change to Supporting Information: Changed Dataset

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

Population Validation

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

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

Business Rules

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

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

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

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

PREFIX	BUSINESS RULES: N - NHS Data Standards and Policy Rules
N1	Psychiatric PATIENTS only.
N2	Not defined or approved by the Data Coordination Board or its predecessors the 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 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 DATA DUPLICATION

Change to Supporting Information: Changed Description

It is acknowledged that the [Secondary Uses Service](#) processes can be directed to create duplicate Commissioning Data Set records and on occasion to wrongly delete records. This may occur if data senders do not correctly apply the rules associated with the [Commissioning Data Set Submission Protocol](#) such as the protocol dates and the sender and recipient codes applicable to interchanges.

~~It is not advisable to mix the use of Bulk and Net protocol for Commissioning Data Set submissions for the same sender [ORGANISATION](#) and [ORGANISATION SITE](#) as duplication or wrongful record deletion can occur.~~ It is not advisable to mix the use of Bulk and Net protocol for Commissioning Data Set submissions for the same sender [ORGANISATION](#) and [ORGANISATION SITE](#) code as duplication or wrongful record deletion can occur.

Anticipating possible causes of duplication

Data senders can take steps to avoid Commissioning Data Set duplication in the [Secondary Uses Service](#) by anticipating situations which could result in changes to the data applied in the [Commissioning Data Set Submission Protocols](#) and by taking action to ensure that key data items that need to be retained consistently in the lifetime of the Commissioning Data Set record are not changed.

Data senders should note the following guidance on situations where extra vigilance is needed and action to ensure consistent and correct application of data elements used in net or bulk protocols:

~~Changes of address in patient demographic data~~

~~A change of [POSTCODE](#) following a change of [PATIENT USUAL ADDRESS](#) can change the [CDS PRIME RECIPIENT IDENTITY](#) in bulk update submissions. Where possible, data senders should monitor changes to postcodes when preparing Commissioning Data Set data for submission in order to help prepare to minimise its impact on the integrity of the Commissioning Data Set data.~~

New Patient Care or other local systems used in Commissioning Data Set processing

When a new [PATIENT](#) care system or other system is implemented or used for preparing the Commissioning Data Set output data, it must be ensured that the Commissioning Data Set is generated to the appropriate specification required. The sender must ensure that any data events that may impact on key fields in the Commissioning Data Set are managed correctly.

~~For example, if the [CDS SENDER IDENTITY](#) is sourced from the new system it is important to check that its format will not be changed (eg from 5 to 3 characters, or inserting site codes in the 4th and 5th characters instead of zeros).~~ For example, if the [CDS SENDER IDENTITY](#) is sourced from the new system it is important to check that its format will not be changed (eg from 5 to 3 characters).

Sub-contracting

If a provider sub-contracts healthcare services and associated Commissioning Data Set submissions to a second provider, both parties need to actively engage in coordinating their arrangements for Commissioning Data Set submissions, ensuring that [Commissioning Data Set Submission Protocol](#) rules are applied appropriately to maintain the Commissioning Data Set data integrity in the [Secondary Uses Service](#) database.

New XML Schema translation supplier

If a provider changes supplier arrangements for XML Schema translation, it is important that the new supplier is provided with the information required about the [Commissioning Data Set Submission Protocols](#) that have been used in previous Commissioning Data Set submissions in order to ensure that data integrity is maintained in the ongoing Commissioning Data Set XML Schema processes and in the [Secondary Uses Service](#) database.

COMMISSIONING DATA SET MANDATED DATA FLOWS

Change to Supporting Information: Changed Description

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

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

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

CDS TYPE	DESCRIPTION	MIN FREQUENCY	DIRECTIVE	DATA FLOW
CDS 040	Accident And Emergency	Monthly	Accident and Emergency Attendances were mandated to flow nationally from 1st April 2005, see DSCN 32/2004	All Accident and Emergency Attendances occurring during the time period being reported and defined by the Commissioning Data Set Submission Protocol being used.
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 Emergency Care Attendances for EMERGENCY CARE DEPARTMENT TYPES 03 and 04 were mandated to flow from October 2018. See SCCI0092-2062	Data is expected to flow on a daily basis where possible, but a weekly frequency is the minimum requirement.
CDS 020	Out-Patient	Monthly	Out-Patient Attendance Commissioning Data Sets (including Ward Attenders) were mandated to be submitted to the Secondary Uses Service from 1st October 2001, see DSCN 05/2001 . Out-Patient Attendance Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009. NURSE and MIDWIFE attendances and Attendances for nursing care were enabled to be carried in the Out-Patient Attendance Commissioning Data Set from 1 April 2005, DSCN 32/2004 Other Care Professional Attendances where an appropriate Treatment Function exists may also be submitted. Out-patient records where the activity relates to the Allied Health Professional Referral To Treatment	Due to the high volumes involved, these are often submitted on a weekly basis.

			<p>Measurement standard must be submitted to the Secondary Uses Service (in accordance with ISN ISB0092 Amd 06/2011, and must include the PATIENT PATHWAY data group data items. Note that this is only supported in Commissioning Data Set version 6-2 onwards, with the introduction of data element WAITING TIME MEASUREMENT TYPE.</p>	
CDS 021	Future Out-Patients	As Required for piloting	From 01/01/2008, submissions to support local activities and commissioning will be supported for piloting purposes only.	
CDS 030	Elective Admission List End of Period (Standard)	Monthly if used	<p>All Providers should endeavour to support this data flow.</p> <p>Elective Admission List End of Period Census (Standard) Commissioning Data Set records where the activity relates to a 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.</p>	<p>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.</p>
CDS 040	Elective Admission List End of Period (New)	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
CDS 050	Elective Admission List End of Period (Old)	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
CDS 060	Elective Admission List Event During Period (Add)	Monthly if used	<p>Optional</p> <p>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.</p>	May be submitted where an entry has been added to the ELECTIVE ADMISSION LIST during the time period reported.
CDS 070	Elective Admission List Event During Period (Remove)	Monthly if used	<p>Optional</p> <p>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.</p>	May be submitted where an entry has been removed from the ELECTIVE ADMISSION LIST during the time period reported.
CDS 080	Elective Admission List Event During Period (Offer)	Monthly if used	<p>Optional</p> <p>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.</p>	May be submitted where an offer has been made during the time period reported.
CDS 090	Elective Admission List Event During Period (Available / Unavailable)	Monthly if used	Optional	May be submitted where a patient becomes Available or Unavailable during the time period reported.

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

CDS 200		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 .
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COMMISSIONING DATA SET NOTATION

Change to Supporting Information: Changed Description, Dataset

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

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

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

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

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

Status Column Notation

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

STATUS	MEANING	DESCRIPTION
M	MANDATORY	<p>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.</p> <p>If a data item is shown as MANDATORY, this should also be regarded as REQUIRED by the Department of Health and Social Care.</p> <p>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.</p> <p>For instance, although the Consultant Episode - Clinical Diagnosis Group (ICD) is marked as R=REQUIRED (and therefore need not actually be populated), if it is used then both the DIAGNOSIS SCHEME IN USE and the PRIMARY DIAGNOSIS (ICD) are marked as M=MANDATORY and must both be present.</p>
R	REQUIRED	<p>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.</p> <p>Note that "temporal" conditions may mean that there are instances where this directive cannot be fulfilled.</p> <p>For instance in a CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set, ICD and OPCS data elements are marked as "Required" indicating that this data should be included. However, if at the time of submission to the Secondary Uses Service this data remains incomplete (perhaps awaiting coding in the ORGANISATION), the remaining data in the CDS record should still be submitted. Once</p>

		the ORGANISATION has updated its systems with the data, the CDS Type relating to that ACTIVITY should then be resubmitted to the Secondary Uses Service .
O	OPTIONAL	This signifies that the collection and submission of this Commissioning Data Set data is OPTIONAL . Its inclusion in the Commissioning Data Set is therefore determined by "local agreement" between the ORGANISATIONS exchanging the data. Note that even if marked O=OPTIONAL , any data included in a Commissioning Data Set submission to the Secondary Uses Service must comply with its specification published in the NHS Data Model and Dictionary otherwise the data may be deemed invalid and rejected.
X	X	This is used where the Data Element name has been included in the Commissioning Data Set design, usually for pilot use, but is not yet authorised for transmission by the wider NHS. The Data Element will be in italics and not linked to the Data Element where one exists.

Repeats Column Notation

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

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

Rules Column Notation

An entry in the "[Rules](#)" column shows that a specific Rule applies to submission of an individual Data Element.

The meaning of these Rules can be found in [Commissioning Data Set Business Rules](#).

Notation Examples

The following are examples of some common scenarios.

EXAMPLE 1: A MANDATORY Data Group with differing Sub-Groups and component data status conditions.			
The following example shows a MANDATORY Data Group - therefore the Data Group must be present for the CDS Type to be validated and accepted for processing by the Secondary Uses Service .			
When a Data Group is used:			
<ol style="list-style-type: none"> 1. All MANDATORY Sub Groups and/or Data Elements must be present 2. Any REQUIRED Sub Groups and/or Data Elements must be present if the data is available 3. Any OPTIONAL Sub Groups and/or Data Elements may be omitted 			
The following data structure is one of three options when completing the Patient Identity Data Group:			
1..1	DATA GROUP: VERIFIED IDENTITY STRUCTURE Must be used where the NHS NUMBER STATUS INDICATOR CODE National Code Value = 01 = Verified		Rules
R	0..1	DATA GROUP: LOCAL IDENTIFIER STRUCTURE	
	M	1..1 LOCAL PATIENT IDENTIFIER	F

		M	1..1	ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	F
M	1..1	Data Element Components			Rules
		M	1..1	NHS NUMBER	F
		M	1..1	NHS NUMBER STATUS INDICATOR CODE	V
		M	1..1	POSTCODE OF USUAL ADDRESS	S3
		R	0..1	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	F
		R	0..1	PERSON BIRTH DATE	F S3 S12

EXPLANATION:

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

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

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

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

EXAMPLE 2:

A REQUIRED Data Group with differing component data status conditions.

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

When the Data Group is used:

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

Notation		DATA GROUP: CONSULTANT EPISODE - CLINICAL DIAGNOSIS GROUP (ICD)			
Group	Group	FUNCTION:			
Status	Repeats	To carry the details of the ICD coded Clinical Diagnoses.			
R	0..1				
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
		O	0..1	PRESENT ON ADMISSION INDICATOR	F
O	0..*	DATA GROUP: SECONDARY DIAGNOSIS			Rules
		M	1..1	SECONDARY DIAGNOSIS (ICD)	F H4
		O	0..1	PRESENT ON ADMISSION INDICATOR	F

EXPLANATION:

The Data Group "Status" 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 **O=OPTIONAL**, may be omitted, but if populated it must be in the correct format. The "**Repeats**" notation of 0..* indicates that unlimited occurrences of this Data Element are valid. Each occurrence must contain a valid [SECONDARY DIAGNOSIS \(ICD\)](#).

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

EXPLANATION:

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

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

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

- [CDS Overview](#)
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- [CDS Addressing Grid](#)
- [CDS Business Rules](#)
- [CDS Data Duplication](#)
- [CDS Mandated Data Flows](#)
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- **CDS XML Schema:**
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- [CDS Version 6-2 XML Schema Constraints](#)
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- [CDS Version 6-2-3 XML Schema Constraints](#)

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 [Accident and Emergency Attendance](#) by [Health Care Providers](#), including [PATIENTS](#) receiving private treatment. 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.

[Referral To Treatment Clock Stop Administrative Events](#) may also flow using the [CDS V6-2 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 Accident and Emergency Attendances, Out Patient Attendances, Future Attendances, Admitted Patient Care and Elective Admission List data. 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, Out-Patient Attendances, Future Attendances, Admitted Patient Care and Elective Admission List data.

COMMISSIONING DATA SET SUBMISSION AND ORGANISATION MERGERS

Change to Supporting Information: Changed Description

[ORGANISATIONS](#) can function as independent senders of [Commissioning Data Sets](#) and have service level agreements with Acute, Community or Mental Health [ORGANISATIONS](#) for the submission of this data. ~~These agreements usually relate to clinical services that are subcontracted to that provider or where clinical services are facilitated on that site but owned by the commissioner of the agreement. These agreements usually relate to clinical services that are subcontracted to that Health Care Provider or where clinical services are facilitated on that site but owned by the commissioner of the agreement.~~

[ORGANISATION](#) mergers do not always result in an immediate merger of IT facilities and their often disparate systems to enable a single flow of commissioning data to the [Secondary Uses Service](#). In this case, data flows to the [Secondary Uses Service](#) for multiple sites from multiple senders must be very carefully managed in order to avoid inadvertent deletion or duplication of records in the [Secondary Uses Service](#).

~~In these cases, Senders are strongly advised to only use the Net Change Update Mechanism of the [Commissioning Data Set Submission Protocol](#) as data integrity is more manageable using the Net Change process rather than the Bulk Replacement process. For further guidance, see the NHS Digital website at: [Secondary Uses Service \(SUS\) Guidance](#).~~

CDS Net Change

~~When using the Net Change process, multiple data flows from different sites or systems using the same [CDS INTERCHANGE SENDER IDENTITY](#) must ensure that each Commissioning Data Set record has a properly maintained [CDS UNIQUE IDENTIFIER](#).~~

~~If not, these submissions will most likely conflict and overwrite each other causing substantial data corruption in the [Secondary Uses Service](#) data base. It is recommended that wherever possible, individual sites or systems use a uniquely allocated [CDS INTERCHANGE SENDER IDENTITY](#) for submissions to the [Secondary Uses Service](#).~~

CDS Bulk Replacement

~~When using the Bulk Replacement process, a sender must not make multiple data flows from different [ORGANISATION SITES](#) or systems using the same [CDS SENDER IDENTITY](#) and provider site code or the interchanges will conflict and overwrite each other causing substantial data corruption in the [Secondary Uses Service](#) data base.~~

~~To prevent this happening, individual sites and systems within an [ORGANISATION](#) must use a unique [CDS SENDER IDENTITY](#) and provider site code combination for Commissioning Data Set submissions to the [Secondary Uses Service](#). This can be achieved by utilising Provider and Site Codes already registered with the [Organisation Data Service](#) which will then differentiate multiple Commissioning Data Set flows for the same provider by using the last 2 digits of the [ORGANISATION CODE](#).~~

End Of Year Considerations

~~It may be necessary to avoid changes to systems processes for multiple flows at the end of the financial year, and retain the ability to use the previously used [Commissioning Data Set Submission Protocol](#) for data submitted earlier in the year, until the [ORGANISATION](#) has completed any refresh of data for that year. This would then ensure a complete set of commissioning data for that year for the [National Tariff Payment System](#) and [Hospital Episode Statistics](#) purposes.~~

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](#).

Two Update Mechanisms are available:

- ~~**Net Change** – to support the management of an individual [CDS Type](#) in the [Secondary Uses Service](#) database and enables Commissioning data to be inserted/ updated or deleted.
CDS Senders are expected to use the Net Change Update Mechanism wherever possible.~~
- ~~**Bulk Replacement** – to support the management of bulk commissioning data for an identified [CDS BULK REPLACEMENT GROUP CODE](#) of data for a specified time period and for a specified [CDS PRIME RECIPIENT IDENTITY](#).
CDS Senders should only use the Bulk Replacement Update Mechanism in exceptional circumstances.~~

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](#) option of the CDS Transaction Header Group. The [Secondary Uses Service](#) uses the following data to manage the database:

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

Note that [CDS SENDER IDENTITY](#) is used for [CDS V6-2](#), [CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set](#) 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 all other Commissioning Data Set versions after [CDS V6-2](#).

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

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

Where [CDS UPDATE TYPE](#) 1 is required (delete/cancellation), an empty XML element called 'Delete Transaction' can be used instead of submitting the original [CDS Type](#) record, after the [CDS V6-2 Type 005N - CDS Transaction Header Group - Net Change Protocol](#). See the CDS V6-2- 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](#) must not change during the lifetime of the CDS data.~~ 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](#) option of the CDS Transaction Header Group. The [Secondary Uses Service](#) uses the following data to manage the database:

- [CDS SENDER IDENTITY](#)
- [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](#)
- [CDS PRIME RECIPIENT IDENTITY](#)

Note that [CDS SENDER IDENTITY](#) is used for [CDS V6-2](#), [CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set](#) 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 all other Commissioning Data Set versions after [CDS V6-2](#).

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](#) must not change during the lifetime of the Commissioning Data Set record.~~ 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](#).

~~The [CDS PRIME RECIPIENT IDENTITY](#) must be identified in each Commissioning Data Set and must not be changed during the lifetime of the Commissioning Data Set record otherwise the data stored in the [Secondary Uses Service](#) database may lose its integrity (e.g. duplicate Commissioning data may be stored).~~

For this reason it is advised that the [ORGANISATION CODE \(RESIDENCE RESPONSIBILITY\)](#) should always be used to determine the [CDS PRIME RECIPIENT IDENTITY](#) as detailed in the [Commissioning Data Set Addressing Grid](#). Senders must also be aware that if the [ORGANISATION CODE \(RESIDENCE RESPONSIBILITY\)](#) is itself derived from the [PATIENT's POSTCODE OF USUAL ADDRESS](#) then great care must be taken to manage all elements of this relationship.

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.

For submissions of [CDS V6-2](#), [CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set](#) 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](#).

Versions of the [CDS Type 005B - CDS Transaction Header Group - Bulk Update Protocol](#) and [CDS Type 005N - CDS Transaction Header Group - Net Change Protocol](#) from [CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set](#) onwards use [ORGANISATION IDENTIFIER \(CDS RECIPIENT\)](#) which is no longer Mandatory for submission; however the requirement for this data element to support access to data remains.

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: [SUS Guidance](#).

It is strongly advised that users of the Bulk Replacement Mechanism maintain a correctly generated [CDS UNIQUE IDENTIFIER](#) within the Commissioning data. 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](#) is used. Often this is done by changing the last 2 digits of the 5 digit code (the Site element of the [ORGANISATION CODE](#)). 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 \(CDS RECIPIENT\)](#) is used.

Note: Data sent using the same [CDS SENDER IDENTITY](#) by two different parties will most likely overwrite each other's data in the [Secondary Uses Service](#) database. **Note:** Data sent using the same [CDS SENDER IDENTITY / ORGANISATION IDENTIFIER \(CDS RECIPIENT\)](#) 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 \(CODE OF PROVIDER\)](#) in order to change the [CDS INTERCHANGE SENDER IDENTITY](#) should this become necessary.~~ 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.

COMMISSIONING DATA SET VERSION 6-2 TYPE LIST

Change to Supporting Information: Changed Description

CDS Layout with CDS XML Schema Rules	Overview
Emergency Care:	
CDS V6-2 Type 010 - Accident and Emergency CDS	CDS V6-2 Type 010 - Accident and Emergency CDS Overview
CDS V6-2-1 Type 011 - Emergency Care CDS	CDS V6-2-1 Type 011 - Emergency Care CDS Overview
CDS V6-2-2 Type 011 - Emergency Care CDS	CDS V6-2-2 Type 011 - Emergency Care CDS Overview
CDS V6-2-3 Type 011 - Emergency Care CDS	CDS V6-2-3 Type 011 - Emergency Care CDS Overview
Outpatient Care:	
CDS V6-2 Type 020 - Outpatient CDS	CDS V6-2 Type 020 - Outpatient CDS Overview
CDS V6-2 Type 021 - Future Outpatient CDS	CDS V6-2 Type 021 - Future Outpatient CDS Overview
Admitted Patient Care:	

CDS V6-2 Type 120 - Admitted Patient Care - Finished Birth Episode CDS	CDS V6-2 Type 120 - Admitted Patient Care - Finished Birth Episode CDS Overview
CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode CDS	CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode CDS Overview
CDS V6-2 Type 140 - Admitted Patient Care - Finished Delivery Episode CDS	CDS V6-2 Type 140 - Admitted Patient Care - Finished Delivery Episode CDS Overview
CDS V6-2 Type 150 - Admitted Patient Care - Other Birth Event CDS	CDS V6-2 Type 150 - Admitted Patient Care - Other Birth Event CDS Overview
CDS V6-2 Type 160 - Admitted Patient Care - Other Delivery Event CDS	CDS V6-2 Type 160 - Admitted Patient Care - Other Delivery Event CDS Overview
CDS V6-2 Type 170 - Admitted Patient Care - Detained and/or Long Term Psychiatric Census CDS	CDS V6-2 Type 170 - Admitted Patient Care - Detained and/or Long Term Psychiatric Census CDS Overview
CDS V6-2 Type 180 - Admitted Patient Care - Unfinished Birth Episode CDS	CDS V6-2 Type 180 - Admitted Patient Care - Unfinished Birth Episode CDS Overview
CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode CDS	CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode CDS Overview
CDS V6-2 Type 200 - Admitted Patient Care - Unfinished Delivery Episode CDS	CDS V6-2 Type 200 - Admitted Patient Care - Unfinished Delivery Episode CDS Overview
Elective Admission List - End Of Period Census Types:	
CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) CDS	CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) CDS Overview
CDS V6-2 Type 040 - Elective Admission List - End of Period Census (Old) CDS	CDS V6-2 Type 040 - Elective Admission List - End of Period Census (Old) CDS Overview
CDS V6-2 Type 050 - Elective Admission List - End of Period Census (New) CDS	CDS V6-2 Type 050 - Elective Admission List - End of Period Census (New) CDS Overview
Elective Admission List - Event During Period Types:	
CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) CDS	CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) CDS Overview
CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) CDS	CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) CDS Overview
CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) CDS	CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) CDS Overview
CDS V6-2 Type 090 - Elective Admission List - Event During Period (Available or Unavailable) CDS	CDS V6-2 Type 090 - Elective Admission List - Event During Period (Available or Unavailable) CDS Overview
CDS V6-2 Type 100 - Elective Admission List - Event During Period (Old Service Agreement) CDS	CDS V6-2 Type 100 - Elective Admission List - Event During Period (Old Service Agreement) CDS Overview
CDS V6-2 Type 110 - Elective Admission List - Event During Period (New Service Agreement) CDS	CDS V6-2 Type 110 - Elective Admission List - Event During Period (New Service Agreement) CDS Overview
Commissioning Data Set Interchange and Message Controls - Mandatory for every Interchange:	
CDS V6-2 Type 001 - CDS Interchange Header	CDS V6-2 Type 001 - CDS Interchange Header Overview
CDS V6-2 Type 002 - CDS Interchange Trailer	CDS V6-2 Type 002 - CDS Interchange Trailer Overview
CDS V6-2 Type 003 - CDS Message Header	CDS V6-2 Type 003 - CDS Message Header Overview
CDS V6-2 Type 004 - CDS Message Trailer	CDS V6-2 Type 004 - CDS Message Trailer Overview
CDS V6-2-1 Type 001 - CDS Interchange Header	CDS V6-2-1 Type 001 - CDS Interchange Header Overview
CDS V6-2-1 Type 002 - CDS Interchange Trailer	CDS V6-2-1 Type 002 - CDS Interchange Trailer Overview
CDS V6-2-1 Type 003 - CDS Message Header	CDS V6-2-1 Type 003 - CDS Message Header Overview
CDS V6-2-1 Type 004 - CDS Message Trailer	CDS V6-2-1 Type 004 - CDS Message Trailer Overview
CDS V6-2-2 Type 001 - CDS Interchange Header	CDS V6-2-2 Type 001 - CDS Interchange Header Overview
CDS V6-2-2 Type 002 - CDS Interchange Trailer	CDS V6-2-2 Type 002 - CDS Interchange Trailer Overview
CDS V6-2-2 Type 003 - CDS Message Header	CDS V6-2-2 Type 003 - CDS Message Header Overview
CDS V6-2-2 Type 004 - CDS Message Trailer	CDS V6-2-2 Type 004 - CDS Message Trailer Overview
CDS V6-2-3 Type 001 - CDS Interchange Header	CDS V6-2-3 Type 001 - CDS Interchange Header Overview
CDS V6-2-3 Type 002 - CDS Interchange Trailer	CDS V6-2-3 Type 002 - CDS Interchange Trailer Overview
CDS V6-2-3 Type 003 - CDS Message Header	CDS V6-2-3 Type 003 - CDS Message Header Overview
CDS V6-2-3 Type 004 - CDS Message Trailer	CDS V6-2-3 Type 004 - CDS Message Trailer Overview

Commissioning Data Set Transaction Header Group - Mandatory for every Commissioning Data Set:	
CDS V6-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol	CDS V6-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol Overview
or	
CDS V6-2 Type 005N - CDS Transaction Header Group - Net Change Protocol	CDS V6-2 Type 005N - CDS Transaction Header Group - Net Change Protocol Overview
or	
CDS V6-2-1 Type 005B - CDS Transaction Header Group - Bulk Update Protocol	CDS V6-2-1 Type 005B - CDS Transaction Header Group - Bulk Update Protocol Overview
or	
CDS V6-2-1 Type 005N - CDS Transaction Header Group - Net Change Protocol	CDS V6-2-1 Type 005N - CDS Transaction Header Group - Net Change Protocol Overview
or	
CDS V6-2-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol	CDS V6-2-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol Overview
or	
CDS V6-2-2 Type 005N - CDS Transaction Header Group - Net Change Protocol	CDS V6-2-2 Type 005N - CDS Transaction Header Group - Net Change Protocol Overview
or	
CDS V6-2-3 Type 005B - CDS Transaction Header Group - Bulk Update Protocol	CDS V6-2-3 Type 005B - CDS Transaction Header Group - Bulk Update Protocol Overview
or	
CDS V6-2-3 Type 005N - CDS Transaction Header Group - Net Change Protocol	CDS V6-2-3 Type 005N - CDS Transaction Header Group - Net Change Protocol Overview

COMMISSIONING DATA SET VERSIONS

Change to Supporting Information: Changed Description

Listed below are the Commissioning Data Set versions since 2001.

Current versions:

- November 2012: [CDS Version 6-2 Type List](#) (updated October 2017 to support CDS Version 6-2-1 and April 2019 to support CDS Version 6-2-2)
- November 2012: [CDS Version 6-2 Type List](#) (updated October 2017 to support CDS Version 6-2-1, April 2019 to support CDS Version 6-2-2 and April 2021 to support CDS Version 6-2-3)

Retired versions:

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

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

DIAGNOSTIC IMAGING DATA SET OVERVIEW

Change to Supporting Information: Changed Description

Introduction

The [Diagnostic Imaging Data Set](#) was introduced by [ISB 1577 Diagnostic Imaging Data Set](#), in response to the lack of detailed data on national data on [Diagnostic Imaging](#) tests for NHS [PATIENTS](#). The original requirement came from the cancer strategy to improve [GP](#) direct access to certain [Diagnostic Imaging](#) tests, as a method was required to monitor implementation of this policy.

The [Diagnostic Imaging Data Set](#), however, has many benefits for example, to:

- Provide NHS data on [GPs](#)' direct access to tests, as well as tests requested via other referral sources. Benchmarking data will be fed back to [GPs](#) and, where appropriate, used to encourage increased use of tests, leading to earlier diagnosis and hence improved outcomes
- Provide more detailed NHS data than is currently available on test type (modality), body site of test and [PATIENT](#) demographics

- Enable analysis of turnaround times for tests
- Enable better analysis of cancer pathways by linking the [National Cancer Registration and Analysis Service](#) data to [Diagnostic Imaging](#) test data for cancer [PATIENTS](#)
- Allow [Public Health England \(PHE\)](#) to calculate more accurate estimates of the distribution of individual radiation dose estimates from medical exposures.

From April 2012 it became a mandatory requirement that all providers of NHS-funded [Diagnostic Imaging](#) tests for NHS [PATIENTS](#) in England submit the central [Diagnostic Imaging Data Set](#) on a monthly basis.

The [Diagnostic Imaging Data Set](#) facilitates the collection of clinical data and the sharing of such data to underpin the delivery of effective [Diagnostic Imaging](#). It is structured around the clinical processes of local Radiology Information Systems (RISs) used by [NHS Trusts](#) and [NHS Foundation Trusts](#). It records administrative data relating to [Diagnostic Imaging](#) test [ACTIVITY](#).

Information is collected relating exclusively to [Diagnostic Imaging](#) test [ACTIVITY](#). The [Diagnostic Imaging Data Set](#) describes [Diagnostic Imaging](#) tests that have taken place as part of a broader [PATIENT PATHWAY](#). This includes [PATIENTS](#) referred from within the [ORGANISATION](#), either as an out-patient, in-patient or from [Accident and Emergency Departments](#), or referred directly from their [GP](#) or another [Health Care Provider](#). This includes [PATIENTS](#) referred from within the [ORGANISATION](#), either as an out-patient, in-patient or from [Emergency Care Department](#), or referred directly from their [GP](#) or another [Health Care Provider](#).

The [Diagnostic Imaging Data Set](#) is collected from NHS funded providers of [Diagnostic Imaging](#) test [SERVICES](#) and submitted via a portal on the [NHS Digital](#) website. The submissions are processed and aggregate extracts are produced for provider and commissioner [ORGANISATIONS](#) and national groups such as the [Department of Health and Social Care](#) and [Public Health England](#). This also allows linkage to the [National Cancer Registration and Analysis Service](#).

Please note that the collection of the [Diagnostic Imaging Data Set](#) does not replace any other collection of diagnostic data such as the Diagnostics Waiting Times and Activity Data Set (DM01), which should continue to be collected.

Data Set Order

- The transmission order of the [Diagnostic Imaging Data Set](#) is different to the order of the items in the NHS Data Model and Dictionary and XML Schema.
- Please see the "Guidance Notes" at: [Diagnostic Imaging Dataset: Guidance for Data Submitters](#), which contains a full list of [Diagnostic Imaging Data Set](#) fields in the order they are submitted.
- Work is planned to amend some of the [Diagnostic Imaging Data Set](#) items and when this is approved by the [Data Coordination Board \(DCB\)](#), the NHS Data Model and Dictionary will be updated to match.

Mandation

The Mandation column indicates the recommendation for the inclusion of data.

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

XML Schema

For guidance on the XML Schema constraints, see the [Diagnostic Imaging Data Set 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](#) may be either: An [Emergency Care Arrival Date](#) is the date the [PATIENT](#):

- the [Arrival Date At Accident and Emergency Department](#) or
- the ~~the Ambulatory Emergency Care Arrival Date.~~
- 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 [Arrival Time At Accident and Emergency Department](#) is an [ACTIVITY DATE TIME](#). An [Emergency Care Arrival Time](#) is an [ACTIVITY DATE TIME](#).

The [Emergency Care Arrival Time](#) may be either: An [Emergency Care Arrival Time](#) is the time the [PATIENT](#):

- the [Arrival Time At Accident and Emergency Department](#) or
- the ~~Ambulatory Emergency Care Arrival Time~~.
- 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](#) may be either: An [Emergency Care Attendance](#) is an individual visit by one [PATIENT](#) to an [Emergency Care Department](#) to receive treatment.

- an [Accident and Emergency Attendance](#) or
- an ~~Ambulatory Emergency Care Attendance~~.

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 be as a result of a request from a [GENERAL PRACTITIONER](#) for help with a diagnosis or treatment.

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.

Any facility set up to receive and treat emergency cases is regarded as an [Emergency Care Department](#) for this purpose.

[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](#).

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

EMERGENCY CARE ATTENDANCE CONCLUSION DATE

Change to Supporting Information: Changed Description

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

The [Emergency Care Attendance Conclusion Date](#) may be either: An [Emergency Care Attendance Conclusion Date](#) is the date:

- the [Accident and Emergency Attendance Conclusion Date](#) or
- the ~~Ambulatory Emergency Care Attendance Conclusion 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.

The Emergency Care Attendance Conclusion Time may be either: An Emergency Care Attendance Conclusion Time is the time, recorded using a 24 hour clock:

- the Accident and Emergency Attendance Conclusion Time or
- the Ambulatory Emergency Care Attendance Conclusion Time.
- 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 CLINICALLY READY TO PROCEED TIMESTAMP

Change to Supporting Information: New Supporting Information

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

An 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 Department, makes a clinical decision that the PATIENT no longer requires ongoing care in the Emergency Care Department.

The PATIENT will have one of the following outcomes:

- admitted to a WARD
- transferred to a designated Department / clinical service area outside the Emergency Care Department but within the same Health Care Provider
- transferred to another Health Care Provider for continuation of care
- discharged from the Emergency Care Department.

This supporting information is also known by these names:

Context	Alias
alsoknownas	Clinically Ready to Proceed
plural	Emergency Care Clinically Ready to Proceed Timestamps

EMERGENCY CARE DATE SEEN FOR TREATMENT

Change to Supporting Information: Changed Description

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

The [Emergency Care Date Seen For Treatment](#) may be: [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.

- the [Accident and Emergency Date Seen For Treatment](#) or
- the ~~Ambulatory Emergency Care Date Seen For Treatment~~.

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](#).

An ~~[Emergency Care Department](#)~~ may be either: [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.

- an ~~[Accident and Emergency Department](#)~~ or
- an ~~[Ambulatory Emergency Care Service](#)~~.

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](#).

[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.

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](#).

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

EMERGENCY CARE DEPARTURE DATE

Change to Supporting Information: Changed Description

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

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

Notes:

- the ~~[Accident and Emergency Departure Date](#)~~ or
- the ~~[Ambulatory Emergency Care Departure Date](#)~~.
- 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](#).

The [Emergency Care Departure Time](#) may be either: 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:

- the [Accident and Emergency Departure Time](#) or
- the [Ambulatory Emergency Care Departure Time](#).
- 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

Change to Supporting Information: New Supporting Information

An [Emergency Care Episode](#) is an [ACTIVITY GROUP](#).

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](#).

Each [Emergency Care Episode](#) takes place at a single [Emergency Care Department](#) and consists of one or more [Emergency Care Attendances](#).

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

This supporting information is also known by these names:

Context	Alias
plural	Emergency Care Episodes

EMERGENCY CARE EXPECTED DATE AND TIMESTAMP OF TREATMENT

Change to Supporting Information: New Supporting Information

An [Emergency Care Expected Date and Timestamp of Treatment](#) is a [PLANNED ACTIVITY DATE TIME](#) and time zone.

An [Emergency Care Expected Date and Timestamp of Treatment](#) is the date, time and time zone a [PATIENT](#) should expect to receive treatment at the [Emergency Care Department](#).

An [Emergency Care Expected Date and Timestamp of Treatment](#) is given to the [PATIENT](#) in advance of arrival at an [Emergency Care Department](#) or on arrival at an [Emergency Care Department](#).

This supporting information is also known by these names:

Context	Alias
plural	Emergency Care Expected Dates and Timestamps of Treatments

EMERGENCY CARE INITIAL ASSESSMENT DATE

Change to Supporting Information: Changed Description

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

The [Emergency Care Initial Assessment Date](#) may be either: 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 [Accident and Emergency Initial Assessment Date](#) or
- the [Ambulatory Emergency Care Initial Assessment Date](#).
- 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](#).

The [Emergency Care Initial Assessment Time](#) may be either: 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 [Accident and Emergency Initial Assessment Time](#) or
- the [Ambulatory Emergency Care Initial Assessment Time](#).
- 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](#).

The [Emergency Care Time Seen For Treatment](#) may be either: 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.

- the [Accident and Emergency Time Seen For Treatment](#) or
- the [Ambulatory Emergency Care Time Seen For Treatment](#).

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

FEMALE GENITAL MUTILATION DATA SET OVERVIEW

Change to Supporting Information: Changed Description

Introduction

The [Female Genital Mutilation Data Set](#) provides essential information in relation to the female genital mutilation population across England.

The [Female Genital Mutilation Data Set](#) is used:

- To publish Official Statistics which will inform the [Department of Health and Social Care, NHS England](#), other Government Agencies and the public, about female genital mutilation when it has been identified
- To identify the potential risk of female genital mutilation to young girls and vulnerable women
- For better planning and management of female genital mutilation [SERVICES](#) at a local level and across England

Data may be input immediately using an input screen via the [NHS Digital](#) Clinical Audit Platform when female genital mutilation is identified, or data extracts for Patients, can be submitted as a bulk upload on a monthly basis for each [ORGANISATION](#).

[CARE CONTACT](#) activities undertaken for female genital mutilation [PATIENTS](#) during the [REPORTING PERIOD](#) are reported in the data upload. This includes any attendances at an [Out-Patient Clinic](#) led by any type of [CARE PROFESSIONAL](#), [Hospital Provider Spells](#), [Accident and Emergency Attendances](#), [Group Therapy](#), [Ward Attendances](#); or any other type of direct [PATIENT](#) facing [CARE CONTACT](#), with an exception to [Sexual and Reproductive Health Clinics](#) and Genitourinary Medicine (GUM) clinics, who are not required to submit the [Female Genital Mutilation Data Set](#) to the [NHS Digital](#). This includes any attendances at an [Out-Patient Clinic](#) led by any type of [CARE PROFESSIONAL](#), [Hospital Provider Spells](#), [Emergency Care Attendances](#), [Group Therapy](#), [Ward Attendances](#); or any other type of direct [PATIENT](#)-facing [CARE CONTACT](#), with an exception to [Sexual and Reproductive Health Clinics](#) and Genitourinary Medicine (GUM) clinics, who are not required to submit the [Female Genital Mutilation Data Set](#) to the [NHS Digital](#).

[SNOMED CT Refset](#) Metadata:

- Female genital mutilation related findings:
 - [Refset](#) FSN: Female genital mutilation related findings simple reference set (foundation metadata concept)
 - [Refset](#) Id: 999002041000000103

For further details relating to the [SNOMED CT Refset](#) Metadata, see the [Data Dictionary for Care \(DD4C\)](#) website at: [Female genital mutilation related findings](#).

- Female genital mutilation related procedures:
 - [Refset](#) FSN: Female genital mutilation related procedures simple reference set (foundation metadata concept)
 - [Refset](#) Id: 999002031000000107

For further details relating to the [SNOMED CT Refset](#) Metadata, see the [Data Dictionary for Care \(DD4C\)](#) website at: [Female genital mutilation related procedures](#).

Data Extract Specification

Description

The [Department of Health and Social Care](#) requires all [NHS Trusts](#), [NHS Foundation Trusts](#) and [GENERAL MEDICAL PRACTITIONERS](#) to generate and provide a data extract in accordance with the [Female Genital Mutilation Data Set](#). This requirement is applicable to all [CARE PROFESSIONALS](#) in these [ORGANISATIONS](#) whenever it has been identified that a woman or young girl has undergone female genital mutilation.

Further information is available on the [NHS Digital](#) website at: [Female Genital Mutilation Datasets](#).

Time period

Data extracted from systems can be submitted as a bulk upload on a quarterly basis for each [ORGANISATION](#).

Format

Data submitted by the bulk upload facility must be formatted in 3 separate comma separated variable (csv) files (i.e. Patient, Attendance or Female Genital Mutilation), which are used to populate the [NHS Digital](#) Clinical Audit Platform. The data elements should be transmitted in the order specified in the [Female Genital Mutilation Data Set](#).

Transmission

Electronic files must be transmitted to [NHS Digital](#) via the Clinical Audit Platform which is a secure web portal.

Connection to the web portal requires registration to the Clinical Audit Platform, which will include the provision of a login account name and password.

Further information about the Clinical Audit Platform and the data upload facility can be found on the [NHS Digital](#) website: at [Clinical Audit Platform](#).

Further guidance on the [Female Genital Mutilation Data Set](#) can be found on the on the [NHS Digital](#) website at: [SCCI2026: Female Genital Mutilation Enhanced Dataset](#).

Mandation

The Mandation column indicates the recommendation for the inclusion of data.

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

ORGANISATION MERGERS

Change to Supporting Information: Changed Description

Introduction

- This guidance explains the circumstances under which [Hospital Provider Spells](#) should close and reopen as a result of a merger or demerger, in terms of NHS Information Standards.
- It specifies which [ORGANISATION CODES](#) / [ORGANISATION IDENTIFIERS](#) should be used for [Hospital Provider Spells](#) which must be closed and reopened for:
 - [DISCHARGE DESTINATION](#) etc, for the closing [Hospital Provider Spell](#) and
 - [SOURCE OF ADMISSION](#) etc, for the new [Hospital Provider Spell](#).

When [Hospital Provider Spells](#) Should be Closed and Reopened

- A [Hospital Provider Spell](#) is provided by one [ORGANISATION](#) acting as a [Health Care Provider](#). This means that the [Hospital Provider Spell](#) is linked to the [ORGANISATION CODE](#) / [ORGANISATION IDENTIFIER](#) of the [Health Care Provider](#).
- If the [ORGANISATION CODE](#) / [ORGANISATION IDENTIFIER](#) changes, the spell must end and another begin with the new [ORGANISATION CODE](#) / [ORGANISATION IDENTIFIER](#).
- If the [Hospital Provider Spell](#) does end, the [Consultant Episode \(Hospital Provider\)](#) within the [Hospital Provider Spell](#) must also end.

The following scenarios explain what this means in terms of [ORGANISATION](#) mergers or demergers. Note that these assume that nothing changes other than the fact that the [ORGANISATIONS](#) merge or demerge, e.g. the [CONSULTANT](#) stays the same, etc.

Mergers

- *Trust A merges with Trust B to produce Trust C, which has a new [ORGANISATION CODE](#) / [ORGANISATION IDENTIFIER](#).*
 - The [ORGANISATION CODE](#) / [ORGANISATION IDENTIFIER](#) will change for both Trust A and B.
 - Therefore [Hospital Provider Spells](#) in both Trust A and B should close, and new [Hospital Provider Spells](#) should be opened using the new [ORGANISATION CODE](#) / [ORGANISATION IDENTIFIER](#) for Trust C.
- *Trust A merges with Trust B to produce an [ORGANISATION](#) which uses Trust A's [ORGANISATION CODE](#) / [ORGANISATION IDENTIFIER](#).*
 - For those [Hospital Provider Spells](#) in Trust A, the [ORGANISATION CODE](#) will not change. Therefore Trust A's [Hospital Provider Spells](#) should not be closed just as a result of the merger. However, for Trust B the [ORGANISATION CODE](#) / [ORGANISATION IDENTIFIER](#) will change.
 - Therefore [Hospital Provider Spells](#) in Trust B should close, and new [Hospital Provider Spells](#) should be opened using the new [ORGANISATION CODE](#) / [ORGANISATION IDENTIFIER](#) for Trust A.

Demergers

- *Trust A splits into Trust B and Trust C, both of which have a new [ORGANISATION CODE](#) / [ORGANISATION IDENTIFIER](#).*
 - The [ORGANISATION CODE](#) / [ORGANISATION IDENTIFIER](#) will change for both Trust B and C.
 - Therefore all [Hospital Provider Spells](#) in Trust A should close, and new [Hospital Provider Spells](#) should be opened in Trust B and C using the new [ORGANISATION CODES](#) / [ORGANISATION IDENTIFIERS](#) for each.
- *Trust A splits into Trust B and C. Trust B retains Trust A's [ORGANISATION CODE](#) / [ORGANISATION IDENTIFIER](#) and Trust C is issued with a new one.*
 - The [ORGANISATION CODE](#) / [ORGANISATION IDENTIFIER](#) for [Hospital Provider Spells](#) in Trust A which are taken over by Trust B will not change.
 - Therefore they should not be closed just as a result of the merger.
 - However, Trust A's [Hospital Provider Spells](#) which are taken over by Trust C should close, and new [Hospital Provider Spells](#) should be opened using the new [ORGANISATION CODE](#) / [ORGANISATION IDENTIFIER](#) for Trust C.

The National Codes Used when [Hospital Provider Spells](#) are Closed and Reopened

If [Hospital Provider Spells](#) are to be closed and reopened only as a result of [Organisation Mergers](#) or demergers, for most cases the codes below should be used.

• The CLOSED [Hospital Provider Spell](#)

[DISCHARGE DESTINATION](#)

This depends on the type of [WARD](#) the [PATIENT](#) is in, but will be either:

- 51 NHS other [Hospital Provider](#) - [WARD](#) for general [PATIENTS](#) or the younger physically disabled
- 52 NHS other [Hospital Provider](#) - [WARD](#) for maternity [PATIENTS](#) or [Neonates](#)
- 53 NHS other [Hospital Provider](#) - [WARD](#) for [PATIENTS](#) who are mentally ill or have [Learning Disabilities](#)

[DISCHARGE METHOD](#)

- 1 [PATIENT](#) discharged on clinical advice or with clinical consent

• The REOPENED [Hospital Provider Spell](#)

[ADMISSION METHOD](#)

- 81 Transfer of any admitted [PATIENT](#) from other [Hospital Provider](#) other than in an emergency

Note that this [ADMISSION METHOD](#) is classed under "Other Admission". It is not elective and the [PATIENT](#) does therefore not have an entry on an [Elective Admission List](#).

[SOURCE OF ADMISSION](#)

Again, this depends on the type of [WARD](#) the [PATIENT](#) is in, but will be either:

- ~~51 NHS other [Hospital Provider](#) - [WARD](#) for general [PATIENTS](#) or the younger physically disabled or [Accident and Emergency Department](#)~~
- 51 NHS other [Hospital Provider](#) - [WARD](#) for general [PATIENTS](#) or the younger physically disabled or [Emergency Care Department](#)
- 52 NHS other [Hospital Provider](#) - [WARD](#) for maternity [PATIENTS](#) or [Neonates](#)
- 53 NHS other [Hospital Provider](#) - [WARD](#) for [PATIENTS](#) who are mentally ill or have [Learning Disabilities](#)

[REFERRER CODE](#)

This will be the referrer to the [Hospital Provider Spell](#) within which the [PATIENT](#) was receiving care before the merger, i.e. the "original" [Hospital Provider Spell](#).

Guidance for Merging Organisations to support Sending of Commissioning Data Sets to the [Secondary Uses Service](#)

- The [Secondary Uses Service](#) have published information regarding issues that may affect the approach to submitting data to the [Secondary Uses Service](#).
- The guidance is available on the [NHS Digital](#) website at: [SUS Guidance: "How do I send data to SUS?"](#).

REFERRAL TO TREATMENT CLOCK STOP ADMINISTRATIVE EVENT

Change to Supporting Information: Changed Description

[DSCN 18/2006](#) published in December 2006, defined essential new data items required to support the measurement of 18 week [REFERRAL TO TREATMENT PERIODS](#) (monitoring of DH PSA target 13 - "By 2008, no one will have to wait longer than 18 weeks from GP referral to hospital treatment").

In particular, [DSCN 18/2006](#) introduced the following new data items.

- [PATIENT PATHWAY IDENTIFIER](#)
- [REFERRAL TO TREATMENT PERIOD START DATE](#)
- [REFERRAL TO TREATMENT PERIOD END DATE](#)

Strategic reporting of 18 weeks will be undertaken by the [Secondary Uses Service](#) using data obtained via the [Commissioning Data Sets](#). The data items defined in [DSCN 18/2006](#) are enabled to flow in Commissioning Data Set.

However, an event which results in an update to the [REFERRAL TO TREATMENT PERIOD STATUS](#) may occur outside the events that are defined in the [Commissioning Data Sets](#) (typically Outpatient or Inpatient encounters) and will therefore not flow to the [Secondary Uses Service](#). These types of events have been termed as "administrative events". They can be defined as any communication event between the [Health Care Provider](#) and the [PATIENT](#) that occurs outside of an outpatient attendance or inpatient admission and that results in the [PATIENT's REFERRAL TO TREATMENT PERIOD STATUS](#) being changed to stop the 18 week clock. These events are not face to face consultations and do not necessarily involve clinical staff.

These [Referral To Treatment Clock Stop Administrative Events](#) may be carried using the Commissioning Data Set Type 020 Outpatient record type. They are differentiated from [PATIENT](#) contact [ACTIVITY](#) by the [FIRST ATTENDANCE](#) value carried within them. [FIRST ATTENDANCE](#) national code 5 "Referral to treatment clock stop administrative event" signifies that an [ACTIVITY](#) has taken place which has ended the [REFERRAL TO TREATMENT PERIOD](#) and changed the [REFERRAL TO TREATMENT PERIOD STATUS](#) to one of the following:

- 30 Start of [First Definitive Treatment](#)
- 31 Start of [Active Monitoring](#) initiated by the [PATIENT](#)
- 32 Start of [Active Monitoring](#) initiated by the [CARE PROFESSIONAL](#)
- 34 Decision not to treat - decision not to treat made or no further contact required
- 35 [PATIENT](#) declined offered treatment
- 36 [PATIENT](#) died before treatment

When to Use Referral To Treatment Clock Stop Administrative Events

These events may happen because:

- The [ACTIVITY](#) ending the event does not qualify as a "patient contact" between a clinician and [PATIENT](#), or
- The [ACTIVITY](#) occurred in a setting where IT systems cannot produce [REFERRAL TO TREATMENT PERIOD](#) data items, or
- The [ACTIVITY](#) would be carried in a Commissioning Data Set record type not currently processed by the [Secondary Uses Service](#)

Secondary Uses Service Processing

The [Secondary Uses Service](#) currently processes the following Commissioning Data Set record types in order to build Referral To Treatment pathways.

- [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#)
- [CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set](#)

All other types are not currently processed and so if they carry the [REFERRAL TO TREATMENT PERIOD END DATE](#) for a [REFERRAL TO TREATMENT PERIOD](#), a [Referral To Treatment Clock Stop Administrative Event](#) must also be sent in order to inform the [Secondary Uses Service](#) of the clock stop.

Note that future versions of the [Secondary Uses Service](#) will also process:

- [CDS V6-2 Type 030 - Elective Admission List - End of Period Census \(Standard\) Commissioning Data Set](#)
- [CDS V6-2 Type 060 - Elective Admission List - Event During Period \(Add\) Commissioning Data Set](#)
- [CDS V6-2 Type 070 - Elective Admission List - Event During Period \(Remove\) Commissioning Data Set](#)
- [CDS V6-2 Type 080 - Elective Admission List - Event During Period \(Offer\) Commissioning Data Set](#)

The dates when [ORGANISATIONS](#) submitting [REFERRAL TO TREATMENT PERIOD](#) data to the [Secondary Uses Service](#) can cease having to also send a [Referral To Treatment Clock Stop Administrative Event](#) when a clock stop is carried in one of the Elective Admission List Commissioning Data Set Types, will be notified as part of the [Secondary Uses Service](#) release documentation. It is also anticipated that [CDS V6-2 Type 021 - Future Outpatient CDS](#) will be accepted as a standard by the [Data Coordination Board](#). A cancelled future [APPOINTMENT](#) record could carry a [REFERRAL TO TREATMENT PERIOD](#) Clock Stop. Again the timescales will be notified as part of the [Secondary Uses Service](#) release documentation.

There are no current plans for the [Secondary Uses Service](#) to process the remaining Commissioning Data Set Types:

- [CDS V6-2 Type 010 - Accident and Emergency 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](#)
- [CDS V6-2 Type 090 - Elective Admission List - Event During Period \(Available or Unavailable\) Commissioning Data Set](#)
- [CDS V6-2 Type 100 - Elective Admission List - Event During Period \(Old Service Agreement\) Commissioning Data Set](#)
- [CDS V6-2 Type 110 - Elective Admission List - Event During Period \(New Service Agreement\) Commissioning Data Set](#)
- [CDS V6-2 Type 120 - Admitted Patient Care - Finished Birth Episode Commissioning Data Set](#)
- [CDS V6-2 Type 140 - Admitted Patient Care - Finished Delivery Episode Commissioning Data Set](#)
- [CDS V6-2 Type 150 - Admitted Patient Care - Other Birth Event Commissioning Data Set](#)
- [CDS V6-2 Type 160 - Admitted Patient Care - Other Delivery Event Commissioning Data Set](#)
- [CDS V6-2 Type 170 - Admitted Patient Care - Detained and or Long Term Psychiatric Census Commissioning Data Set](#)
- [CDS V6-2 Type 180 - Admitted Patient Care - Unfinished Birth Episode Commissioning Data Set](#)

- [CDS V6-2 Type 200 - Admitted Patient Care - Unfinished Delivery Episode Commissioning Data Set](#)

This is because a [Referral To Treatment Clock Stop Administrative Event](#) occurring in the scenarios where these record types are generated, would be rare. However this will be reviewed as part of the ongoing maintenance of the [Referral To Treatment Clock Stop Administrative Event](#), and the requirements for the [Secondary Uses Service](#).

When NOT to Use a [Referral To Treatment Clock Stop Administrative Event](#)

The [Referral To Treatment Clock Stop Administrative Event](#) should NOT be used to correct previously submitted records where a [REFERRAL TO TREATMENT PERIOD END DATE](#) was submitted incorrectly to the [Secondary Uses Service](#).

For example, if an [Out-Patient Appointment](#) took place where [First Definitive Treatment](#) was started, but the [REFERRAL TO TREATMENT PERIOD END DATE](#) was not sent in the corresponding [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#) record as it was not entered on the Patient Administration System until later; then the [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#) record should be resubmitted with the correct data. A [Referral To Treatment Clock Stop Administrative Event](#) should NOT be used.

Where an [ORGANISATION](#)'s Patient Administration System supports the submission of cancelled and Did Not Attend appointments in the [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#), the [Referral To Treatment Clock Stop Administrative Event](#) should NOT be used when a [PATIENT](#) has a booked [Out-Patient Appointment](#), which is then cancelled because, for example, the [PATIENT](#) dies. In these cases the [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#) can carry the details of a cancelled [CARE ACTIVITY](#), including the [REFERRAL TO TREATMENT PERIOD END DATE](#) and update to the [REFERRAL TO TREATMENT PERIOD STATUS](#). (Note - not all Patient Administration Systems provide functionality to create and submit Commissioning Data Set records for cancellations/Did Not Attend's as this is not yet mandated - you should contact your Patient Administration System support team to ascertain whether your Patient Administration System supports this. If not, then it is permissible to send a [Referral To Treatment Clock Stop Administrative Event](#) in order to stop the clock in the [Secondary Uses Service](#) instead).

[Referral To Treatment Clock Stop Administrative Events](#) only require a sub-set of the data elements contained in the [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#) record, to be submitted to the [Secondary Uses Service](#). All other data elements not listed should be omitted from the XML submission of the [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#) record to the [Secondary Uses Service](#). The submission of a [Referral To Treatment Clock Stop Administrative Event](#) is not reliant on the use of the Net Change [Commissioning Data Set Submission Protocol](#) to the [Secondary Uses Service](#)

The required data elements making up a [Referral To Treatment Clock Stop Administrative Event](#) are:

Data Element Required	Notes
UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) or PATIENT PATHWAY IDENTIFIER	The Commissioning Data Set Schema version 6-2 requires EITHER the PATIENT PATHWAY IDENTIFIER , or the UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) , to be populated.
ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	If the UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) is used, the ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) should contain X09 (which relates to the Choose and Book system)
REFERRAL TO TREATMENT PERIOD STATUS	This should contain only one of the following codes to signify that the REFERRAL TO TREATMENT PERIOD has ended: <ul style="list-style-type: none"> • 30 Start of First Definitive Treatment • 31 Start of Active Monitoring initiated by the PATIENT • 32 Start of Active Monitoring initiated CARE PROFESSIONAL • 34 Decision not to treat - decision not to treat made or no further contact required • 35 PATIENT declined offered treatment • 36 PATIENT died before treatment
WAITING TIME MEASUREMENT TYPE	This item is XML mandatory in the CDS V6-2 schema.
REFERRAL TO TREATMENT PERIOD START DATE	
REFERRAL TO TREATMENT PERIOD END DATE	
NHS NUMBER	
NHS NUMBER STATUS INDICATOR CODE	
POSTCODE OF USUAL ADDRESS	
ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	
FIRST ATTENDANCE CODE	This should always hold the National code 5 - "Referral to Treatment Period Clock Stop Administrative Event"
APPOINTMENT DATE	

	This field is XML mandatory in Commissioning Data Set Schema version 6-2 for Type 020 Outpatients, and for the purposes of the Referral To Treatment Clock Stop Administrative Event , should hold the same date as the REFERRAL TO TREATMENT PERIOD END DATE
AGE AT CDS ACTIVITY DATE	This field is XML mandatory in the Commissioning Data Set Schema version 6-2 for Type 020 Outpatients, and should hold the PATIENTS age at REFERRAL TO TREATMENT PERIOD END DATE
ORGANISATION CODE (CODE OF PROVIDER)	This field is mandatory in the CDS V6-2 schema
ORGANISATION CODE (CODE OF COMMISSIONER)	This field is mandatory in the CDS V6-2 schema

SECONDARY USES SERVICE

Change to Supporting Information: Changed Dataset

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

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

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

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

URGENT TREATMENT CENTRE

Change to Supporting Information: Changed Description

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

~~[Urgent Treatment Centres \(UTC\)](#) are [Community and Primary Care facilities providing access to urgent care for a local population](#). [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.~~

~~All [Urgent Treatment Centres](#) are classed as [EMERGENCY CARE DEPARTMENT TYPE](#) National Code 'Other type of A&E/minor injury [ACTIVITY](#) with designated accommodation for the reception of accident and emergency [PATIENTS](#). The department may be doctor led or [NURSE](#) led and treats at least minor injuries and illnesses and can be routinely accessed without [APPOINTMENT](#). A [SERVICE](#) mainly or entirely [APPOINTMENT](#) based (for example a [GP Practice](#) or [Out-Patient Clinic](#)) is excluded even though it may treat a number of [PATIENTS](#) with minor illness or injury. Excludes NHS walk-in centres'.~~

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

XML SCHEMA TRUD DOWNLOAD

Change to Supporting Information: Changed Description

Background:

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

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

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

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

XML Schema Download:

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

- [Cancer Outcomes and Services Data Set \(COSDS\)](#)
- [Community Services Data Set \(CSDS\)](#)
- [Commissioning Data Set \(CDS\) V6-2](#)
- [Commissioning Data Set \(CDS\) V6-2-1](#)
- [Commissioning Data Set \(CDS\) V6-2-2](#)
- [CDS V6-2-2 Type 011 – Emergency Care Commissioning Data Set](#)
- [Commissioning Data Set \(CDS\) V6-2-3](#)
- [Diagnostic Imaging Data Set \(DIDS\)](#)
- [HIV and AIDS Reporting Data Set \(HARS\)](#)
- [Maternity Services Data Set \(MSDS\)](#)
- [National Cancer Waiting Times Monitoring Data Set \(NCWTMDS\)](#)

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

ACTIVITY GROUP

Change to Class: Changed Attributes

Attributes of this Class are:

~~A and E PATIENT GROUP~~
ACTIVITY GROUP TYPE
ADJUSTED LENGTH OF STAY FOR PATIENT LEVEL INFORMATION COSTING
ADMISSION METHOD
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
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
DISCHARGE DESTINATION
DISCHARGED TO HOSPITAL 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
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
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
PALLIATIVE CARE SPECIALIST SEEN INDICATOR
PALLIATIVE TREATMENT REASON FOR UPPER GASTROINTESTINAL
PATIENT ATTENDANCE SYMPTOMATIC INDICATOR FOR SEXUAL HEALTH SERVICE
PATIENT CLASSIFICATION
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
PREGNANCY OUTCOME
PSYCHIATRIC PATIENT STATUS
SOURCE OF ADMISSION

ADDRESS STRUCTURED

Change to Class: Changed Dataset

A subtype of [ADDRESS](#).

An [ADDRESS](#) comprised of address elements.

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

ADDRESS UNSTRUCTURED

Change to Class: Changed Dataset

A subtype of [ADDRESS](#).

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

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

CARE CONTACT

Change to Class: Changed Attributes

Attributes of this Class are:

~~A and E ATTENDANCE CATEGORY~~
~~A and E INITIAL ASSESSMENT TRIAGE CATEGORY~~
~~A and E STREAM~~
~~ACCIDENT AND EMERGENCY ARRIVAL MODE~~
~~ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL~~

ACUTE ONCOLOGY ASSESSMENT PATIENT PRESENTATION TYPE
ACUTE ONCOLOGY EPISODE OUTCOME
AMBULANCE CALL IDENTIFIER
AMBULANCE CALL RESPONSE CATEGORY
AMBULANCE CALL RESPONSE TYPE
AMBULANCE CALL SOURCE
CARE CONTACT CANCELLATION REASON
CARE CONTACT PATIENT THERAPY MODE
CARE CONTACT SUBJECT
CARE CONTACT TYPE
CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR
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 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
OUT PATIENT ATTENDANCE INDICATOR FOR RADIOTHERAPY DATA SET
PATIENT HIV CARE STATUS
POST EXPOSURE PROPHYLAXIS INDICATOR
PRE EXPOSURE PROPHYLAXIS INDICATOR
PSYCHIATRIC CARE INDICATOR FOR HIV
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

CARE PROFESSIONAL ORGANISATION

Change to Class: Changed Attributes

Attributes of this Class are:

~~LOCAL CARE PROFESSIONAL IDENTIFIER~~

This class has no attributes.

CLINICAL INTERVENTION

Change to Class: Changed Attributes

Attributes of this Class are:

ABDOMINAL XRAY PERFORMED REASON
ABDOMINAL XRAY PERFORMED TO INVESTIGATE ABDOMINAL SIGNS INDICATOR
ABLATIVE THERAPY TYPE
~~ACCIDENT AND EMERGENCY INVESTIGATION~~
~~ACCIDENT AND EMERGENCY TREATMENT~~
ACUTE ONCOLOGY ASSESSMENT PATIENT PRESENTATION TYPE

ACUTE ONCOLOGY EPISODE OUTCOME
ADDITIONAL UNPLANNED PROCEDURE REQUIRED INDICATOR
ADJUNCTIVE THERAPY TYPE
ANAESTHETIC TYPE FOR JOINT REPLACEMENT
ANTIRETROVIRAL THERAPY DRUG REGIMEN GROUP CODE
ANTIRETROVIRAL THERAPY HOME DELIVERY INDICATOR
ARTHROPLASTY REVISION TYPE FOR HIP KNEE AND ANKLE REPLACEMENT
ARTHROPLASTY REVISION TYPE FOR SHOULDER AND ELBOW REPLACEMENT
ASA PHYSICAL STATUS CLASSIFICATION SYSTEM CODE
ASA PHYSICAL STATUS CLASSIFICATION SYSTEM CODE FOR NATIONAL JOINT REGISTRY
ASSOCIATED PROCEDURE TYPE FOR ANKLE REPLACEMENT
BIOLOGICAL GLENOID RESURFACING TYPE FOR SHOULDER REPLACEMENT
BIOPSY ANAESTHETIC TYPE
BIOPSY TYPE FOR CENTRAL NERVOUS SYSTEM TUMOURS
BLOOD PRODUCTS REQUIRED FOLLOWING OESOPHAGECTOMY INDICATION CODE
BLOOD TRANSFUSION PRODUCT TYPE
BLOOD TRANSFUSION TYPE
BONE GRAFT INDICATOR FOR JOINT REPLACEMENT
BONE GRAFT SOURCE FOR JOINT REPLACEMENT
BONE GRAFT STRUCTURE FOR JOINT REPLACEMENT
BREAST ASSESSMENT OUTCOME
BREAST TRIPLE DIAGNOSTIC ASSESSMENT INDICATOR
BRONCHOSCOPY PERFORMED TYPE
CANCER CARE SETTING FOR TREATMENT
CANCER IMAGING MODALITY
CANCER IMAGING OUTCOME
CANCER SURGICAL ADMISSION TYPE
CANCER TREATMENT MODALITY
CARDIOPULMONARY EXERCISE TEST TYPE
CEMENT REMOVAL INDICATOR FOR JOINT REPLACEMENT
CHEMICAL THROMBOPROPHYLAXIS REGIME TYPE FOR JOINT REPLACEMENT
CHEST DRAIN IN SITU INDICATOR
CLINICAL INTERVENTION TEXT STRING
CLINICAL INTERVENTION TYPE
CO MORBIDITY ADJUSTMENT INDICATOR
COMPONENT REMOVAL INDICATOR FOR JOINT REPLACEMENT
COMPUTER GUIDED SURGERY INDICATOR FOR JOINT REPLACEMENT
CONTINUOUS INFUSION OF PULMONARY VASODILATOR RECEIVED INDICATOR
CONTRACEPTION METHOD STATUS
DEINFIBULATION UNDERTAKEN REASON
DELIVERED IN WATER INDICATOR
DELIVERY INSTRUMENT TYPE
DIEPOXYBUTANE TEST RESULT
DRUG REGIMEN ACRONYM
ENDOSCOPIC OR RADIOLOGICAL COMPLICATION TYPE
ENDOSCOPIC PROCEDURE TYPE
ENTERAL FEEDING METHOD
ENTERAL FEED TYPE GIVEN
ESCALATION IN LEVEL OF PATIENT CARE FOLLOWING OESOPHAGECTOMY INDICATOR
EXCISION TYPE FOR CENTRAL NERVOUS SYSTEM TUMOURS
FETAL ORDER
FIRST ANTIRETROVIRAL THERAPY IN THE UNITED KINGDOM INDICATOR
FIXATION TYPE FOR ELBOW REPLACEMENT
FIXATION TYPE FOR SHOULDER REPLACEMENT
FORMULA MILK OR MILK FORTIFIER TYPE
FRACTION NUMBER
GERMLINE GENETIC TEST TYPE OFFERED

HIP JOINT SURGERY PATIENT POSITION
HUMAN PAPILLOMAVIRUS VACCINATION DOSE GIVEN
IMAGE GUIDED SURGERY INDICATOR
IMAGING ANATOMICAL SITE
INFECTION CULTURE TEST INDICATOR
INTERNATIONAL ESOPHAGEAL DATABASE SURGICAL COMPLICATIONS
INTERVENTION SESSION TYPE FOR STOP SMOKING
INTERVENTION SETTING TYPE FOR STOP SMOKING
INTRAPARTUM ANTIBIOTICS GIVEN INDICATOR
INTRAVESICAL CHEMOTHERAPY RECEIVED INDICATOR
INTRAVESICAL IMMUNOTHERAPY RECEIVED INDICATOR
~~INVESTIGATION SCHEME IN USE~~
JOINT REPLACEMENT PATIENT PROCEDURE PERFORMED INDICATOR
JOINT REPLACEMENT REVISION REASON CODE FOR ANKLE
JOINT REPLACEMENT REVISION REASON CODE FOR ELBOW
JOINT REPLACEMENT REVISION REASON CODE FOR HIP
JOINT REPLACEMENT REVISION REASON CODE FOR KNEE
JOINT REPLACEMENT REVISION REASON CODE FOR SHOULDER
KI 67 STAINING PERFORMED INDICATION CODE
LABOUR OR DELIVERY ONSET METHOD
LABOUR OR DELIVERY ONSET METHOD CODE FOR NATIONAL NEONATAL DATA SET
LAPAROTOMY FOR NECROTISING ENTEROCOLITIS INDICATION CODE
LINER REMOVAL INDICATOR FOR JOINT REPLACEMENT
LIVER CANCER SURVEILLANCE SCAN INDICATOR
LIVER SURGERY PERFORMED TYPE
LIVER TRANSARTERIAL EMBOLISATION MATERIAL INJECTION TYPE
MARGIN INVOLVED INDICATION CODE
MARGIN INVOLVED INDICATION CODE FOR COLORECTAL
MATERNITY CARE SETTING
MECHANICAL THROMBOPROPHYLAXIS REGIME TYPE FOR JOINT REPLACEMENT
MECONIUM PRESENT IN LIQUOR INDICATOR
MINIMALLY INVASIVE OESOPHAGECTOMY SURGICAL APPROACH TYPE
MINIMALLY INVASIVE SURGERY INDICATOR FOR JOINT REPLACEMENT
MORE THAN THREE RECTAL WASHOUTS RECEIVED INDICATOR
NEOADJUVANT THERAPY INDICATOR
NEONATAL RESUSCITATION METHOD FOR NATIONAL NEONATAL DATA SET
NEURODEVELOPMENTAL ASSESSMENT ALREADY TAKEN INDICATOR
NEWBORN HEARING SCREENING TEST TYPE
NITRIC OXIDE GIVEN INDICATOR
NUMBER OF TELETHERAPY FIELDS
OBSERVATION SCHEME IN USE
OESOPHAGECTOMY ANASTOMOSIS TYPE
OESOPHAGECTOMY NECK DISSECTION INDICATOR
OESOPHAGECTOMY OESOPHAGEAL CONDUIT TYPE
OESOPHAGECTOMY SURGICAL APPROACH TYPE
OPEN OESOPHAGECTOMY SURGICAL APPROACH TYPE
OPERATION STATUS CODE
PARENTAL CONSENT TO ADMINISTER VITAMIN K INDICATOR
PARENTAL CONSENT TO POST MORTEM INDICATOR
PARENTERAL NUTRITION RECEIVED INDICATOR
PATHOLOGY INVESTIGATION TYPE
PATHOLOGY INVESTIGATION TYPE FOR BREAST SCREENING
PATIENT CONSENT FOR TISSUE BANKED AT DIAGNOSIS INDICATION CODE
PATIENT DIAGNOSIS TREATMENT PROVIDED INDICATION CODE FOR SEXUAL HEALTH SERVICE
PATIENT PROCEDURE PERFORMED INDICATOR
PATIENT PROCEDURE TYPE FOR PRIMARY ANKLE REPLACEMENT
PATIENT PROCEDURE TYPE FOR PRIMARY ELBOW REPLACEMENT

PATIENT PROCEDURE TYPE FOR PRIMARY HIP REPLACEMENT
PATIENT PROCEDURE TYPE FOR PRIMARY KNEE REPLACEMENT
PATIENT PROCEDURE TYPE FOR PRIMARY SHOULDER REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION ANKLE REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION ELBOW REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION HIP REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION KNEE REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION SHOULDER REPLACEMENT
PATIENT SPECIFIC INSTRUMENTS INDICATOR FOR SHOULDER OR KNEE REPLACEMENT
PATIENT TREATED TO CHILDRENS CANCER AND LEUKAEMIA GROUP GUIDELINES INDICATOR
PLANE OF SURGICAL EXCISION INDICATOR
POST MORTEM CARRIED OUT INDICATOR
POST MORTEM CONFIRMED NECROTISING ENTEROCOLITIS DIAGNOSIS INDICATOR
PRETREATMENT PROSTATE BIOPSY TECHNIQUE TYPE
PREVIOUS BONY INFECTION INDICATOR OF TIBIA OR HINDFOOT FOR ANKLE REPLACEMENT
PREVIOUS FRACTURE OF INDEX JOINT INDICATOR FOR ANKLE REPLACEMENT
PREVIOUS INDEX JOINT SURGERY TYPE FOR ANKLE REPLACEMENT
PREVIOUS SURGERY TYPE FOR SHOULDER REPLACEMENT
PRIMARY INDUCTION CHEMOTHERAPY FAILURE INDICATOR
PRINCIPAL DIAGNOSTIC IMAGING TYPE
PROCEDURE SCHEME IN USE
PROSTATE NERVE SPARING SURGERY TYPE
RADICAL PROSTATECTOMY MARGIN STATUS
RADIOISOTOPE
RADIOTHERAPY ACTUAL DOSE
RADIOTHERAPY BEAM TYPE
RADIOTHERAPY INTENT
RADIOTHERAPY PRESCRIBED DOSE
RADIOTHERAPY TREATMENT MODALITY
REGIONAL ANAESTHETIC TECHNIQUE FOR CANCER
RELAPSE METHOD DETECTION TYPE
RENAL VEIN TUMOUR INDICATOR FOR PAEDIATRIC KIDNEY
RENAL VEIN TUMOUR THROMBUS INDICATION CODE FOR UROLOGICAL
REPLOGLIE TUBE IN SITU INDICATOR
RESPIRATORY SUPPORT DEVICE TYPE FOR NATIONAL NEONATAL DATA SET
RESPIRATORY SUPPORT MODE FOR NATIONAL NEONATAL DATA SET
RESUSCITATION METHOD CODE
RETINOPATHY OF PREMATURITY SCREENING OUTCOME STATUS CODE
REVISION PROCEDURE TYPE FOR ANKLE REPLACEMENT
REVISION PROCEDURE TYPE FOR ELBOW REPLACEMENT
REVISION PROCEDURE TYPE FOR HIP REPLACEMENT
REVISION PROCEDURE TYPE FOR KNEE REPLACEMENT
REVISION PROCEDURE TYPE FOR SHOULDER REPLACEMENT
ROTATOR CUFF CONDITION FOR SHOULDER REPLACEMENT
ROTATOR CUFF REPAIRED INDICATOR FOR SHOULDER REPLACEMENT
ROTATOR CUFF REPAIR TYPE FOR SHOULDER REPLACEMENT
SENTINEL LYMPH NODE BIOPSY TYPE
SIGNIFICANT MATERNAL PYREXIA IN LABOUR INDICATOR
STAFF ROLE CARRYING OUT HOLISTIC NEEDS ASSESSMENT OR PERSONALISED CARE AND SUPPORT PLANNING
STEM CELL INFUSION DONOR TYPE
STEM CELL INFUSION SOURCE CODE
STEM CELL TRANSPLANT CONDITIONING REGIMEN
STEROIDS GIVEN DURING PREGNANCY TO MATURE FETAL LUNGS INDICATOR
STOMA PRESENT INDICATOR
SURFACTANT GIVEN INDICATOR
SURGICAL ACCESS TYPE
SURGICAL ACCESS TYPE FOR HEAD AND NECK CANCER

SURGICAL APPROACH FOR PRIMARY HIP REPLACEMENT
SURGICAL APPROACH FOR PRIMARY KNEE REPLACEMENT
SURGICAL APPROACH FOR PRIMARY OR REVISION ANKLE REPLACEMENT
SURGICAL APPROACH FOR PRIMARY OR REVISION ELBOW REPLACEMENT
SURGICAL APPROACH FOR PRIMARY OR REVISION SHOULDER REPLACEMENT
SURGICAL APPROACH FOR REVISION HIP REPLACEMENT
SURGICAL APPROACH FOR REVISION KNEE REPLACEMENT
SURGICAL PALLIATION TYPE
SYSTEMIC ANTI CANCER THERAPY CURATIVE TREATMENT COMPLETED AS PLANNED INDICATOR
SYSTEMIC ANTI CANCER THERAPY CURATIVE TREATMENT NOT COMPLETED OUTCOME REASON
SYSTEMIC ANTI CANCER THERAPY DRUG REGIMEN MODIFICATION INDICATOR FOR DOSE REDUCTION
SYSTEMIC ANTI CANCER THERAPY DRUG REGIMEN TREATMENT INTENT
SYSTEMIC ANTI CANCER THERAPY DRUG ROUTE OF ADMINISTRATION
SYSTEMIC ANTI CANCER THERAPY NON CURATIVE TREATMENT PATIENT BENEFIT INDICATOR
TRACHEOSTOMY TUBE IN SITU INDICATOR
TREATMENT TYPE FOR NECROTISING ENTEROCOLITIS
TREATMENT TYPE FOR PATENT DUCTUS ARTERIOSUS
UNITS OF BLOOD TRANSFUSED FOLLOWING OESOPHAGECTOMY
UNTOWARD INTRAOPERATIVE EVENT CODE FOR ANKLE REPLACEMENT
UNTOWARD INTRAOPERATIVE EVENT CODE FOR ELBOW REPLACEMENT
UNTOWARD INTRAOPERATIVE EVENT CODE FOR HIP REPLACEMENT
UNTOWARD INTRAOPERATIVE EVENT CODE FOR KNEE REPLACEMENT
UNTOWARD INTRAOPERATIVE EVENT CODE FOR SHOULDER REPLACEMENT
VASCULAR LINE TYPE IN SITU
VISUAL INSPECTION CONFIRMED NECROTISING ENTEROCOLITIS DURING LAPAROTOMY INDICATOR
VITAMIN K ADMINISTERED INDICATOR
VITAMIN K ROUTE OF ADMINISTRATION

CRITICAL CARE PERIOD

Change to Class: Changed Description

A subtype of [ACTIVITY GROUP](#).

A period of time within a [Hospital Provider Spell](#) during which a [PATIENT](#) receives critical care.

For [PATIENTS](#) treated in 'neonatal facilities', that is, in [WARDS](#) with a [CRITICAL CARE UNIT FUNCTION](#) of 13, 14 or 15, critical care [PATIENTS](#) include:

- a) All [PATIENTS](#) on a [WARD](#) with a [CRITICAL CARE UNIT FUNCTION](#) *Neonatal Intensive Care Unit* regardless of care being delivered.
- or
- b) All [PATIENTS](#) (excluding Mothers) on a [WARD](#) with a [CRITICAL CARE UNIT FUNCTION](#) *Facility for Babies on a Neonatal Transitional Care Ward* or *Facility for Babies on a Maternity Ward* to whom one or more [CRITICAL CARE ACTIVITIES](#) with codes 01 to 02, 04 - 16 or 22 - 29 is delivered for a period greater than 4 hours.

For [PATIENTS](#) treated in 'adult facilities' or 'other facilities', that is, [WARDS](#) with a [CRITICAL CARE UNIT FUNCTION](#) of 01-03, 05-12, 90 or 91, the following conditions apply:

- A new [CRITICAL CARE PERIOD](#) starts when the [PATIENT](#) is admitted to a critical care location regardless of [CRITICAL CARE LEVEL](#).
- Outreach activity, although part of critical care, should not be recorded as a [CRITICAL CARE PERIOD](#).
- ~~Resuscitation conducted outside designated critical care locations, e.g. as part of conventional care in operating theatres and [Accident and Emergency Departments](#), should not be recorded as a [CRITICAL CARE PERIOD](#) even though many aspects of the care given may satisfy the definitions for Level 2 or Level 3 [CRITICAL CARE LEVELS](#).~~
- Resuscitation conducted outside designated critical care locations, e.g. as part of conventional care in operating theatres and [Emergency Care Department](#), should not be recorded as a [CRITICAL CARE PERIOD](#) even though many aspects of the care given may satisfy the definitions for Level 2 or Level 3 [CRITICAL CARE LEVELS](#).

- Repeated admissions to the same unit should be recorded as separate [CRITICAL CARE PERIODS](#) identified by different [CRITICAL CARE START DATES](#). A transfer to a different critical care location within the same [Hospital Provider Spell](#) will initiate a new [CRITICAL CARE PERIOD](#) identified by the differing [CRITICAL CARE UNIT FUNCTION](#).
- A change of [Consultant Episode \(Hospital Provider\)](#) or brief transfers for investigation and/or treatment do not end the [CRITICAL CARE PERIOD](#).
- A [CRITICAL CARE PERIOD](#) ends when the [PATIENT](#) is discharged from the critical care location, or dies, or the care that is being delivered in a non-standard location (see below) is [CRITICAL CARE LEVEL](#) National Code 00 'Level 0' or 01 'Level 1'.
- Critical care locations are described by [CRITICAL CARE UNIT FUNCTION](#) and [UNIT BED CONFIGURATION](#). Critical Care beds may include occasional non-standard locations using a ward area or operating department when conventional critical care beds are not available. Non standard locations may only be recorded if the [CRITICAL CARE LEVEL](#) is National Code 02 'Level 2' or 03 'Level 3' and the delivery of care is greater than four hours. For [CRITICAL CARE PERIODS](#) with [CRITICAL CARE UNIT FUNCTIONS](#) of either National Code 90 'non standard location using a ward area' or National Code 91 'non standard location using the operating department', care provided in these locations must exceed four hours, and must include [CLINICAL INTERVENTIONS](#), monitoring and supervision normally associated with a critical care area i.e. intensive therapy unit or high dependency unit. Further the care provided must be continuously supervised by currently practising critical care doctors and [NURSES](#) who would normally work in critical care.
- The type of [ORGAN SYSTEM SUPPORTED](#) is recorded and the duration of each organ system support is calculated from the [ACTIVITY PROPERTY EFFECTIVE DATE](#) and the [ACTIVITY PROPERTY END DATE](#).
- A [CRITICAL CARE PERIOD](#) does not include the following:
 - a. Surgical and anaesthetic intra-operative care
 - b. Post-operative care within an operating department except where level 2 or level 3 care are provided for more than 4 hours
 - c. Care delivered in a cardiac or coronary care unit
 - d. Imaging procedures
 - e. Endoscopy procedures
 - f. Care delivered in an [Accident and Emergency Department](#)
- A [CRITICAL CARE PERIOD](#) does not include the following:
 - Surgical and anaesthetic intra-operative care
 - Post-operative care within an operating department except where level 2 or level 3 care are provided for more than 4 hours
 - Care delivered in a cardiac or coronary care unit
 - Imaging procedures
 - Endoscopy procedures
 - Care delivered in an [Emergency Care Department](#).

Commissioning Data Set Transmission

- The [CRITICAL CARE PERIOD](#) may overlap Episodes, i.e. the [CRITICAL CARE START DATE](#) may precede the start of the [CONSULTANT/ MIDWIFE / NURSE](#) Episode; similarly the [CRITICAL CARE PERIOD](#) may not have ended by the end of the Episode.
- The Data Elements [CRITICAL CARE START DATE](#), [CRITICAL CARE LOCAL IDENTIFIER](#) and [CRITICAL CARE UNIT FUNCTION](#) must always be present.
- Where applicable, Support Days and Critical Care Level Days should only be entered when the [CRITICAL CARE PERIOD](#) is finished and the [CRITICAL CARE DISCHARGE DATE](#) is entered.
- The [CRITICAL CARE DISCHARGE DATE](#) must be on or before the [DISCHARGE DATE \(HOSPITAL PROVIDER SPELL\)](#).

LOCATION

Change to Class: Changed Attributes

Attributes of this Class are:

~~ACCIDENT AND EMERGENCY INCIDENT LOCATION TYPE~~
 ACTIVITY LOCATION TYPE CODE
 ACUTE ONCOLOGY ASSESSMENT LOCATION
 LOCATION CLASS
 LOCATION IN HOSPITAL TYPE
 LOCATION OF HIGHEST LEVEL OF CARE
 PATIENT LOCATION FOR NHS CONTINUING HEALTHCARE CHECKLIST
 PLACE OF SAFETY INDICATOR

LODGED PATIENT

Change to Class: Changed Description

A PATIENT temporarily accommodated in an Accident and Emergency Department or elsewhere for whom a DECISION TO ADMIT has been made; but who remains waiting in the nursing care of the Accident and Emergency Department for longer than is appropriate for his/her condition before moving to a WARD. A PATIENT temporarily accommodated in an Emergency Care Department or elsewhere for whom a DECISION TO ADMIT has been made; but who remains waiting in the nursing care of the Emergency Care Department for longer than is appropriate for his/her condition before moving to a WARD.

This occurs in cases where:

- Pre-arrangements have been made for movement to a WARD, or
- A DECISION TO ADMIT has been made as a result of an Accident and Emergency Attendance. Any facility set up to treat emergency and/or walk in cases is regarded as an Accident and Emergency Department for this purpose.
- A DECISION TO ADMIT has been made as a result of an Emergency Care Attendance. Any facility set up to treat emergency and/or walk in cases is regarded as an Emergency Care Department for this purpose.

PATIENT DIAGNOSIS

Change to Class: Changed Attributes

Attributes of this Class are:

~~ACCIDENT AND EMERGENCY DIAGNOSIS
BASIS OF DIAGNOSIS FOR CANCER
BREAST CANCER INVASIVE STATUS
CEREBRAL PALSY TYPE CODE FOR NATIONAL NEONATAL DATA SET
CHOLANGIOCARCINOMA PRESENCE CATEGORY
CYSTIC FIBROSIS BANDING
DIAGNOSIS SCHEME IN USE
FEMALE GENITAL MUTILATION IDENTIFIED TYPE
FEMALE GENITAL MUTILATION TYPE 4 CODE
HISTOLOGY CONFIRMED NECROTISING ENTEROCOLITIS FOLLOWING LAPAROTOMY INDICATOR
HISTORY OF FEMALE GENITAL MUTILATION INDICATOR
HYPOXIC ISCHEMIC ENCEPHALOTHAPY GRADE
LIFE THREATENING SYMPTOMS AT DIAGNOSIS INDICATOR
LIVER CIRRHOSIS CAUSE TYPE
LIVER CIRRHOSIS TYPE
LONG HEAD BICEPS PRESENT INDICATOR FOR SHOULDER REPLACEMENT
MATERNITY COMPLICATING DIAGNOSIS INDICATOR
MATERNITY COMPLICATING MEDICAL DIAGNOSIS
MATERNITY MEDICAL DIAGNOSIS TYPE
NEONATAL ABSTINENCE SYNDROME OBSERVED INDICATOR
OBSTETRIC DIAGNOSIS
OTHER MYELODYSPLASIA SYMPTOMS AT DIAGNOSIS
PATIENT DIAGNOSIS CONFIRMED INDICATION CODE FOR SEXUAL HEALTH SERVICE
PATIENT DIAGNOSIS INDICATION FOR PRIMARY ANKLE REPLACEMENT
PATIENT DIAGNOSIS INDICATION FOR PRIMARY ELBOW REPLACEMENT
PATIENT DIAGNOSIS INDICATION FOR PRIMARY HIP REPLACEMENT
PATIENT DIAGNOSIS INDICATION FOR PRIMARY KNEE REPLACEMENT
PATIENT DIAGNOSIS INDICATION FOR PRIMARY SHOULDER REPLACEMENT
PATIENT DIAGNOSIS INDICATOR
PATIENT DIAGNOSIS SITE OF INFECTION FOR SEXUAL HEALTH SERVICE
POST HAEMORRHAGIC HYDROCEPHALUS OBSERVED DURING CRANIAL ULTRASOUND SCAN INDICATOR
PRESENTING COMPLAINT CODING SIGNIFICANCE
PRESENT ON ADMISSION INDICATOR
PREVIOUS DIAGNOSED CONDITION INDICATOR
PRIMARY CANCER SITE FOR CANCER FASTER DIAGNOSIS PATHWAY
PRIMARY DIAGNOSIS~~

PROVISIONAL DIAGNOSIS
SEIZURE OCCURRED INDICATOR
SEPSIS SUSPECTED INDICATOR
SEVERE CARDIORESPIRATORY DISEASE INDICATOR
TUMOUR OR LESION LATERALITY

PERSON NAME STRUCTURED

Change to Class: Changed Dataset

A subtype of [PERSON NAME](#).

A full name comprised of one or more separate [PERSON NAMES](#) in sequence.

The [PERSON NAME](#) must contain at least one [PERSON NAME](#) of the type 'Person Family Name'.

PERSON NAME UNSTRUCTURED

Change to Class: Changed Dataset

A subtype of [PERSON NAME](#).

The full name of a [PERSON](#) expressed as a single textual record.

PERSON PROPERTY QUALIFIER

Change to Class: Changed Attributes

Attributes of this Class are:

ANATOMICAL AREA
ANATOMICAL SIDE
ANATOMICAL SIDE FOR IMAGING
ANATOMICAL SIDE FOR NATIONAL JOINT REGISTRY
HANDEDNESS CODE FOR JOINT REPLACEMENT
HYDRONEPHROSIS CODE
PRIMARY EXTRANODAL CANCER SITE
RADIOTHERAPY TREATMENT REGION

PLANNED ACTIVITY DATE TIME

Change to Class: Changed Attributes

Attributes of this Class are:

~~PLANNED ACTIVITY DATE~~
K [PLANNED ACTIVITY DATE](#)
K [PLANNED ACTIVITY TIME](#)
[PLANNED ACTIVITY DATE AND TIME TYPE](#)
PLANNED ACTIVITY DATE TYPE

REFERRAL REQUEST

Change to Class: Changed Attributes

Attributes of this Class are:

BENIGN THERAPEUTIC OPERATION INDICATOR
CANCER DIAGNOSTIC REFERRAL ROUTE
COMMISSIONER REFERENCE NUMBER
REASON FOR REFERRAL TO COMMUNITY CARE

REASON FOR REFERRAL TO MENTAL HEALTH
REFERRAL CLOSURE REASON
REFERRAL REJECTION REASON
REFERRAL REQUEST ACCEPTED DATE FOR NHS CONTINUING HEALTHCARE FAST TRACK
REFERRAL REQUEST DISCOUNTED DATE FOR NHS CONTINUING HEALTHCARE STANDARD
REFERRAL REQUEST DISCOUNTED REASON FOR NHS CONTINUING HEALTHCARE STANDARD
REFERRAL REQUEST RECEIVED DATE
REFERRAL REQUEST RECEIVED TIME
SCREENING REFERRAL SOURCE
SERVICE TYPE REQUESTED
SOURCE OF REFERRAL FOR A and E
SOURCE OF REFERRAL FOR COMMUNITY
SOURCE OF REFERRAL FOR FEMALE GENITAL MUTILATION
SOURCE OF REFERRAL FOR MATERNITY
SOURCE OF REFERRAL FOR MENTAL HEALTH
SOURCE OF REFERRAL FOR OUT-PATIENTS
TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE

A AND E ATTENDANCE CATEGORY (RETIRED), renamed from **A AND E ATTENDANCE CATEGORY**

Change to Attribute: Changed Description, Dataset, Name, status to Retired

An indication of whether a [PATIENT](#) is making first or follow up attendance at a particular [Accident and Emergency Department](#). **This item has been retired from the NHS Data Model and Dictionary.**

Note:

An attendance at a [Consultant Clinic](#) following an [Accident and Emergency Attendance](#) is an [Out Patient Attendance Consultant](#) and not an [Accident and Emergency Attendance](#) even if the clinic may be held in or near the [Accident and Emergency Department](#), e.g. a Fracture Clinic. **The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.**

National Codes: 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.

- 1 First [Accident and Emergency Attendance](#) – the first in a series, or the only attendance, in a particular [Accident and Emergency Episode](#)
- 2 Follow up [Accident and Emergency Attendance](#) – planned: a subsequent planned attendance at the same department, and for the same incident as the first attendance
- 3 Follow up [Accident and Emergency Attendance](#) – unplanned: a subsequent unplanned attendance at the same department, and for the same incident as the first attendance

A AND E ATTENDANCE CATEGORY (RETIRED), renamed from **A AND E ATTENDANCE CATEGORY**

Change to Attribute: Changed Description, Dataset, Name, status to Retired

- Changed Description
- null
- Changed Name from Data_Dictionary.Attributes.A.A_AND_E_ATTENDANCE_CATEGORY to Retired.Data_Dictionary.Attributes.A.A_AND_E_ATTENDANCE_CATEGORY
- Retired A AND E ATTENDANCE CATEGORY

A AND E INITIAL ASSESSMENT TRIAGE CATEGORY (RETIRED), renamed from **A AND E INITIAL ASSESSMENT TRIAGE CATEGORY**

Change to Attribute: Changed Description, Name, status to Retired

The category assigned to a [PATIENT](#) as a result of an initial assessment by medical or nursing staff in an [Accident and Emergency Department](#). **This item has been retired from the NHS Data Model and Dictionary.**

The triage category is used to determine the [PATIENT](#)'s priority for treatment, and to inform the [PATIENT](#) of their waiting time. **The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.**

National Codes: 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.

- 1 ~~Immediate resuscitation.
[PATIENTS](#) in need of immediate treatment for preservation of life.~~
- 2 ~~Very urgent.
Seriously ill or injured [PATIENTS](#) whose lives are not in immediate danger.~~
- 3 ~~Urgent.
[PATIENTS](#) with serious problems, but apparently stable condition.~~
- 4 ~~Standard.
Standard A&E cases without immediate danger or distress.~~
- 5 ~~Non-urgent.
[PATIENTS](#) whose conditions are not true accidents or emergencies.~~

References:

Triage and casemix accident and emergency medicine. Marrow, J. European Journal of Emergency Medicine 1998; 5: 53-58

A AND E INITIAL ASSESSMENT TRIAGE CATEGORY (RETIRED), renamed from A AND E INITIAL ASSESSMENT TRIAGE CATEGORY

Change to Attribute: Changed Description, Name, status to Retired

- Changed Description
- Changed Name from Data_Dictionary.Attributes.A.A_AND_E_INITIAL_ASSESSMENT_TRIAGE_CATEGORY to Retired.Data_Dictionary.Attributes.A.A_AND_E_INITIAL_ASSESSMENT_TRIAGE_CATEGORY
- Retired A AND E INITIAL ASSESSMENT TRIAGE CATEGORY

A AND E PATIENT GROUP (RETIRED), renamed from A AND E PATIENT GROUP

Change to Attribute: Changed Description, Dataset, Name, status to Retired

A coded classification to identify the reason for an [Accident and Emergency Episode](#). **This item has been retired from the NHS Data Model and Dictionary.**

National Codes: The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

- 10 ~~Read traffic accident~~
- 20 ~~Assault~~
- 30 ~~Deliberate self-harm~~
- 40 ~~Sports injury~~
- 50 ~~Firework injury~~
- 60 ~~Other accident~~
- 70 ~~Brought in dead~~
- 80 ~~Other than above~~

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.

A AND E PATIENT GROUP (RETIRED), renamed from A AND E PATIENT GROUP

Change to Attribute: Changed Description, Dataset, Name, status to Retired

- Changed Description
- null
- Changed Name from Data_Dictionary.Attributes.A.A_AND_E_PATIENT_GROUP to Retired.Data_Dictionary.Attributes.A.A_AND_E_PATIENT_GROUP
- Retired A AND E PATIENT GROUP

A AND E STREAM (RETIRED), renamed from A AND E STREAM

Change to Attribute: Changed Description, Name, status to Retired

This records the streaming classification assigned to an [Accident and Emergency Attendance](#), within an [Accident and Emergency Department](#). Streaming is a system whereby [PATIENTS](#) are allocated to different flows according to their needs. These flows are individually staffed and continue to function whatever the pressures in other streams. Within any stream, at any one time, there may be [PATIENTS](#) with different [A AND E INITIAL ASSESSMENT TRIAGE CATEGORIES](#). An [Accident and Emergency Department](#) will have either simple streaming or full streaming in place and will use the appropriate classification. **This item has been retired from the NHS Data Model and Dictionary.**

National Codes: The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

- Simple streaming
- 1 Minor case
- 2 Major case
- 3 Resuscitation
- Full streaming
- 4 Self-Care (those [PATIENTS](#) Who attend A&E and do not need investigation or hospital treatment. After a thorough assessment the [PATIENTS](#) are given appropriate advice on self care and are discharged. They will also be advised on indications for further contact)
- 5 Primary Care (those [PATIENTS](#) with conditions who could be treated by a primary care team);
- 6 Minor Injury and Moderate Illness (Ambulatory care) ([PATIENTS](#) who need some investigation or treatment for an injury but are unlikely to be admitted);
- 7 Clinical Assessment (Majors) (those [PATIENTS](#) needing a more thorough clinical assessment and may need a series of investigations or observation before definitive treatment can be determined.)
- 8 Resuscitation ([PATIENTS](#) with serious illness or injury that need emergency assessment and care.)

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.

A AND E STREAM (RETIRED), renamed from **A AND E STREAM**

Change to Attribute: Changed Description, Name, status to Retired

- Changed Description
- Changed Name from Data_Dictionary.Attributes.A.A_AND_E_STREAM to Retired.Data_Dictionary.Attributes.A.A_AND_E_STREAM
- Retired A AND E STREAM

ACCIDENT AND EMERGENCY ARRIVAL MODE (RETIRED), renamed from **ACCIDENT AND EMERGENCY ARRIVAL MODE**

Change to Attribute: Changed Description, Dataset, Name, status to Retired

The mode by which a [PATIENT](#) arrived at an [Accident and Emergency Department](#). **This item has been retired from the NHS Data Model and Dictionary.**

National Codes: The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

- 1 Brought in by [Emergency Ambulance](#) (including helicopter/"Air Ambulance")
- 2 Other

For guidance on the use of this data item in the Accident and Emergency Clinical Quality Indicators, further information is available on the [Department of Health and Social Care National Archives](#) at: [A&E clinical quality indicators: Implementation guidance and data definitions](#). 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.

ACCIDENT AND EMERGENCY ARRIVAL MODE (RETIRED), renamed from **ACCIDENT AND EMERGENCY ARRIVAL MODE**

Change to Attribute: Changed Description, Dataset, Name, status to Retired

- Changed Description
- null
- Changed Name from Data_Dictionary.Attributes.A.Acc.ACCIDENT_AND_EMERGENCY_ARRIVAL_MODE to Retired.Data_Dictionary.Attributes.A.ACCIDENT_AND_EMERGENCY_ARRIVAL_MODE
- Retired ACCIDENT AND EMERGENCY ARRIVAL MODE

ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL (RETIRED), renamed from **ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL**

Change to Attribute: Changed Description, Dataset, Name, status to Retired

A code to identify how an [Accident and Emergency Attendance](#) concluded. **This item has been retired from the NHS Data Model and Dictionary.**

National Codes: **The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.**

- 01 Admitted to a [Hospital Bed](#) /became a [LODGED PATIENT](#) of the same [Health Care Provider](#)
- 02 Discharged – follow up treatment to be provided by [GENERAL PRACTITIONER](#)
- 03 Discharged – did not require any follow up treatment
- 04 Referred to A&E Clinic
- 05 Referred to Fracture Clinic
- 06 Referred to other [Out Patient Clinic](#)
- 07 Transferred to other [Health Care Provider](#)
- 10 Died in [Department](#)
- 11 Referred to other health [CARE PROFESSIONAL](#)
- 12 Left [Department](#) before being seen for treatment
- 13 Left [Department](#) having refused treatment
- 14 Other

For the Accident and Emergency Clinical Quality Indicators, further guidance on National Code '[Left Department before being seen for treatment](#)' is available on the [Department of Health and Social Care](#) National Archives at: [A&E clinical quality indicators: Implementation guidance and data definitions](#). **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.**

ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL (RETIRED), renamed from ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL

Change to Attribute: Changed Description, Dataset, Name, status to Retired

- Changed Description
- null
- Changed Name from Data_Dictionary.Attributes.A.Acc.ACCIDENT_AND_EMERGENCY_ATTENDANCE DISPOSAL to Retired.Data_Dictionary.Attributes.A.ACCIDENT_AND_EMERGENCY_ATTENDANCE DISPOSAL
- Retired ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL

ACCIDENT AND EMERGENCY DEPARTMENT TYPE (RETIRED), renamed from ACCIDENT AND EMERGENCY DEPARTMENT TYPE

Change to Attribute: Changed Description, Dataset, Name, status to Retired

The type of [Accident and Emergency Department](#) according to the [ACTIVITY](#) performed. **This item has been retired from the NHS Data Model and Dictionary.**

National Codes: **The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.**

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

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.

ACCIDENT AND EMERGENCY DEPARTMENT TYPE (RETIRED), renamed from ACCIDENT AND EMERGENCY DEPARTMENT TYPE

Change to Attribute: Changed Description, Dataset, Name, status to Retired

- Changed Description
- null
- Changed Name from Data_Dictionary.Attributes.A.Acc.ACCIDENT_AND_EMERGENCY_DEPARTMENT_TYPE to Retired.Data_Dictionary.Attributes.A.ACCIDENT_AND_EMERGENCY_DEPARTMENT_TYPE
- Retired ACCIDENT AND EMERGENCY DEPARTMENT TYPE

ACCIDENT AND EMERGENCY DIAGNOSIS (RETIRED), renamed from ACCIDENT AND EMERGENCY DIAGNOSIS

Change to Attribute: Changed Description, Dataset, Name, status to Retired

A broad coding of types of diagnoses which may be made as a result of [Accident and Emergency Attendances](#). This item has been retired from the NHS Data Model and Dictionary.

For further information, see the [Accident and Emergency Diagnosis Tables](#). The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ACCIDENT AND EMERGENCY DIAGNOSIS (RETIRED), renamed from ACCIDENT AND EMERGENCY DIAGNOSIS

Change to Attribute: Changed Description, Dataset, Name, status to Retired

- Changed Description
- null
- Changed Name from Data_Dictionary.Attributes.A.Acc.ACCIDENT_AND_EMERGENCY_DIAGNOSIS to Retired.Data_Dictionary.Attributes.A.ACCIDENT_AND_EMERGENCY_DIAGNOSIS
- Retired ACCIDENT AND EMERGENCY DIAGNOSIS

ACCIDENT AND EMERGENCY INCIDENT LOCATION TYPE (RETIRED), renamed from ACCIDENT AND EMERGENCY INCIDENT LOCATION TYPE

Change to Attribute: Changed Description, Dataset, Name, status to Retired

The type of place where the incident occurred which led to an [Accident and Emergency Episode](#). This item has been retired from the NHS Data Model and Dictionary.

Note: This applies to trauma and accident cases only. The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

~~National Codes:~~ 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.

- 10 Home
- 40 Work
- 50 [Educational Establishment](#)
- 60 Public place
- 91 Other

ACCIDENT AND EMERGENCY INCIDENT LOCATION TYPE (RETIRED), renamed from ACCIDENT AND EMERGENCY INCIDENT LOCATION TYPE

Change to Attribute: Changed Description, Dataset, Name, status to Retired

- Changed Description
- null
- Changed Name from Data_Dictionary.Attributes.A.Acc.ACCIDENT_AND_EMERGENCY_INCIDENT_LOCATION_TYPE to Retired.Data_Dictionary.Attributes.A.ACCIDENT_AND_EMERGENCY_INCIDENT_LOCATION_TYPE
- Retired ACCIDENT AND EMERGENCY INCIDENT LOCATION TYPE

ACCIDENT AND EMERGENCY INVESTIGATION (RETIRED), renamed from ACCIDENT AND EMERGENCY INVESTIGATION

Change to Attribute: Changed Description, Dataset, Name, status to Retired

A broad coding of types of investigation which may be requested to assist with diagnosis as a result of [Accident and Emergency Attendances](#). **This item has been retired from the NHS Data Model and Dictionary.**

For further information, see the [Accident and Emergency Investigation Table](#). **The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.**

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ACCIDENT AND EMERGENCY INVESTIGATION (RETIRED), renamed from ACCIDENT AND EMERGENCY INVESTIGATION

Change to Attribute: Changed Description, Dataset, Name, status to Retired

- Changed Description
- null
- Changed Name from Data_Dictionary.Attributes.A.Acc.ACCIDENT_AND_EMERGENCY_INVESTIGATION to Retired.Data_Dictionary.Attributes.A.ACCIDENT_AND_EMERGENCY_INVESTIGATION
- Retired ACCIDENT AND EMERGENCY INVESTIGATION

ACCIDENT AND EMERGENCY TREATMENT (RETIRED), renamed from ACCIDENT AND EMERGENCY TREATMENT

Change to Attribute: Changed Description, Dataset, Name, status to Retired

A broad coding of types of treatment or guidance which may be provided to a [PATIENT](#) as a result of [Accident and Emergency Attendances](#). **This item has been retired from the NHS Data Model and Dictionary.**

For further information, see the [Accident and Emergency Treatment Tables](#). **The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.**

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ACCIDENT AND EMERGENCY TREATMENT (RETIRED), renamed from ACCIDENT AND EMERGENCY TREATMENT

Change to Attribute: Changed Description, Dataset, Name, status to Retired

- Changed Description
- null
- Changed Name from Data_Dictionary.Attributes.A.Acc.ACCIDENT_AND_EMERGENCY_TREATMENT to Retired.Data_Dictionary.Attributes.A.ACCIDENT_AND_EMERGENCY_TREATMENT
- Retired ACCIDENT AND EMERGENCY TREATMENT

ACTIVITY DATE

Change to Attribute: Changed Dataset

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

The specific nature of the [ACTIVITY DATE](#) will be identified by the [ACTIVITY DATE TYPE](#).

ACTIVITY DATE AND TIME TYPE

Change to Attribute: Changed Description

The type of date and time that defines the usage with regard to the [ACTIVITY](#).

An [ACTIVITY](#) may have many dates and times associated with it but may only have one date and time of a particular type.

National Codes:

- 300 Maternal Critical Incident Date and Time (Retired 1 April 2019)
- 301 Procedure Date and Time (Retired September 2018)
- 302 Baby First Feed Date and Time (Retired 1 April 2019)
- 303 Date and Time of Decision to Deliver (Retired 1 April 2019)
- 304 Discharge Date and Time (Hospital Provider Spell Postpartum) (Retired 1 April 2019)
- 305 Oxytocin Administered Date and Time (Retired 1 April 2019)
- 306 Rupture of Membranes Date and Time (Retired September 2018)
- 307 Transfer Start Date and Time (Neonatal Unit) (Retired 1 April 2019)
- 308 Urgent Care Service Accessed Date and Time (Retired 01 September 2015)
- 309 Clinical Intervention Date and Time (Retired September 2018)
- 310 Critical Care Period Start Date and Time (Retired September 2018)
- 311 Parents Seen By Senior Staff Member Date and Time (Retired September 2018)
- 312 Critical Care Period Discharge Date and Time (Retired September 2018)
- 313 Arrival Date and Time at Accident and Emergency Department (Retired September 2018)
- 314 Assault Date and Time (Retired September 2018)
- ??? [Care Professional Clinical Responsibility Timestamp](#)
- ??? [Assessment Tool Validation Timestamp](#)
- ??? [Emergency Care Clinically Ready To Proceed Timestamp](#)

ACTIVITY DATE TYPE

Change to Attribute: Changed Description

The type of date that defines the usage with regard to the [ACTIVITY](#).

An [ACTIVITY](#) may have many dates associated with it but may only have one date of a particular type.

National Codes:

- 001 Angiogram Date (Retired July 2012)
- ~~002~~ [Arrival Date At Accident and Emergency Department](#)
- 002** [Arrival Date At Accident and Emergency Department \(Retired 01 November 2020\)](#)
- 003 Breast Assessment Date (Retired 1 January 2013)
- 004 Cancer Dental Assessment Date (Retired September 2018)
- 005 Colorectal or Stoma Nurse Seen Date (Retired 1 January 2013)
- 006 Coronary Angiography Date (Retired July 2012)
- 007 Care Programme Approach Review Date (Retired September 2018)
- 008 Date Biopsy Taken (Retired 01 April 2014)
- 009 [Discharge Date](#)
- 010 [Discharge Ready Date](#)
- 011 [End Date](#)
- 012 Event Date (Retired July 2012)
- 013 Expected Delivery Date (Retired September 2012)
- 014 [First Antenatal Assessment Date](#)
- 015 Full Postnatal Examination Date (Retired September 2012)
- 016 Initial Patient Contact Date (Retired July 2012)
- 017 Investigation Transfer Date (Retired July 2012)
- 018 Intrauterine Device Application Date (Retired September 2012)
- 019 Intrauterine Device Fitted Date (Retired September 2012)
- 020 Last Dosage Date (Retired April 2019)
- 021 Mental Health Care Assessment Date (Retired September 2012)
- 022 Miscarriage Date (Retired September 2012)
- 023 Pathology Result Due Date (Retired April 2019)
- 024 Patient Informed Biopsy Result Date (Retired April 2019)
- 025 Patient Informed Of Outcome Date (Retired September 2012)
- 026 Smoking Quit Date (Retired October 2017)
- 027 Review Planned Date (Retired 01 April 2014)
- 028 Screening Result Date (Retired 01 April 2014)
- 029 Screening Result Sent Date (Retired April 2019)

030 Specialist Palliative Care Date (Retired 01 April 2014)
031 [Start Date](#)
032 Cancer Symptoms First Noted Date (Retired September 2018)
033 Attendance Date (Retired September 2018)
034 [Clinical Intervention Date](#)
035 Immunisation Completion Date (Retired 01 September 2015)
036 Clinical Status Assessment Date (Retired September 2018)
037 Dose Given Date (Retired September 2012)
038 Test Date (Retired September 2012)
039 Contact Date (Retired September 2018)
040 Appointment Date (Retired September 2018)
041 Primary Procedure Date (Retired September 2018)
042 Second Operation Date (Retired 01 April 2014)
043 Speech and Language Assessment Date (Retired September 2018)
044 Third Operation Date (Retired 01 April 2014)
045 Date First Seen (Retired September 2018)
046 Statutory Assessment Date (Retired 01 January 2016)
047 Screening Test Date (Retired September 2018)
048 Genitourinary Care Contact Date (Retired January 2014)
049 [Consultant Upgrade Date](#)
101 Referral Closure Date (Community Care) (Retired 01 September 2015)
102 Discharge Letter Issued Date (Community Care) (Retired 01 September 2015)
103 Systemic Anti-Cancer Therapy Administration Date (Retired September 2018)
104 [Procedure Date](#)
105 Immunisation Date (Retired September 2018)
106 Antenatal Appointment Date (Retired 1 April 2019)
107 Antenatal Booking Appointment Date (Retired September 2018)
108 [Pregnancy First Contact Date](#)
109 Screening Test Information Given Date (Retired 1 April 2019)
110 [Assessment Date For Transplant Suitability](#)
111 [Accident and Emergency Initial Assessment Date](#)
112 [Accident and Emergency Date Seen For Treatment](#)
113 [Accident and Emergency Attendance Conclusion Date](#)
114 [Accident and Emergency Departure Date](#)
115 Accident and Emergency Initial Assessment Date (Retired 01 November 2020)
116 Accident and Emergency Date Seen For Treatment (Retired 01 November 2020)
117 Accident and Emergency Attendance Conclusion Date (Retired 01 November 2020)
118 Accident and Emergency Departure Date (Retired 01 November 2020)
115 Clinical Assessment Date (Retired September 2018)
116 Imaging or Radiodiagnostic Event Date (Retired September 2018)
117 [Neonatal Critical Care Daily Care Date](#)
118 Two Year Neonatal Outcomes Assessment Date (Retired September 2018)
119 Date of Pregnancy Outcome (Current Fetus) (Retired 1 April 2019)
120 Neonatal Critical Incident Date (Retired 1 April 2019)
121 American Joint Committee on Cancer Stage Date (Retired September 2018)
122 Ann Arbor Stage Date (Retired September 2018)
123 Barcelona Clinic Liver Cancer Stage Date (Retired September 2018)
124 Binet Stage Date (Retired September 2018)
125 Chang Staging System Stage Date (Retired September 2018)
126 Clinical Stage Date (Pancreatic Cancer) (Retired September 2018)
127 Final Figo Stage Date (Retired September 2018)
128 Holistic Needs Assessment Completed Date (Retired September 2018)
129 Intergroup Rhabdomyosarcoma Study Post Surgical Group Date (Retired September 2018)
130 International Neuroblastoma Staging System Date (Retired 01 April 2017)
131 Myeloma International Staging System Stage Date (Retired September 2018)
132 Modified Dukes Stage Date (Retired September 2018)
133 [Multidisciplinary Team Discussion Date \(Cancer\)](#)
134 [Multidisciplinary Team Meeting Date \(Cancer\)](#)
135 Murphy St Jude Stage Date (Retired September 2018)
136 Rai Stage Date (Retired 01 April 2017)

137 Retinoblastoma Assessment Date (Retired September 2018)

138 TNM Stage Grouping Date (Final Pretreatment) (Retired September 2018)

139 TNM Stage Grouping Date (Integrated) (Retired September 2018)

140 Wilms Tumour Stage Date (Retired September 2018)

141 [Care Contact Cancellation Date](#)

142 [Care Contact Date](#)

143 Child Protection Plan End Date (Retired September 2018)

144 Child Protection Plan Start Date (Retired September 2018)

145 [Discharge Letter Issued Date \(Mental Health and Community Care\)](#)

146 Health Visitor First Antenatal Visit Date (Retired September 2018)

147 Infant Physical Examination Date (Retired September 2018)

148 Onward Referral Date (Retired September 2018)

149 [Referral Closure Date](#)

150 [Referral Rejection Date](#)

151 [Replacement Appointment Booked Date](#)

152 [Replacement Appointment Date Offered](#)

153 Service Discharge Date (Retired September 2018)

154 Date of Restrictive Intervention (Retired 01 April 2019)

155 [Indirect Activity Date](#)

156 Mental Health Crisis Plan Creation Date (Retired 01 April 2017)

157 Mental Health Crisis Plan Last Updated Date (Retired 01 April 2017)

158 [Care Plan Agreed Date](#)

159 [Care Plan Creation Date](#)

160 [Care Plan Implementation Date](#)

161 [Care Plan Last Updated Date](#)

162 Five Forensic Pathways Assessment Date (Retired September 2018)

163 International Neuroblastoma Risk Group Staging System Stage Date (Retired September 2018)

164 Stage Grouping Date (Testicular Cancer) (Retired September 2018)

165 [Emergency Care Arrival Date](#)

166 [Emergency Care Initial Assessment Date](#)

167 [Emergency Care Date Seen For Treatment](#)

168 [Emergency Care Attendance Conclusion Date](#)

169 [Emergency Care Departure Date](#)

170 Injury Date (Retired September 2018)

171 Referred To Service Assessment Date (Retired September 2018)

172 Intended Smoking Quit Date (Moved to [PLANNED ACTIVITY DATE TYPE](#) September 2018)

173 [Cancer Transformation Agreed Date \(Primary Cancer Pathway\)](#)

174 [Cancer Progression Agreed Date \(Primary Cancer Pathway\)](#)

175 [Clinical Trial Decision Date](#)

176 Treatment Start Date (Cancer) (Retired September 2018)

177 Cancer Faster Diagnosis Pathway End Date (Retired September 2018)

178 Cancer Referral To Treatment Period Start Date (Retired September 2018)

179 Cancer Treatment Period Start Date (Retired September 2018)

180 [Observable Entity Date](#)

181 [Package of Care or Year of Care Start Date \(Contract Monitoring\)](#)

182 [NHS Continuing Healthcare Standard Checklist Completed Date](#)

183 [Clinical Commissioning Group Eligibility Decision Date \(NHS Continuing Healthcare Standard\)](#)

184 [Clinical Commissioning Group Eligibility Decision Outcome Communicated To Patient Date \(NHS Continuing Healthcare Standard\)](#)

185 [NHS Continuing Healthcare Fast Track Pathway Tool Completed Date](#)

186 [NHS Continuing Healthcare Request Received Date](#)

187 [NHS Continuing Healthcare Local Resolution Formal Meeting Date](#)

188 [NHS Continuing Healthcare Local Resolution Informal Meeting Date](#)

189 [Local Resolution Eligibility Decision Outcome Communicated To Patient Date \(NHS Continuing Healthcare\)](#)

190 [NHS Continuing Healthcare Care Package Eligibility Status Change Date](#)

191 [NHS Continuing Healthcare Eligibility Start Date Following Independent Review](#)

192 [NHS Continuing Healthcare Previously Unassessed Period Of Care Decision Made Date](#)

193 [NHS Continuing Healthcare Previously Unassessed Period Of Care Eligibility Decision Communicated To Requester Date](#)

194 [Unbundled Care Activity Date](#)

195 [Activity Date for Age \(Contract Monitoring\)](#)

- 196 [Activity End Date \(Contract Monitoring\)](#)
- 197 [Activity Start Date \(Contract Monitoring\)](#)

ACTIVITY GROUP TYPE

Change to Attribute: Changed Description

The type of [ACTIVITY GROUP](#).

National Codes:

- 04 [Accident and Emergency Episode](#)
- 01 [Accident and Emergency Episode \(Retired 01 November 2020\)](#)
- 02 Acute Myocardial Infarction Care Spell (Retired July 2012)
- 03 Augmented Care Period (Retired 1 April 2006)
- 04 [Breast Cancer Care Spell](#)
- 05 [Cancer Care Spell](#)
- 06 [Care Home Stay \(Consultant Care\)](#)
- 07 [Care Home Stay \(Midwife Care\)](#)
- 08 [Care Home Stay \(Nursing Care\)](#)
- 09 [Care Home Stay \(Residential\)](#)
- 10 [Care Programme Approach Care Episode](#)
- 11 [Colorectal Cancer Care Spell](#)
- 12 Community Episode (Retired 01 January 2016)
- 13 Mental Health Care Professional Episode (Acute Home-Based) (Retired 01 January 2016)
- 14 [Consultant Episode \(Hospital Provider\)](#)
- 15 [Consultant Out-Patient Episode](#)
- 16 Dental Episode (Retired 01 April 2014)
- 17 [Drug Misuse Episode](#) (Retired 1 April 2019)
- 18 [Sexual Health and HIV Episode](#)
- 19 [Head and Neck Cancer Care Spell](#)
- 20 Home Dialysis Episode (Retired October 2019)
- 21 [Hospital Provider Spell](#)
- 22 [Lung Cancer Care Spell](#)
- 23 Adult Mental Health, Learning Disability or Autism Spectrum Disorder Care Spell (Retired 01 January 2016)
- 24 [Midwife Episode](#)
- 25 [Neonatal Level Of Care Period](#)
- 26 [Nursing Episode](#)
- 27 [Palliative Care Episode](#)
- 28 [Person Stop Smoking Episode](#)
- 29 Pregnancy Episode (Retired 1 April 2019)
- 30 Professional Staff Group Episode (Retired 01 January 2016)
- 31 Regular Attender Episode (Retired 01 January 2016)
- 32 Road Traffic Accident Treatment (Retired 01 April 2014)
- 33 [Sarcoma Cancer Care Spell](#)
- 34 [Skin Cancer Care Spell](#)
- 35 Supervised Discharge Episode (Retired 01 April 2014)
- 36 Supervision Register Episode (Retired 01 April 2014)
- 37 [Upper Gastrointestinal Cancer Care Spell](#)
- 38 [Urological Cancer Care Spell](#)
- 39 [Ward Stay](#)
- 40 [Hospital Stay](#)
- 41 [Care Spell](#)
- 42 [CRITICAL CARE PERIOD](#)
- 43 [PATIENT PATHWAY](#)
- 44 [REFERRAL TO TREATMENT PERIOD](#)
- 45 [Active Monitoring](#)
- 46 Supervised Community Treatment Recall (Retired 01 January 2016)
- 47 Supervised Community Treatment (Retired 01 January 2016)

48	Mental Health Care Without Patient Consent (Retired 01 January 2016)
49	Cancer Treatment Period
50	Gynaecological Cancer Care Spell
51	Mental Health Care Spell (Retired 01 January 2016)
52	Improving Access to Psychological Therapies Care Spell (Retired 1 April 2020)
53	Adult Mental Health Care Team Episode (Retired 01 January 2016)
54	Mental Health NHS Day Care Episode (Retired 01 January 2016)
55	Mental Health Delayed Discharge Period
56	Mental Health Care Cluster Assignment Period (Retired 01 January 2016)
57	Mental Health Care Coordinator Assignment Period
58	Child and Adolescent Mental Health Clinical Intervention Episode (Retired 01 January 2016)
59	Child and Adolescent Mental Health Care Spell (Retired 01 January 2016)
60	Maternity Episode
61	HIV Episode
62	Central Nervous System Cancer Care Spell
63	Children Teenagers and Young Adults Cancer Care Spell
64	Haematological Cancer Care Spell
65	Lung Cancer Care Spell (Retired 1 April 2018)
66	Commissioner Assignment Period
67	Breast Screening Episode
68	High Risk Breast Screening Episode
69	Open Breast Screening Episode
70	Neonatal Critical Care Spell
71	Radiotherapy Episode
72	Healthy Person Stay
73	Mental Health Responsible Clinician Assignment Period
74	Mental Health Conditional Discharge Period
75	Mental Health Act Legal Status Classification Period (Moved to PERSON PROPERTY ASSIGNMENT PERIOD TYPE 01 January 2016)
76	Care Professional Admitted Care Episode
77	Liver Cancer Care Spell
78	NHS Continuing Healthcare
79	NHS-funded Nursing Care
80	Package of Care
81	Acute Oncology Episode
82	Personalised Care and Support Planning
83	Community Bed-based Intermediate Care
84	Crisis Response Intermediate Care
85	Home-based Intermediate Care
86	Reablement Intermediate Care
??	Emergency Care Episode

ACTIVITY IDENTIFIER

Change to Attribute: Changed Dataset

A unique number or set of characters that is applicable to only one [ACTIVITY](#) for a [PATIENT](#) within an [ORGANISATION](#).

ACTIVITY SERVICE REQUEST DATE

Change to Attribute: Changed Dataset

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

ACTIVITY SERVICE REQUEST TIME

Change to Attribute: Changed Dataset

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

ACTIVITY TIME

Change to Attribute: Changed Description, Dataset

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

This may include representation of a time zone.

The specific nature of the time will be identified by the [ACTIVITY TIME TYPE](#).

ACTIVITY TIME TYPE

Change to Attribute: Changed Description

The type of time that defines the usage with regard to the [ACTIVITY](#).

An [ACTIVITY](#) may have many times associated with it but may only have one time of a particular type.

National Codes:

- 50 [Accident and Emergency Attendance Conclusion Time](#)
- 54 [Accident and Emergency Departure Time](#)
- 52 [Accident and Emergency Initial Assessment Time](#)
- 53 [Accident and Emergency Time Seen For Treatment](#)
- 50 Accident and Emergency Attendance Conclusion Time (Retired 01 November 2020)
- 51 Accident and Emergency Departure Time (Retired 01 November 2020)
- 52 Accident and Emergency Initial Assessment Time (Retired 01 November 2020)
- 53 Accident and Emergency Time Seen For Treatment (Retired 01 November 2020)
- 54 Arrival At Hospital Time (Retired April 2012)
- 55 ARRIVAL TIME (Retired April 2012)
- 56 [End Time](#)
- 57 Event Time (Retired July 2012)
- 58 Initial Patient Contact Time (Retired July 2012)
- 59 Last Dosage Time (Retired April 2019)
- 60 [Pathology Result Due Time](#) (Retired April 2019)
- 61 [Start Time](#)
- 62 Theatre Case Time In To Theatre Suite (Retired September 2012)
- 63 Theatre Case Time Out Of Theatre (Retired September 2012)
- 64 Theatre Case Time Out Of Theatre Suite (Retired September 2012)
- 65 Time Seen (Retired September 2018)
- 66 Discharge Ready Time (Retired April 2012)
- 67 [Arrival Time At Accident and Emergency Department](#)
- 67 Arrival Time At Accident and Emergency Department (Retired 01 November 2020)
- 68 Arrival Time For Transport Requests (Retired September 2015)
- 69 [Discharge Time](#)
- 70 [Clinical Intervention Time](#)
- 71 [Care Contact Time](#)
- 72 [Indirect Activity Time](#)
- 73 Service Discharge Time (Retired September 2018)
- 74 [Referral Closure Time](#)
- 75 Onward Referral Time (Retired September 2018)
- 76 [Emergency Care Arrival Time](#)
- 77 [Emergency Care Initial Assessment Time](#)
- 78 [Emergency Care Time Seen For Treatment](#)
- 79 [Emergency Care Attendance Conclusion Time](#)
- 80 [Emergency Care Departure Time](#)

- 81 Injury Time (Retired September 2018)
- 82 Referred To Service Assessment Time (Retired September 2018)
- 83 [Procedure Time](#)
- 84 [Care Plan Agreed Time](#)
- 85 [Care Plan Creation Time](#)
- 86 [Care Plan Last Updated Time](#)
- 87 [Referral Rejection Time](#)
- 88 [Observable Entity Time](#)

ADDRESS

Change to Attribute: Changed Dataset

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

ADMISSION METHOD

Change to Attribute: Changed Description

The method of admission to a [Hospital Provider Spell](#).

Note: see [ELECTIVE ADMISSION TYPE](#) for a full definition of [Elective Admission](#).

Notes:

- The following National Codes have been introduced to replace National Code 28 'Other means': National Code 28 will be retired in the next version of the [Commissioning Data Set](#):
 - 2A 'Emergency Admission: [Accident and Emergency Department](#) of another provider where the [PATIENT](#) had not been admitted'
 - 2B 'Emergency Admission: Transfer of an admitted [PATIENT](#) from another [Hospital Provider](#) in an emergency'
 - 2C 'Emergency Admission: Baby born at home as intended'
 - 2D 'Emergency Admission: Other emergency admission'
- The following National Codes have been introduced to replace National Code 28 'Other means': National Code 28 will be retired in the next version of the [Commissioning Data Set](#):
 - 2A 'Emergency Care Department of another provider where the [PATIENT](#) had not been admitted'
 - 2B 'Emergency Admission: Transfer of an admitted [PATIENT](#) from another [Hospital Provider](#) in an emergency'
 - 2C 'Emergency Admission: Baby born at home as intended'
 - 2D 'Emergency Admission: Other emergency admission'
- The following National Codes are **not** valid for use in the [Mental Health Services Data Set](#):
 - 2C 'Emergency Admission: Baby born at home as intended'
 - 28 'Emergency Admission: Other means'
 - 31 'Maternity Admission: Admitted ante partum'
 - 32 'Maternity Admission: Admitted post partum'
 - 82 'Other Admission: The birth of a baby in this [Health Care Provider](#)'
 - 83 'Other Admission: Baby born outside the [Health Care Provider](#) except when born at home as intended'
- National Code descriptions have been updated to remove National Code headings and add prefixes. 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.
 - The explanation of the National Code description prefixes are:
 - [Elective Admission](#): when the [DECISION TO ADMIT](#) could be separated in time from the actual admission. Note that this does not include a transfer from another [Hospital Provider](#) (see National Code 81 below)
 - [Emergency Admission](#): when admission is unpredictable and at short notice because of clinical need
 - [Maternity Admission](#): of a pregnant or recently pregnant woman to a maternity [WARD](#) (including [Delivery](#) facilities) except when the intention is to terminate the pregnancy
 - [Other Admission](#): not specified above.
- National Code descriptions have been updated to remove National Code headings and add prefixes. 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.
 - The explanation of the National Code description prefixes are:
 - [Elective Admission](#): when the [DECISION TO ADMIT](#) could be separated in time from the actual admission. Note that this does not include a transfer from another [Hospital Provider](#) (see National Code 81 below)
 - [Emergency Admission](#): when admission is unpredictable and at short notice because of clinical need
 - [Maternity Admission](#): of a pregnant or recently pregnant woman to a maternity [WARD](#) (including [Delivery](#) facilities) except when the intention is to terminate the pregnancy
 - [Other Admission](#): not specified above

- The following National Codes have been updated in DCB0092-2062: Commissioning Data Sets: Emergency Care Data Set. The Data Set specifications that contain these items will be updated in the next version of the Information Standard where it is not already correct:
 - 21 'Emergency Admission: [Emergency Care Department](#) or dental casualty department of the [Health Care Provider](#)'
 - 2A 'Emergency Admission: [Emergency Care Department](#) of another provider where the [PATIENT](#) had not been admitted'
 - 28 'Emergency Admission: Other means'.

National Codes:

- 11 [Elective Admission](#): Waiting list
- 12 [Elective Admission](#): Booked
- 13 [Elective Admission](#): Planned
- 24 ~~Emergency Admission: Accident and emergency or dental casualty department of the [Health Care Provider](#)~~
- 21 [Emergency Admission: \[Emergency Care Department\]\(#\) or dental casualty department of the \[Health Care Provider\]\(#\)](#)
- 22 Emergency Admission: [GENERAL PRACTITIONER](#): after a request for immediate admission has been made direct to a [Hospital Provider](#), i.e. not through a Bed bureau, by a [GENERAL PRACTITIONER](#) or deputy
- 23 Emergency Admission: Bed bureau
- 24 Emergency Admission: [Consultant Clinic](#), of this or another [Health Care Provider](#)
- 25 Emergency Admission: Admission via Mental Health Crisis Resolution Team
- 2A ~~Emergency Admission: [Accident and Emergency Department](#) of another provider where the [PATIENT](#) had not been admitted~~
- 2A [Emergency Admission: \[Emergency Care Department\]\(#\) of another provider where the \[PATIENT\]\(#\) had not been admitted](#)
- 2B Emergency Admission: Transfer of an admitted [PATIENT](#) from another [Hospital Provider](#) in an emergency
- 2C Emergency Admission: Baby born at home as intended
- 2D Emergency Admission: Other emergency admission
- 28 ~~Emergency Admission: Other means, examples are:

 - admitted from the [Accident and Emergency Department](#) of another provider where they had not been admitted
 - transfer of an admitted [PATIENT](#) from another [Hospital Provider](#) in an emergency
 - baby born at home as intended~~
- 28 [Emergency Admission: Other means, examples are:

 - admitted from the \[Emergency Care Department\]\(#\) of another provider where they had not been admitted
 - transfer of an admitted \[PATIENT\]\(#\) from another \[Hospital Provider\]\(#\) in an emergency
 - baby born at home as intended](#)
- 31 Maternity Admission: Admitted ante partum
- 32 Maternity Admission: Admitted post partum
- 82 Other Admission: The birth of a baby in this [Health Care Provider](#)
- 83 Other Admission: Baby born outside the [Health Care Provider](#) except when born at home as intended
- 81 Other Admission: Transfer of any admitted [PATIENT](#) from other [Hospital Provider](#) other than in an emergency

AMBULANCE CALL IDENTIFIER

Change to Attribute: Changed Dataset

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

ANATOMICAL AREA (RETIRED), renamed from ANATOMICAL AREA

Change to Attribute: Changed Description, Name, status to Retired

A coded representation of parts of the human body. **This item has been retired from the NHS Data Model and Dictionary.**

This together with [ANATOMICAL SIDE](#) gives the anatomical site of clinical problems presented at an [Accident and Emergency Attendance](#). **The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.**

National Codes: 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.

- 01 Brain
- 02 Head
- 03 Face
- 04 Eye
- 05 Ear
- 06 Nose

07	Mouth, jaw, teeth
08	Throat
09	Neck
10	Shoulder
11	Axilla
12	Upper arm
13	Elbow
14	Forearm
15	Wrist
16	Hand
17	Digit
18	Cervical spine
19	Thoracic spine
20	Lumbosacral spine
21	Pelvis
22	Chest
23	Breast
24	Abdomen
25	Back/buttocks
26	Ano-rectal
27	Genitalia
28	Hip
29	Groin
30	Thigh
31	Knee
32	Lower leg
33	Ankle
34	Foot
35	Toe
36	Multiple site

ANATOMICAL AREA (RETIRED), renamed from ANATOMICAL AREA

Change to Attribute: Changed Description, Name, status to Retired

- Changed Description
 - Changed Name from Data_Dictionary.Attributes.A.Ana.ANATOMICAL_AREA to Retired.Data_Dictionary.Attributes.A.ANATOMICAL_AREA
 - Retired ANATOMICAL AREA
-

CANCER SURGICAL ADMISSION TYPE

Change to Attribute: Changed Description

The type of surgical admission during a [Cancer Care Spell](#).

[CANCER SURGICAL ADMISSION TYPE](#) is derived from [ADMISSION METHOD](#).

- [CANCER SURGICAL ADMISSION TYPE](#) is National Code 'Elective Admission' where [ADMISSION METHOD](#) is: National Code 'Waiting list', 'Booked' or 'Planned'
- ~~[CANCER SURGICAL ADMISSION TYPE](#) is National Code 'Emergency Admission' where [ADMISSION METHOD](#) is: National Code 'Accident and emergency or dental casualty department of the [Health Care Provider](#)', '[GENERAL PRACTITIONER](#): after a request for immediate admission has been made direct to a [Hospital Provider](#), i.e. not through a Bed bureau, by a [GENERAL PRACTITIONER](#) or deputy', 'Bed bureau', '[Consultant Clinic](#), of this or another [Health Care Provider](#)', 'Admission via Mental Health Crisis Resolution Team', '[Accident and Emergency Department](#) of another provider where the [PATIENT](#) had not been admitted', 'Transfer of an admitted [PATIENT](#) from another [Hospital Provider](#) in an emergency', 'Other emergency admission' or 'Other means'.~~
- [CANCER SURGICAL ADMISSION TYPE](#) is National Code 'Emergency Admission' where [ADMISSION METHOD](#) is: National Code '[Emergency Care Department](#) or dental casualty department of the [Health Care Provider](#)', '[GENERAL PRACTITIONER](#): after a request for immediate admission has been made direct to a [Hospital Provider](#), i.e. not through a Bed bureau, by a [GENERAL PRACTITIONER](#) or deputy', 'Bed bureau', '[Consultant Clinic](#), of this or another [Health Care Provider](#)', 'Admission via Mental Health Crisis Resolution Team', '[Emergency Care Department](#) of another provider where the [PATIENT](#) had not been admitted', 'Transfer of an admitted [PATIENT](#) from another [Hospital Provider](#) in an emergency', 'Other emergency admission' or 'Other means'.

National Codes:

- 1 Elective admission
- 2 Emergency admission

CARE CONTACT TYPE

Change to Attribute: Changed Description

The type of [CARE CONTACT](#).

National Codes:

- 04 [Accident and Emergency Attendance](#)
- 01 [Accident and Emergency Attendance \(Retired 01 November 2020\)](#)
- 02 Acute Home-Based Contact (Retired 01 January 2016)
- 03 Audiology Attendance (Retired 01 April 2014)
- 04 [Cancer Clinical Status Assessment](#)
- 05 [Care Programme Approach Review](#)
- 06 [Clinic Attendance Consultant](#)
- 07 Clinic Attendance Sexual and Reproductive Health Service (Retired November 2014)
- 08 [Clinic Attendance Midwife](#)
- 09 [Clinic Attendance Non-Consultant](#)
- 10 [Clinic Attendance Nurse](#)
- 11 Contact Tracing Activity (Retired 01 April 2014)
- 12 Dental Treatment Contact (Retired 01 April 2014)
- 13 Day Care Attendance (Retired 01 January 2016)
- 14 [Domiciliary Consultation](#)
- 15 Emergency Dental Attendance (Retired 01 April 2014)
- 16 Face To Face Contact Community Care (Retired 01 January 2016)
- 17 Face To Face Contact CPA Care Coordinator (Retired 01 January 2016)
- 18 Face To Face Contact Dental (Retired 01 April 2014)
- 19 Face To Face Contact Optical (Retired 01 April 2014)
- 20 Face To Face Contact Social Worker (Retired 01 April 2011)
- 21 Face To Face Contact Surveillance (Retired 01 April 2014)
- 22 [Sexual and Reproductive Health Domiciliary Visit](#)
- 23 [Genitourinary Consultant Clinic Attendance](#)
- 24 GMP Consultation (Retired 01 April 2014)
- 25 GMP Practice Consultation (Retired 01 April 2014)
- 26 Home Assessment Visit (Retired 01 January 2016)
- 27 [Maternity Domiciliary Visit](#)
- 28 Night Consultation Visit (Retired 01 April 2014)
- 29 [Nurse or Midwife Contact](#)
- 30 [Out-Patient Attendance Consultant](#)
- 31 Registration Health Check (Retired 01 April 2014)
- 32 Sheltered Work Attendance (Retired 01 April 2011)
- 33 Sight Test (Retired 01 April 2014)
- 34 Social Services Statutory Assessment (Retired 01 January 2016)
- 35 Professional Advice And Support Contact (Retired 01 April 2014)
- 36 Professional Staff Group Contact (Retired 01 January 2016)
- 37 Telephone Contact NHS Direct (Mental Health) (Retired 01 April 2011)
- 38 [Theatre Case](#)
- 39 [Ward Attendance](#)
- 40 Genitourinary Care Contact (Retired January 2014)
- 41 [Improving Access to Psychological Therapies Contact](#)
- 42 NHS Health Check Assessment (Retired April 2019)
- 43 Antenatal Booking Appointment (Retired 1 April 2019)
- 44 [Pregnancy First Contact](#)
- 45 [Nutritional Assessment](#)
- 46 [HIV Clinic Attendance](#)

- 47 [Multi-Disciplinary Consultation \(National Tariff Payment System\)](#)
- 48 [Multi-Professional Consultation \(National Tariff Payment System\)](#)
- 49 [Two Year Neonatal Outcomes Assessment](#)
- 50 [Radiotherapy Attendance](#)
- 51 [Holistic Needs Assessment](#)
- 52 [Emergency Care Attendance](#)

CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR FOR EMERGENCY CARE

Change to Attribute: Changed Dataset

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

National Codes:

- Y Yes - the [CARE PROFESSIONAL](#) is responsible for discharge of the [PATIENT](#)
- N No - the [CARE PROFESSIONAL](#) is not responsible for discharge of the [PATIENT](#)

CARE PROFESSIONAL TIER FOR EMERGENCY CARE

Change to Attribute: Changed Dataset

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

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

National Codes:

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

CARER SUPPORT INDICATOR

Change to Attribute: Changed Dataset

An indication of whether [Carer](#) support is available to the [PATIENT](#) at their normal residence.

This does not include any paid support or support from a voluntary organisation, unless the [PATIENT](#) is normally resident in a [Care Home](#) and care is provided by a [Care Worker](#).

National Codes:

- 01 Yes - [Carer](#) support is available
- 02 No - [Carer](#) support is not available

CDS BULK REPLACEMENT GROUP CODE

Change to Attribute: Changed Description, Dataset

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

Note: [Notes:](#)

- National Code 160 '*Emergency Care Attendance*' is **only** valid for:
 - [CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#)
 - [CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#)
 - [CDS V6-2-2 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#)
 - [CDS V6-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#)
- National Code 160 '*Emergency Care Attendance*' is **only** valid for:
 - [CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#)
 - [CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#)
 - [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 140 '*Accident and Emergency Attendance*' will no longer be accepted from 01 November 2020.

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
140	Accident and Emergency Attendance
150	Future Outpatient
160	Emergency Care Attendance

CDS INTERCHANGE APPLICATION REFERENCE

Change to Attribute: Changed Dataset

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

National Codes:

NHSCDS CDS Interchange

CDS INTERCHANGE CONTROL COUNT

Change to Attribute: Changed Dataset

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

CDS INTERCHANGE CONTROL REFERENCE

Change to Attribute: Changed Dataset

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

CDS INTERCHANGE RECEIVER IDENTITY

Change to Attribute: Changed Dataset

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

CDS INTERCHANGE SENDER IDENTITY

Change to Attribute: Changed Dataset

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

CDS INTERCHANGE TEST INDICATOR

Change to Attribute: Changed Dataset

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

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

National Codes:

- 1 The whole Interchange contains Test data
- 0 The whole Interchange contains Production data
(zero)

CDS MESSAGE REFERENCE

Change to Attribute: Changed Dataset

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

CDS MESSAGE TYPE

Change to Attribute: Changed Dataset

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

National Codes:

- NHSCDS CDS Message

CDS MESSAGE VERSION NUMBER

Change to Attribute: Changed Description, Dataset

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

CDS PROTOCOL IDENTIFIER CODE

Change to Attribute: Changed Dataset

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

National Codes:

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

CDS TYPE CODE

Change to Attribute: Changed Description, Dataset

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

Note:Notes:

- National Code 11 '~~Emergency Care Attendance~~' is **only** valid for:
 - ~~CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol~~
 - ~~CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol~~
 - ~~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~~
- National Code 011 '~~Emergency Care Attendance~~' is **only** valid for:
 - ~~CDS V6-2-1 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol~~
 - ~~CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol~~
 - ~~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~~
- [CDS Type 010 'Accident and Emergency Attendance'](#) will no longer be accepted from 01 November 2020.

National Codes:

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

CDS UPDATE TYPE

Change to Attribute: Changed Dataset

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

National Codes:

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

CLINICAL CLASSIFICATION CODE

Change to Attribute: Changed Dataset

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

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

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

CLINICAL TERMINOLOGY CODE

Change to Attribute: Changed Dataset

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

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

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

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

CLINICAL TRIAL IDENTIFIER

Change to Attribute: Changed Dataset

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

CODED CLINICAL ENTRY SEQUENCE NUMBER

Change to Attribute: Changed Dataset

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

COMMISSIONER REFERENCE NUMBER

Change to Attribute: Changed Dataset

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

DECIDED TO ADMIT DATE

Change to Attribute: Changed Dataset

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

DECIDED TO ADMIT TIME

Change to Attribute: Changed Dataset

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

DIAGNOSIS SCHEME IN USE

Change to Attribute: Changed Description, Dataset

The type of [CODED CLINICAL ENTRY](#) used for the [PATIENT DIAGNOSIS](#).

Notes:

- National Code 01 '[Accident & Emergency Diagnosis](#)' is **not** valid for the [Community Services Data Set](#), [Maternity Services Data Set](#) and [Mental Health Services Data Set](#)
- National Code 04 '[Read Coded Clinical Terms](#) Version 2' is **not** valid for the [Mental Health Services Data Set](#)
- National Code 05 '[Read Coded Clinical Terms](#) Version 3 (CTV3)' (previously known as 3.1) is **not** supported in the Commissioning Data Sets and [Mental Health Services Data Set](#)
- National Code 06 '[SNOMED CT](#)' is **not** valid for Commissioning Data Set version 6-2.

National Codes:

- 04 [Accident & Emergency Diagnosis](#)
- 01 [Accident & Emergency Diagnosis \(Retired 01 November 2020\)](#)
- 02 [ICD-10](#)
- 03 [Read Code 4Byte Version \(retired 1 October 2009\)](#)
- 04 [Read Coded Clinical Terms](#) Version 2
- 05 [Read Coded Clinical Terms](#) Version 3 (CTV3)
- 06 [SNOMED CT](#)

EMERGENCY CARE ATTENDANCE CATEGORY

Change to Attribute: Changed Dataset

The category of [Emergency Care Attendance](#).

National Codes:

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

EMERGENCY CARE DEPARTMENT TYPE

Change to Attribute: Changed Description, Dataset

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

The [EMERGENCY CARE DEPARTMENT TYPE](#) definitions will be updated at the next iteration of [DCB0092-2062- Commissioning Data Sets: Emergency Care Data Set](#), to amend the National Code values to support the introduction of [Urgent Treatment Centres](#).

National Codes:

- 04 ~~Emergency departments are a [CONSULTANT](#) led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency [PATIENTS](#)~~
- 02 ~~Consultant led mono specialty accident and emergency service (e.g. ophthalmology, dental) with designated accommodation for the reception of [PATIENTS](#)~~
- 03 ~~Other type of A&E/minor injury [ACTIVITY](#) with designated accommodation for the reception of accident and emergency [PATIENTS](#). The department may be doctor led or [NURSE](#) led and treats at least minor injuries and illnesses and can be routinely accessed without [APPOINTMENT](#). A [SERVICE](#) mainly or entirely [APPOINTMENT](#) based (for example a [GP Practice](#) or [Out Patient Clinic](#)) is excluded even though it may treat a number of [PATIENTS](#) with minor illness or injury. Excludes NHS walk-in centres~~
- 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 V6-2-1 Type 011 – Emergency Care Commissioning Data Set](#) / [CDS V6-2-2 Type 011 – Emergency Care Commissioning Data Set](#) and must not be submitted in the [CDS V6-2 Type 010 – Accident and Emergency Commissioning Data Set](#) or the [Patient Level Information Costing System Acute Data Set – Emergency Care](#).~~
- 05 Ambulatory Emergency Care Service. Note this is **only** valid for piloting purposes in the [CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set](#) / [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 Acute Data Set - Emergency Care](#).

ETHNIC CATEGORY 2021

Change to Attribute: Changed Dataset

~~This item is being used for development purposes and has not yet been approved.~~ The ethnicity of a PERSON, as specified by the PERSON.

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

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

ETHNIC CATEGORY CODE 2001

Change to Attribute: Changed Dataset

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

[ETHNIC CATEGORY CODE 2001](#) is the classification used for the 2001 census.

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

National Codes:

White

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

Mixed

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

Asian or Asian British

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

Black or Black British

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

Other Ethnic Groups

- R Chinese
- S Any other ethnic group

- Z Not stated

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

EVENT DATE

Change to Attribute: Changed Dataset

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

EVENT TIME

Change to Attribute: Changed Description, Dataset

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

[This may include representation of a time zone.](#)

GENERAL MEDICAL PRACTITIONER PPD CODE

Change to Attribute: Changed Dataset

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

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

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

England and Wales General Medical Practitioner Code format

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

Scottish General Medical Practitioner Code format

Practitioner Code Type	Character Position								Allocated By	Allocated To	Known As	Notes
	1	2	3	4	5	6	7	8				

Scottish General Medical Practitioner Code	S	0-9	0-9	0-9	0-9	0-9	0-9	0-9	Information Standards Division (Scotland)	GMPs in Scotland	GMP	
--------------------------------------------------------	---	-----	-----	-----	-----	-----	-----	-----	----------------------------------------------------	---------------------	-----	--

Northern Ireland General Medical Practitioner Code format

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

GEOGRAPHIC CO-ORDINATE

Change to Attribute: Changed Dataset

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

INITIAL DIAGNOSIS CARE SETTING OR SERVICE FOR HIV

Change to Attribute: Changed Description

The type of care setting or [SERVICE](#) in the United Kingdom where the initial Human Immunodeficiency Virus (HIV) positive diagnostic test was performed.

Notes:

- National Code 06 '[Emergency Care Department \(including minor injuries department\)](#)' has been updated 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 it is not already correct.

National Codes:

- 01 Genitourinary Medicine (GUM) and/or Human Immunodeficiency Virus (HIV) clinic
- 02 Antenatal clinic
- 03 [General Medical Practitioner Practice](#)
- 04 Medical admissions for in-patient care
- 05 Infectious disease unit (outpatient only)
- 06 [Accident and Emergency Department \(including minor injuries department\)](#)
- 06 [Emergency Care Department \(including minor injuries department\)](#)
- 07 Other NHS Outpatient
- 08 Drug Misuse Service
- 09 [Prison](#)
- 10 Blood Transfusion Service
- 11 Other setting or [SERVICE](#) in the United Kingdom (not specified)
- 12 Community Setting
- 13 Home Testing
- 14 Self Sampling Service
- 15 Private Medical Clinic
- 16 [Pharmacy](#)

INVESTIGATION SCHEME IN USE (RETIRED), renamed from **INVESTIGATION SCHEME IN USE**

Change to Attribute: Changed Description, Dataset, Name, status to Retired

The type of [CODED CLINICAL ENTRY](#) used for basis of an investigation. **This item has been retired from the NHS Data Model and Dictionary.**

National Codes: **The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.**

04 Accident & Emergency Investigation

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.

INVESTIGATION SCHEME IN USE (RETIRED), renamed from **INVESTIGATION SCHEME IN USE**

Change to Attribute: Changed Description, Dataset, Name, status to Retired

- Changed Description
- null
- Changed Name from `Data_Dictionary.Attributes.I.Int.INVESTIGATION_SCHEME_IN_USE` to `Retired.Data_Dictionary.Attributes.I.INVESTIGATION_SCHEME_IN_USE`
- Retired INVESTIGATION SCHEME IN USE

LOCAL CARE PROFESSIONAL IDENTIFIER (RETIRED), renamed from **LOCAL CARE PROFESSIONAL IDENTIFIER**

Change to Attribute: Changed Description, Dataset, Name, status to Retired

A unique number or set of characters allocated to a [CARE PROFESSIONAL](#) by an [ORGANISATION](#) will not be recognised nationally. **This item has been retired from the NHS Data Model and Dictionary.**

The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

LOCAL CARE PROFESSIONAL IDENTIFIER (RETIRED), renamed from **LOCAL CARE PROFESSIONAL IDENTIFIER**

Change to Attribute: Changed Description, Dataset, Name, status to Retired

- Changed Description
- null
- Changed Name from `Data_Dictionary.Attributes.L.Lo.LOCAL_CARE_PROFESSIONAL_IDENTIFI` to `Retired.Data_Dictionary.Attributes.L.LOCAL_CARE_PROFESSIONAL_IDENTIFI`
- Retired LOCAL CARE PROFESSIONAL IDENTIFIER

LOCAL PATIENT IDENTIFIER

Change to Attribute: Changed Dataset

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

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

LODGING END TIME

Change to Attribute: Changed Description

The time that the responsibility for nursing care is transferred from an [Accident and Emergency Attendance](#) to a [WARD](#) thus ending the period as a [LODGED PATIENT](#). This will be the same as [ACTIVITY TIME](#) of type '[A and E DEPARTURE TIME](#)' if the [PATIENT](#) was lodged as a result of an [Accident and Emergency Attendance](#). The time that the responsibility for nursing care is transferred from an [Emergency Care Attendance](#) to a [WARD](#) thus ending the period as a [LODGED PATIENT](#). This will be the same as [ACTIVITY TIME](#) of type '[EMERGENCY CARE DEPARTURE TIME](#)' if the [PATIENT](#) was lodged as a result of an [Emergency Care Attendance](#).

The transfer of responsibility may occur when the [PATIENT](#) is received into a [Hospital Bed](#) in an appropriate [WARD](#), an [OPERATING THEATRE](#) or another setting for immediate treatment (e.g. an X-ray Department) before being received into a [Hospital Bed](#) in an appropriate [WARD](#).

A [Hospital Bed](#) in an Accident and Emergency observation and assessment [WARD](#) may be a transfer of responsibility but a trolley, bed or chair in a corridor would not.

LODGING START TIME

Change to Attribute: Changed Description

The time when medical staff with [RIGHTS OF ADMISSION](#) to [Hospital Beds](#) take clinical responsibility for a [PATIENT](#), but the [PATIENT](#) has to remain waiting in the nursing care of an [Accident and Emergency Department](#) until they can be transferred to a [WARD](#). The time when medical staff with [RIGHTS OF ADMISSION](#) to [Hospital Beds](#) take clinical responsibility for a [PATIENT](#), but the [PATIENT](#) has to remain waiting in the nursing care of an [Emergency Care Department](#) until they can be transferred to a [WARD](#). This starts a period of time as a [LODGED PATIENT](#).

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE

Change to Attribute: Changed Dataset

A code which identifies the [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION](#).

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

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

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Mental Health Act legal status findings simple reference set
- [Refset](#) Id: 99900307100000100

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

National Codes:

01	Informal
02	Formally detained under Mental Health Act Section 2
03	Formally detained under Mental Health Act Section 3
04	Formally detained under Mental Health Act Section 4
05	Formally detained under Mental Health Act Section 5(2)
06	Formally detained under Mental Health Act Section 5(4)
07	Formally detained under Mental Health Act Section 35
08	Formally detained under Mental Health Act Section 36
09	Formally detained under Mental Health Act Section 37 with section 41 restrictions
10	Formally detained under Mental Health Act Section 37
12	Formally detained under Mental Health Act Section 38
13	Formally detained under Mental Health Act Section 44
14	Formally detained under Mental Health Act Section 46
15	Formally detained under Mental Health Act Section 47 with section 49 restrictions
16	Formally detained under Mental Health Act Section 47
17	Formally detained under Mental Health Act Section 48 with section 49 restrictions
18	Formally detained under Mental Health Act Section 48

- 19 Formally detained under Mental Health Act Section 135
- 20 Formally detained under Mental Health Act Section 136
- 31 Formally detained under Criminal Procedure (Insanity) Act 1964 as amended by the Criminal Procedures (Insanity and Unfitness to Plead) Act 1991
- 32 Formally detained under other acts
- 33 Supervised Discharge (Mental Health (Patients in the Community) Act 1995) (Retired 03 November 2008 - but may apply to some patients until 3 May 2009)
- 34 Formally detained under Mental Health Act Section 45A (Retired 01 September 2014)
- 35 Subject to guardianship under Mental Health Act Section 7
- 36 Subject to guardianship under Mental Health Act Section 37
- 37 Formally detained under Mental Health Act Section 45A (Limited direction in force)
- 38 Formally detained under Mental Health Act Section 45A (Limitation direction ended)

NHS NUMBER

Change to Attribute: Changed Description, Dataset

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

This will not vary by any [ORGANISATION](#) of which a [PERSON](#) is a [PATIENT](#).

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

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

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

Digit Position

(starting from the left) Factor:

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

Step 2 Add the results of each multiplication together.

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

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

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

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

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

Note:

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

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

NHS NUMBER STATUS INDICATOR CODE

Change to Attribute: Changed Dataset

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

Note:

- National Code 08 'Trace postponed (baby under six weeks old)' is **not** valid for the [Improving Access to Psychological Therapies Data Set](#), [Maternity Services Data Set](#) and [Mental Health Services Data Set](#).

National Codes:

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

NHS SERVICE AGREEMENT LINE NUMBER

Change to Attribute: Changed Dataset

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

NHS SERVICE AGREEMENT NUMBER

Change to Attribute: Changed Dataset

A number used to uniquely identify a [NHS SERVICE AGREEMENT](#) by an [ORGANISATION](#) acting as commissioner of patient care services.

OBSERVATION VALUE

Change to Attribute: Changed Dataset

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

ORGANISATION CODE

Change to Attribute: Changed Dataset

An [ORGANISATION CODE](#) is a code which identifies an [ORGANISATION](#) uniquely.

[ORGANISATION CODES](#) are managed by:

- [Organisation Data Service \(ODS\)](#)
- [NHS Prescription Services](#)
- [NHS Dental Services](#).

Notes:

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

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

ORGANISATION IDENTIFIER

Change to Attribute: Changed Dataset

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

Note:

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

The Format/Length of a published code for an [ORGANISATION](#) is min an3 max an8.

ORGANISATION SITE CODE

Change to Attribute: Changed Dataset

An [ORGANISATION SITE CODE](#) is a code which identifies an [ORGANISATION SITE](#) uniquely.

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

Notes:

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

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

ORGANISATION SITE IDENTIFIER

Change to Attribute: Changed Dataset

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

Note:

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

The Format/Length of a published code for an [ORGANISATION SITE](#) is min an5 max an9.

OVERSEAS VISITOR CHARGING CATEGORY

Change to Attribute: Changed Dataset

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

See [Overseas Visitor Charging Category](#) for more information.

National Codes:

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

P Decision Pending on [OVERSEAS VISITOR CHARGING CATEGORY](#)

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

OVERSEAS VISITOR STATUS CLASSIFICATION

Change to Attribute: Changed Dataset

A classification of [OVERSEAS VISITOR STATUS](#).

National Codes:

- 1 Exempt from payment - subject to [Reciprocal Healthcare Agreement](#)
- 2 Exempt from payment - other
- 3 To pay hotel fees only
- 4 To pay all fees

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

PATIENT PATHWAY IDENTIFIER

Change to Attribute: Changed Dataset

An identifier, which together with the [ORGANISATION CODE](#) / [ORGANISATION IDENTIFIER](#) of the issuer, uniquely identifies a [PATIENT PATHWAY](#).

This is a specific type of the attribute [ACTIVITY IDENTIFIER](#).

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

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

PATIENT SOURCE SETTING TYPE FOR DIAGNOSTIC IMAGING

Change to Attribute: Changed Description

The type of setting that the [PATIENT](#) came from at the time of request for [Diagnostic Imaging](#) for use in the [Diagnostic Imaging Data Set](#).

Notes:

- National Code 05 '[Emergency Care Department \(this Health Care Provider\)](#)' has been updated 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 it is not already correct.

National Codes:

- 01 Admitted Patient Care - Inpatient (this [Health Care Provider](#)). This National Code is based on [INTENDED MANAGEMENT](#) at the time of the [DIAGNOSTIC TEST REQUEST](#).
- 02 Admitted Patient Care - Day case (this [Health Care Provider](#)). This National Code is based on [INTENDED MANAGEMENT](#) at the time of the [DIAGNOSTIC TEST REQUEST](#).
- 03 Outpatient (this [Health Care Provider](#))
- 04 GP Direct Access
- 05 ~~[Accident and Emergency Department \(this Health Care Provider\)](#)~~
- 05 [Emergency Care Department \(this Health Care Provider\)](#)
- 06 Other [Health Care Provider](#)
- 07 Other

PERSON AGE

Change to Attribute: Changed Dataset

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

PERSON BIRTH DATE

Change to Attribute: Changed Dataset

The date on which a [PERSON](#) was born or is officially deemed to have been born.

Note:

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

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

PERSON GENDER CODE

Change to Attribute: Changed Dataset

The classification is phenotypical rather than genotypical, i.e. it does not provide codes for medical or scientific purposes.

Notes:

- National Code '*Not Known*' means that the sex of a [PERSON](#) has not been recorded
- National Code '*Not Specified*' means indeterminate, i.e. unable to be classified as either male or female.

National Codes:

0	Not Known
1	Male
2	Female
9	Not Specified

Note:

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

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

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

PERSON NAME WORD TEXT

Change to Attribute: Changed Dataset

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

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

PERSON OBSERVATION TEXT STRING

Change to Attribute: Changed Dataset

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

PERSON PROPERTY EFFECTIVE END DATE

Change to Attribute: Changed Dataset

The date when a [PERSON PROPERTY](#) is no longer applicable to the [PATIENT](#).

PERSON PROPERTY EFFECTIVE END TIME

Change to Attribute: Changed Dataset

The time when a [PERSON PROPERTY](#) is no longer applicable to the [PATIENT](#).

PERSON PROPERTY EFFECTIVE START DATE

Change to Attribute: Changed Dataset

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

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

PERSON PROPERTY EFFECTIVE START TIME

Change to Attribute: Changed Dataset

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

PERSON PROPERTY RECORDED DATE

Change to Attribute: Changed Dataset

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

PERSON PROPERTY RECORDED TIME

Change to Attribute: Changed Description, Dataset

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

~~In a computerised system this data would be derived from the time the information was entered.~~ This may include a representation of a time zone.

~~This item is not referenced in a data set in the NHS Data Model and Dictionary. It has been retained to ensure the modelling is consistent.~~ In a computerised system this data would be derived from the time the information was entered.

PERSON SCORE

Change to Attribute: Changed Dataset

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

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

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

PERSON STATED GENDER CODE

Change to Attribute: Changed Dataset

The gender of a [PERSON](#).

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

National Codes:

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

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

PLANNED ACTIVITY DATE

Change to Attribute: Changed Dataset

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

The specific nature of the date will be identified by the [PLANNED ACTIVITY DATE TYPE](#).

PLANNED ACTIVITY DATE AND TIME TYPE

Change to Attribute: New Attribute

The type of date and time that defines the usage with regard to the [PLANNED ACTIVITY](#).

A [PLANNED ACTIVITY](#) may have many dates and times associated with it but may only have one date and time of a particular type.

National Codes:

- ?? [Emergency Care Expected Date and Timestamp of Treatment](#)

This attribute is also known by these names:

Context	Alias
plural	PLANNED ACTIVITY DATE AND TIME TYPES

PLANNED ACTIVITY TIME

Change to Attribute: New Attribute

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

This may include representation of a time zone.

This attribute is also known by these names:

Context	Alias
plural	PLANNED ACTIVITY TIMES

PLANNED ACTIVITY TIME

Change to Attribute: New Attribute

PLANNED ACTIVITY TIME

Data Elements:

EMERGENCY CARE EXPECTED DATE AND TIMESTAMP OF TREATMENT

POSTCODE

Change to Attribute: Changed Dataset

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

[POSTCODES](#) may also be used to identify a [GEOGRAPHIC AREA](#).

Note:

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

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

PRESENT ON ADMISSION INDICATOR

Change to Attribute: Changed Dataset

An indication of whether a [PATIENT DIAGNOSIS](#) was already present when the [PATIENT](#) started a [Hospital Provider Spell](#).

National Codes:

Y	PATIENT DIAGNOSIS already present
N	PATIENT DIAGNOSIS not already present

Note:

This data item is included in Commissioning Data Set version 6-2, but should not be submitted until further development by [NHS Digital](#) has been undertaken.

PROCEDURE SCHEME IN USE

Change to Attribute: Changed Dataset

The type of [CODED CLINICAL ENTRY](#) used for the [CLINICAL INTERVENTION](#).

Notes:

- The following National Codes are **not** valid for the [Community Services Data Set](#), [Maternity Services Data Set](#) and [Mental Health Services Data Set](#):
 - 01 'Accident & Emergency Treatment'
 - 02 'OPCS-4'
- National Code 05 '[Read Coded Clinical Terms](#) Version 3 (CTV3)' (previously known as 3.1) is **not** supported in the Commissioning Data Sets
- National Code 06 '[SNOMED CT](#)' is **not** valid for Commissioning Data Set version 6-2.

National Codes:

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

PROFESSIONAL REGISTRATION BODY CODE

Change to Attribute: Changed Dataset

A code which identifies the [PROFESSIONAL REGISTRATION BODY](#).

Notes:

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

National Codes:

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

PROFESSIONAL REGISTRATION ENTRY IDENTIFIER

Change to Attribute: Changed Dataset

The registration identifier allocated by an [ORGANISATION](#).

Examples include:

- [GENERAL DENTAL COUNCIL REGISTRATION NUMBER](#)
- [GENERAL MEDICAL COUNCIL REFERENCE NUMBER](#).

PROVIDER REFERENCE NUMBER

Change to Attribute: Changed Dataset

The number convention agreed locally between a provider and Commissioner for use within a Commissioning Data Set message.

RECORD IDENTIFIER

Change to Attribute: Changed Dataset

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

REFERRAL TO TREATMENT PERIOD END DATE

Change to Attribute: Changed Dataset

The end date of a [REFERRAL TO TREATMENT PERIOD](#).

This is a specific type of the attribute [ACTIVITY DATE](#).

[REFERRAL TO TREATMENT PERIOD END DATE](#) will be one of the following:

- the [ACTIVITY DATE](#):
 - when the [PATIENT](#) is admitted for [First Definitive Treatment](#). If the start of a [PATIENT](#)'s treatment is cancelled (by the [Health Care Provider](#) or [PATIENT](#)) after admission, the [REFERRAL TO TREATMENT PERIOD](#) will continue.
 - for [First Definitive Treatment](#) undertaken in an outpatient setting.
 - for [First Definitive Treatment](#) undertaken by an [NHS Allied Health Professional Service \(Referral To Treatment Measurement\)](#).
 - when the decision not to treat is made, with no further action at this time communicated to the [PATIENT](#). This will include [Discharge After Patient Did Not Attend](#) and discharge back to primary care for treatment.
 - when the [PATIENT](#) declines offered treatment.
 - when the [PATIENT](#) did not attend for the first [ACTIVITY](#) during a [REFERRAL TO TREATMENT PERIOD](#). See [REFERRAL TO TREATMENT PERIOD](#) for guidance on [PATIENTS](#) who do not attend.
 - the clinical decision is made (and agreed with the [PATIENT](#)) that [Active Monitoring](#) will begin. If a [PATIENT](#) subsequently requires further treatment this decision would start a new [REFERRAL TO TREATMENT PERIOD](#) as part of the same [PATIENT PATHWAY](#). This includes any treatment that is planned for a specific date in the future as ongoing monitoring.
 - a clinical decision is made and has been communicated to the [PATIENT](#), and subsequently their [GENERAL PRACTITIONER](#) and/or other referring [CARE PROFESSIONAL](#) without undue delay, to add the [PATIENT](#) to a transplant list.

or

- the [PERSON DEATH DATE](#).

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

REFERRAL TO TREATMENT PERIOD START DATE

Change to Attribute: Changed Description, Dataset

The start date of a [REFERRAL TO TREATMENT PERIOD](#).

This is a specific type of the attribute [ACTIVITY DATE](#).

A [REFERRAL TO TREATMENT PERIOD START DATE](#) will be one of the following:

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

Referral To Treatment Consultant Led Waiting Times:

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

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

A [REFERRAL TO TREATMENT PERIOD](#) may also start from [SERVICE REQUESTS](#) to [CONSULTANTS](#) from [GENERAL DENTAL PRACTITIONERS](#), [General Practitioners with Extended Roles](#), [OPTOMETRISTS](#) and [Orthoptists](#), [National Screening Programmes](#), [Specialist NURSES](#), other [CARE PROFESSIONALS](#) where commissioning [ORGANISATIONS](#) have approved these mechanisms locally.

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

~~A [REFERRAL TO TREATMENT PERIOD](#) will also start where [PATIENTS](#) are transferred to an elective [Consultant Led Service](#) through [SERVICE REQUESTS](#) from [Accident and Emergency Departments](#) including [Minor injuries units](#) and [Walk In Centres](#). A [REFERRAL TO TREATMENT PERIOD](#) will also start where [PATIENTS](#) are transferred to an elective [Consultant Led Service](#) through [SERVICE REQUESTS](#) from [Emergency Care Departments](#) including [Minor injuries units](#), [Walk In Centres](#) and [Urgent Treatment Centres](#).~~

Allied Health Professional Referral To Treatment Measurement:

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

Intermediate Care Measurement:

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

REFERRAL TO TREATMENT PERIOD STATUS

Change to Attribute: Changed Dataset

The status of an [ACTIVITY](#) (or anticipated [ACTIVITY](#)) for the [REFERRAL TO TREATMENT PERIOD](#) decided by the lead [CARE PROFESSIONAL](#).

Notes:

- National Code 33 '*End of the [REFERRAL TO TREATMENT PERIOD](#): Did not attend - the [PATIENT](#) did not attend the first [CARE ACTIVITY](#) after the referral*' may only be used where:
 - The [PATIENT](#) did not attend their first [APPOINTMENT](#) following the [REFERRAL REQUEST](#) that started the [REFERRAL TO TREATMENT PERIOD](#), provided that the [Health Care Provider](#) can demonstrate that the [APPOINTMENT](#) was clearly communicated to the [PATIENT](#).
 - [REFERRAL TO TREATMENT PERIODS](#) with [REFERRAL TO TREATMENT PERIOD STATUS](#) of National Code 33 are excluded from the measurement of the 18 weeks [Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#) and the count of [Allied Health Professional Referral To Treatment Measurement REFERRAL TO TREATMENT PERIODS](#).
- National Code 34 '*End of the [REFERRAL TO TREATMENT PERIOD](#): Decision not to treat - decision not to treat made or no further contact required*' includes a:
 - [Discharge After Patient Did Not Attend](#) the second or a subsequent [CARE ACTIVITY](#) after the referral
 - Change resulting in care no longer being commissioned by the English NHS
 - Referral to a [Consultant Led Service](#) during a [Referral To Treatment Period Excluded From Target](#) for the same condition, disease or injury. A new [REFERRAL TO TREATMENT PERIOD](#) will start.
- Where the [REFERRAL TO TREATMENT PERIOD STATUS](#) is National Code 99 '*REFERRAL TO TREATMENT PERIOD STATUS not yet known*', the status is treated as if the [ACTIVITY](#) is a subsequent [ACTIVITY](#) during a [REFERRAL TO TREATMENT PERIOD](#). In this case the [REFERRAL TO TREATMENT PERIOD STATUS](#) should be corrected once it is possible to determine the correct value.
- National Code descriptions have been updated to remove National Code headings and add prefixes where required. 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.
 - The explanation of the National Code description prefixes are:
 - First [ACTIVITY](#): The first [ACTIVITY](#) in a [REFERRAL TO TREATMENT PERIOD](#) where the [First Definitive Treatment](#) will be a subsequent [ACTIVITY](#)
 - Subsequent [ACTIVITY](#): Subsequent [ACTIVITY](#) during a [REFERRAL TO TREATMENT PERIOD](#)
 - End of the [REFERRAL TO TREATMENT PERIOD](#): [ACTIVITY](#) that ends the [REFERRAL TO TREATMENT PERIOD](#)
 - Not part of a [REFERRAL TO TREATMENT PERIOD](#): [ACTIVITY](#) that is not part of a [REFERRAL TO TREATMENT PERIOD](#).

National Codes:

10 First [ACTIVITY](#) in a [REFERRAL TO TREATMENT PERIOD](#)

- 11 First [ACTIVITY](#) at the start of a new [REFERRAL TO TREATMENT PERIOD](#) following [Active Monitoring](#)
- 12 First [ACTIVITY](#) at the start of a new [REFERRAL TO TREATMENT PERIOD](#) following a decision to refer directly to the [CONSULTANT](#) or [NHS Allied Health Professional Service \(Referral To Treatment Measurement\)](#) for a separate condition
- 20 Subsequent [ACTIVITY](#) during a [REFERRAL TO TREATMENT PERIOD](#) - further [ACTIVITIES](#) anticipated
- 21 Subsequent [ACTIVITY](#) by another [Health Care Provider](#) following a transfer to another [Health Care Provider](#) during a [REFERRAL TO TREATMENT PERIOD](#) anticipated
- 30 End of the [REFERRAL TO TREATMENT PERIOD](#): Start of [First Definitive Treatment](#)
- 31 End of the [REFERRAL TO TREATMENT PERIOD](#): Start of [Active Monitoring](#) initiated by the [PATIENT](#)
- 32 End of the [REFERRAL TO TREATMENT PERIOD](#): Start of [Active Monitoring](#) initiated by the [CARE PROFESSIONAL](#)
- 33 End of the [REFERRAL TO TREATMENT PERIOD](#): Did not attend - the [PATIENT](#) did not attend the first [CARE ACTIVITY](#) after the referral
- 34 End of the [REFERRAL TO TREATMENT PERIOD](#): Decision not to treat - decision not to treat made or no further contact required
- 35 End of the [REFERRAL TO TREATMENT PERIOD](#): [PATIENT](#) declined offered treatment
- 36 End of the [REFERRAL TO TREATMENT PERIOD](#): [PATIENT](#) died before treatment
- 90 Not part of a [REFERRAL TO TREATMENT PERIOD](#): After treatment - [First Definitive Treatment](#) occurred previously (e.g. admitted as an emergency from A&E or the [ACTIVITY](#) is after the start of treatment)
- 91 Not part of a [REFERRAL TO TREATMENT PERIOD](#): [CARE ACTIVITY](#) during [Active Monitoring](#)
- 92 Not part of a [REFERRAL TO TREATMENT PERIOD](#): Not yet referred for treatment, undergoing diagnostic tests by [GENERAL PRACTITIONER](#) before referral
- 98 Not part of a [REFERRAL TO TREATMENT PERIOD](#): [ACTIVITY](#) not applicable to [REFERRAL TO TREATMENT PERIODS](#)
- 99 [REFERRAL TO TREATMENT PERIOD STATUS](#) not yet known

SAFEGUARDING VULNERABILITY FACTORS TYPE

Change to Attribute: Changed Description

The type of [Child Safeguarding](#) vulnerability factors identified.

~~National Codes:~~Notes:

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

•
National Code 01 '[Repeat Emergency Care Attendances](#)' has been updated 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 it is not already correct.

~~National Codes:~~

- 01 [Repeat **Emergency Care Attendances**](#)
- 02 [Concerning parent child interaction](#)
- 03 [Worrying parent behaviour / Mental Health concerns](#)
- 04 [Worrying child behaviour](#)
- 05 [Self harm](#)
- 06 [Genital injury \(excluding Female Genital Mutilation \(FGM\)\)](#)

07	Referral from Social Services or Police
08	Previously known to Social Services
09	Significant injury in child (in the last 12 months)
10	Domestic abuse
11	History inconsistent with injuries
12	Disclosure of abuse
13	Bullying
14	Delay in presentation (Children with frequent minor injuries and there is a delay in presentation to medical staff)
15	Other (Retired 01 September 2015)
16	Female Genital Mutilation (FGM)
98	Other (not listed)

SOURCE OF ADMISSION

Change to Attribute: Changed Description

The source of admission to a [Hospital Provider Spell](#) or a [Nursing Episode](#) when the [PATIENT](#) is in a [Hospital Site](#) or a [Care Home](#).

National Code 51 '~~NHS other hospital provider - WARD for general PATIENTS or the younger physically disabled or A & E department~~' should not be used if the [PATIENT](#) arrives at an [Accident and Emergency Department](#) and is admitted to the same [Hospital Provider](#). National Code 51 '~~NHS other hospital provider - WARD for general PATIENTS or the younger physically disabled or Emergency Care Department~~' should not be used if the [PATIENT](#) arrives at an [Emergency Care Department](#) and is admitted to the same [Hospital Provider](#).

Notes:

- The following National Codes have been introduced for the [Mental Health Services Data Set](#) **only** to add further granularity to National Code 39 '~~Penal establishment, Court, or Police Station / Police Custody Suite~~'. However, National Code 39 is still valid for the [Mental Health Services Data Set](#) where extra detail cannot be collected:
 - 40 '~~Penal establishment~~'
 - 41 '~~Court~~'
 - 42 '~~Police Station / Police Custody Suite~~'
- National Code 79 '~~Babies born in or on the way to hospital~~' is **not** valid for the [Mental Health Services Data Set](#).
- National Code 79 '~~Babies born in or on the way to hospital~~' is **not** valid for the [Mental Health Services Data Set](#).
- National Code 51 '~~NHS other Hospital Provider - WARD for general PATIENTS or the younger physically disabled or Emergency Care Department~~' has been updated 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 it is not already correct.

National Codes:

19	Usual place of residence unless listed below, for example, a private dwelling whether owner occupied or owned by Local Authority , housing association or other landlord. This includes wardened accommodation but not residential accommodation where health care is provided. It also includes PATIENTS with no fixed abode.
29	Temporary place of residence when usually resident elsewhere (e.g. hotels, residential Educational Establishments)
39	Penal establishment, Court , or Police Station / Police Custody Suite
40	Penal establishment
41	Court
42	Police Station / Police Custody Suite
49	NHS other Hospital Provider - high security psychiatric accommodation in an NHS Hospital Provider (NHS Trust or NHS Foundation Trust)
51	NHS other Hospital Provider - WARD for general PATIENTS or the younger physically disabled or Emergency Care Department
52	NHS other Hospital Provider - WARD for maternity PATIENTS or Neonates
53	NHS other Hospital Provider - WARD for PATIENTS who are mentally ill or have Learning Disabilities
54	NHS run Care Home
65	Local Authority residential accommodation i.e. where care is provided
66	Local Authority foster care
79	Babies born in or on the way to hospital
85	Non-NHS (other than Local Authority) run Care Home
87	Non NHS run hospital
88	Non-NHS (other than Local Authority) run Hospice

~~National Codes:~~

- 19 Usual place of residence unless listed below, for example, a private dwelling whether owner-occupied or owned by [Local Authority](#), housing association or other landlord. This includes wardened accommodation but not residential accommodation where health care is provided. It also includes [PATIENTS](#) with no fixed abode.
- 20 Temporary place of residence when usually resident elsewhere (e.g. hotels, residential [Educational Establishments](#))
- 30 Penal establishment, [Court](#), or Police Station / [Police Custody Suite](#)
- 40 Penal establishment
- 41 [Court](#)
- 42 Police Station / [Police Custody Suite](#)
- 49 NHS other [Hospital Provider](#) – high security psychiatric accommodation in an NHS [Hospital Provider](#) ([NHS Trust](#) or [NHS Foundation Trust](#))
- 51 NHS other [Hospital Provider](#) – [WARD](#) for general [PATIENTS](#) or the younger physically disabled or A & E department
- 52 NHS other [Hospital Provider](#) – [WARD](#) for maternity [PATIENTS](#) or [Neonates](#)
- 53 NHS other [Hospital Provider](#) – [WARD](#) for [PATIENTS](#) who are mentally ill or have [Learning Disabilities](#)
- 54 NHS run [Care Home](#)
- 65 [Local Authority](#) residential accommodation i.e. where care is provided
- 66 [Local Authority](#) foster care
- 79 Babies born in or on the way to hospital
- 85 Non-NHS (other than [Local Authority](#)) run [Care Home](#)
- 87 Non-NHS run hospital
- 88 Non-NHS (other than [Local Authority](#)) run [Hospice](#)

SOURCE OF REFERRAL FOR A AND E (RETIRED), renamed from SOURCE OF REFERRAL FOR A AND E

Change to Attribute: Changed Description, Dataset, Name, status to Retired

The source of referral of each [Accident and Emergency Episode](#). This item has been retired from the NHS Data Model and Dictionary.

National Codes: The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

- 00 [GENERAL MEDICAL PRACTITIONER](#)
- 01 Self referral
- 02 [Local Authority](#) Social Services
- 03 Emergency services
- 04 Work
- 05 [Educational Establishment](#)
- 06 Police
- 07 [Health Care Provider](#): same or other
- 08 Other
- 92 [GENERAL DENTAL PRACTITIONER](#)
- 93 Community Dental Service

References:

National Purchasing Unit for Dental Service Increment For Teaching (SIFT), 1996.

Dental SIFT: Proposals for Minimum Data Set (MDS) requirements. 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.

SOURCE OF REFERRAL FOR A AND E (RETIRED), renamed from SOURCE OF REFERRAL FOR A AND E

Change to Attribute: Changed Description, Dataset, Name, status to Retired

- Changed Description
- null
- Changed Name from Data_Dictionary.Attributes.S.Smo.SOURCE_OF_REFERRAL_FOR_A_and_E to Retired.Data_Dictionary.Attributes.S.SOURCE_OF_REFERRAL_FOR_A_and_E
- Retired SOURCE OF REFERRAL FOR A and E

SOURCE OF REFERRAL FOR COMMUNITY

Change to Attribute: Changed Description

The source of a [SERVICE REQUEST](#) to a [Community Health Service](#).

Notes:

- National Code 05 '[Emergency Care Department \(including Minor Injuries Units, Walk In Centres and Urgent Treatment Centres\)](#)' has been updated 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 it is not already correct.

National Codes:

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

SOURCE OF REFERRAL FOR MATERNITY

Change to Attribute: Changed Description

The source of referral of the mother to the [Maternity Service](#) for the [Maternity Episode](#).

National Codes:Notes:

- 01 ~~[General Medical Practitioner Practice](#)~~
- 02 ~~Self referral~~
- 03 ~~Other [Maternity Service](#)~~
- 04 ~~[Early Pregnancy Unit \(EPU\)](#)~~
- 05 ~~[Accident and Emergency Department \(including Minor Injuries Units and Walk In Centres\)](#)~~
- 06 ~~[School](#)~~
- 07 ~~[Prison](#)~~
- 08 ~~Social Services~~
- 09 ~~[Health Visiting Service](#)~~
- 98 ~~Other (not listed)~~

- National Code 05 '[Emergency Care Department \(including Minor Injuries Units, Walk In Centres and Urgent Treatment Centres\)](#)' has been updated 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 it is not already correct.

National Codes:

- 01 [General Medical Practitioner Practice](#)

02	Self referral
03	Other Maternity Service
04	Early Pregnancy Unit (EPU)
05	Emergency Care Department (including Minor Injuries Units, Walk In Centres and Urgent Treatment Centres)
06	School
07	Prison
08	Social Services
09	Health Visiting Service
98	Other (not listed)

SOURCE OF REFERRAL FOR MENTAL HEALTH

Change to Attribute: Changed Description

The source of referral to a [Mental Health Service](#).

Notes:

- The following National Codes are for use in the [Improving Access to Psychological Therapies Data Set](#) **only**:
 - M8 'Other: Debt Agency'
 - N1 'Stepped up from low intensity [Improving Access to Psychological Therapies Service](#)'
 - N2 'Stepped down from high intensity [Improving Access to Psychological Therapies Service](#)'
- National Code N3 [Improving Access to Psychological Therapies Service](#) is **only** valid for use in the [Mental Health Services Data Set](#)
- ~~National Code descriptions have been updated to remove National Code headings and add prefixes where required. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.~~
- National Code descriptions have been updated to remove National Code headings and add prefixes where required. The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct
- National Code H1 'Acute Secondary Care: [Emergency Care Department](#)' has been updated 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 it is not already correct.

National Codes:

A1	Primary Health Care: General Medical Practitioner Practice
A2	Primary Health Care: Health Visitor
A3	Other Primary Health Care
A4	Primary Health Care: Maternity Service
B1	Self-Referral: Self
B2	Self-Referral: Carer/Relative
C1	Local Authority and Other Public Services: Social Services
C2	Local Authority and Other Public Services: Education Service / Educational Establishment
C3	Local Authority and Other Public Services: Housing Service
D1	Employer
D2	Employer: Occupational Health
E1	Justice System: Police
E2	Justice System: Courts
E3	Justice System: Probation Service
E4	Justice System: Prison
E5	Justice System: Court Liaison and Diversion Service
E6	Justice System: Youth Offending Team
F1	Child Health: School Nurse
F2	Child Health: Hospital-based Paediatrics
F3	Child Health: Community-based Paediatrics
G1	Independent sector - Medium Secure Inpatients
G2	Independent Sector - Low Secure Inpatients
G3	Other Independent Sector Mental Health Services
G4	Voluntary Sector
H1	Acute Secondary Care: Emergency Care Department
H2	Other secondary care specialty
I1	Temporary transfer from another Mental Health NHS Trust
I2	Permanent transfer from another Mental Health NHS Trust

Internal referrals from Community Mental Health Team (within own NHS Trust) (Retired 1 April 2020)

- J1 Community Mental Health Team (Adult Mental Health) (Retired 1 April 2020)
- J2 Community Mental Health Team (Older People) (Retired 1 April 2020)
- J3 Community Mental Health Team (Learning Disabilities) (Retired 1 April 2020)
- J4 Community Mental Health Team (Child and Adolescent Mental Health) (Retired 1 April 2020)

Internal referrals from Inpatient Service (within own NHS Trust) (Retired 1 April 2020)

- K1 Inpatient Service (Adult Mental Health) (Retired 1 April 2020)
- K2 Inpatient Service (Older People) (Retired 1 April 2020)
- K3 Inpatient Service (Forensics) (Retired 1 April 2020)
- K4 Inpatient Service (Child and Adolescent Mental Health) (Retired 1 April 2020)
- K5 Inpatient Service (Learning Disabilities) (Retired 1 April 2020)

Transfer by graduation (within own NHS Trust) (Retired 1 April 2020)

- L1 Transfer by graduation from Child and Adolescent Mental Health Service to Adult Mental Health Services (Retired 1 April 2020)
- L2 Transfer by graduation from Adult Mental Health Services to Older Peoples Mental Health Services (Retired 1 April 2020)
- M1 Other: Asylum Services
- M2 Other: Telephone or Electronic Access Service
- M3 Other: Out of Area Agency
- M4 Other: Drug Action Team / Drug Misuse Agency
- M5 Other: Jobcentre Plus
- M6 Other SERVICE or agency
- M7 Other: Single Point of Access Service
- M8 Other: Debt Agency
- N1 Stepped up from low intensity Improving Access to Psychological Therapies Service
- N2 Stepped down from high intensity Improving Access to Psychological Therapies Service
- N3 Improving Access to Psychological Therapies Service
- P1 Internal Referral

National Codes:

- A1 Primary Health Care: General Medical Practitioner Practice
- A2 Primary Health Care: Health Visitor
- A3 Other Primary Health Care
- A4 Primary Health Care: Maternity Service
- B1 Self Referral: Self
- B2 Self Referral: Carer/Relative
- C1 Local Authority and Other Public Services: Social Services
- C2 Local Authority and Other Public Services: Education Service / Educational Establishment
- C3 Local Authority and Other Public Services: Housing Service
- D1 Employer
- D2 Employer: Occupational Health
- E1 Justice System: Police
- E2 Justice System: Courts
- E3 Justice System: Probation Service
- E4 Justice System: Prison
- E5 Justice System: Court Liaison and Diversion Service
- E6 Justice System: Youth Offending Team
- F1 Child Health: School Nurse
- F2 Child Health: Hospital-based Paediatrics
- F3 Child Health: Community-based Paediatrics
- G1 Independent sector – Medium Secure Inpatients
- G2 Independent Sector – Low Secure Inpatients
- G3 Other Independent Sector: Mental Health Services
- G4 Voluntary Sector
- H1 Acute Secondary Care: Accident and Emergency Department
- H2 Other secondary care specialty
- I1 Temporary transfer from another Mental Health NHS Trust
- I2 Permanent transfer from another Mental Health NHS Trust
- ~~Internal referrals from Community Mental Health Team (within own NHS Trust) (Retired 1 April 2020)~~
- J1 Community Mental Health Team (Adult Mental Health) (Retired 1 April 2020)

J2	Community Mental Health Team (Older People) (Retired 1 April 2020)
J3	Community Mental Health Team (Learning Disabilities) (Retired 1 April 2020)
J4	Community Mental Health Team (Child and Adolescent Mental Health) (Retired 1 April 2020)
	Internal referrals from Inpatient Service (within own NHS Trust) (Retired 1 April 2020)
K1	Inpatient Service (Adult Mental Health) (Retired 1 April 2020)
K2	Inpatient Service (Older People) (Retired 1 April 2020)
K3	Inpatient Service (Forensics) (Retired 1 April 2020)
K4	Inpatient Service (Child and Adolescent Mental Health) (Retired 1 April 2020)
K5	Inpatient Service (Learning Disabilities) (Retired 1 April 2020)
	Transfer by graduation (within own NHS Trust) (Retired 1 April 2020)
L1	Transfer by graduation from Child and Adolescent Mental Health Service to Adult Mental Health Services (Retired 1 April 2020)
L2	Transfer by graduation from Adult Mental Health Services to Older Peoples Mental Health Services (Retired 1 April 2020)
M1	Other: Asylum Services
M2	Other: Telephone or Electronic Access Service
M3	Other: Out of Area Agency
M4	Other: Drug Action Team / Drug Misuse Agency
M5	Other: Jobcentre Plus
M6	Other: SERVICE or agency
M7	Other: Single Point of Access Service
M8	Other: Debt Agency
N1	Stepped up from low intensity Improving Access to Psychological Therapies Service
N2	Stepped down from high intensity Improving Access to Psychological Therapies Service
N3	Improving Access to Psychological Therapies Service
P1	Internal Referral

SOURCE OF REFERRAL FOR OUT-PATIENTS

Change to Attribute: Changed Description

The source of referral of each [Consultant Out-Patient Episode](#).

Notes:

- National Code 12 'referral from a [General Practitioner with an Extended Role \(GPwER\)](#) or [Dentist with Enhanced Skills \(DES\)](#)' has been updated in [Data Dictionary Change Notice 1752 "Practitioners with a Special Interest Name Change"](#). The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.
- National Code descriptions have been updated to remove National Code headings and add prefixes where required. 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.
 - The explanation of the National Code description prefixes are:
 - [CONSULTANT](#) initiated: Initiated by the [CONSULTANT](#) responsible for the [Consultant Out-Patient Episode](#)
 - [CONSULTANT](#) not initiated: Not initiated by the [CONSULTANT](#) responsible for the [Consultant Out-Patient Episode](#).
- Where a [PATIENT](#) is referred by a [GENERAL PRACTITIONER](#) acting in the capacity of a [General Practitioner with an Extended Role \(GPwER\)](#), National Code 12 '[CONSULTANT](#) not initiated following a referral from a [General Practitioner with an Extended Role \(GPwER\)](#) or [Dentist with Enhanced Skills \(DES\)](#)' should be used.
- Where a [PATIENT](#) is referred by that [GENERAL PRACTITIONER](#) acting in their capacity as an ordinary [GENERAL MEDICAL PRACTITIONER](#), or as an ordinary [GENERAL DENTAL PRACTITIONER](#), National Code 03 '[CONSULTANT](#) not initiated following a referral from a [GENERAL MEDICAL PRACTITIONER](#)' or National Code 92 '[CONSULTANT](#) not initiated following a referral from a [GENERAL DENTAL PRACTITIONER](#)' should be used as appropriate.
- Two Week Wait Referrals made by Specialist [NURSES](#) in Primary Care, under the authority of the [GENERAL MEDICAL PRACTITIONER](#) leading their team, should continue to be classified as referrals from the [GENERAL PRACTITIONER](#) (National Code 03 '[CONSULTANT](#) not initiated following a referral from a [GENERAL MEDICAL PRACTITIONER](#)'). Referrals from Specialist [NURSES](#) in Secondary Care should be classified as National Code 13 '[CONSULTANT](#) not initiated following a referral from a Specialist [NURSE \(Secondary Care\)](#)'.
- Two Week Wait Referrals made by Specialist [NURSES](#) in Primary Care, under the authority of the [GENERAL MEDICAL PRACTITIONER](#) leading their team, should continue to be classified as referrals from the [GENERAL PRACTITIONER](#) (National Code 03 '[CONSULTANT](#) not initiated following a referral from a [GENERAL MEDICAL PRACTITIONER](#)'). Referrals from Specialist [NURSES](#) in Secondary Care should be classified as National Code 13 '[CONSULTANT](#) not initiated following a referral from a Specialist [NURSE \(Secondary Care\)](#)'.
- The following National Codes have been updated in DCB0092-2062: Commissioning Data Sets: Emergency Care Data Set. The Data Set specifications that contain these items will be updated in the next version of the Information Standard where it is not already correct:
 - 10 '[CONSULTANT](#) initiated following an [Emergency Care Attendance \(including Minor Injuries Units, Walk In Centres and Urgent Treatment Centres\)](#)'
 - 04 '[CONSULTANT](#) not initiated following a referral from a [General Practitioner with an Extended Role \(GPwER\)](#) or [Dentist with Enhanced Skills \(DES\)](#)'
 - 05 '[CONSULTANT](#) not initiated following a referral from a [CONSULTANT](#), other than in an [Emergency Care Department](#)'.

National Codes:

- 01 [CONSULTANT](#) initiated following an emergency admission
- 02 [CONSULTANT](#) initiated following a [Domiciliary Consultation](#)
- 40 [CONSULTANT](#) initiated following an [Accident and Emergency Attendance](#) (including Minor Injuries Units and Walk In Centres)
- 10 [CONSULTANT](#) initiated following an [Emergency Care Attendance](#) (including Minor Injuries, Walk In Centres and [Urgent Treatment Centres](#))
- 11 [CONSULTANT](#) initiated: Other (not listed)
- 03 [CONSULTANT](#) not initiated following a referral from a [GENERAL MEDICAL PRACTITIONER](#)
- 92 [CONSULTANT](#) not initiated following a referral from a [GENERAL DENTAL PRACTITIONER](#)
- 12 [CONSULTANT](#) not initiated following a referral from a [General Practitioner with an Extended Role \(GPwER\)](#) or [Dentist with Enhanced Skills \(DES\)](#)
- 04 [CONSULTANT](#) not initiated following a referral from an [Accident and Emergency Department](#) (including Minor Injuries Units and Walk In Centres)
- 05 [CONSULTANT](#) not initiated following a referral from a [CONSULTANT](#), other than in an [Accident and Emergency Department](#)
- 04 [CONSULTANT](#) not initiated following a referral from an [Emergency Care Department](#) (including Minor Injuries Units, Walk In Centres and [Urgent Treatment Centres](#))
- 05 [CONSULTANT](#) not initiated following a referral from a [CONSULTANT](#), other than in an [Emergency Care Department](#)
- 06 [CONSULTANT](#) not initiated following a self-referral
- 07 [CONSULTANT](#) not initiated following a referral from a [Prosthetist](#)
- 13 [CONSULTANT](#) not initiated following a referral from a Specialist [NURSE](#) (Secondary Care)
- 14 [CONSULTANT](#) not initiated following a referral from an Allied Health Professional
- 15 [CONSULTANT](#) not initiated following a referral from an [OPTOMETRIST](#)
- 16 [CONSULTANT](#) not initiated following a referral from an [Orthoptist](#)
- 17 [CONSULTANT](#) not initiated following a referral from a National [Screening Programme](#)
- 93 [CONSULTANT](#) not initiated following a referral from a Community Dental Service
- 97 [CONSULTANT](#) not initiated following a referral: Other (not listed)

TREATMENT FUNCTION CODE

Change to Attribute: Changed Dataset

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

[TREATMENT FUNCTION CODE](#) is recorded to report the specialised service within which the [PATIENT](#) is treated.

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

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

[TREATMENT FUNCTION CODES](#) should be used for all data sets/collections unless otherwise stated e.g. [National Workforce Data Set](#) uses [MAIN SPECIALTY CODES](#).

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

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

Assigning a Treatment Function Code:

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

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

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

Note:

- New National Codes for [TREATMENT FUNCTION CODE](#) were introduced from 2 April 2020 as part of the update to the [DCB0028: Treatment Function and Main Specialty Standard](#).
 - Page 8 of the "Change Specification" provides a list of the new [TREATMENT FUNCTION CODES](#).
 - Note that new codes should not be reported nationally until the functionality to do so becomes available in the next release of the affected data sets and any associated XML Schemas.
 - Prior to these updates, health and care [ORGANISATIONS](#) must review the impact of this information standard and make appropriate changes to local health IT systems from 2 April 2020 and before 1 April 2021.
 - Where new National Codes are recorded locally, these will need to be mapped to an appropriate existing code for transmission and reporting purposes.

National Codes:

100	General Surgery Service
101	Urology Service
102	Transplant Surgery Service
103	Breast Surgery Service
104	Colorectal Surgery Service
105	Hepatobiliary and Pancreatic Surgery Service
106	Upper Gastrointestinal Surgery Service
107	Vascular Surgery Service
108	Spinal Surgery Service
109	Bariatric Surgery Service
110	Trauma and Orthopaedic Service
111	Orthopaedic Service
113	Endocrine Surgery Service
115	Trauma Surgery Service
120	Ear Nose and Throat Service
130	Ophthalmology Service
140	Oral Surgery Service
141	Restorative Dentistry Service
143	Orthodontic Service
144	Maxillofacial Surgery Service
145	Oral and Maxillofacial Surgery Service
149	not a Treatment Function
150	Neurosurgical Service
160	Plastic Surgery Service
161	Burns Care Service
170	Cardiothoracic Surgery Service
172	Cardiac Surgery Service
173	Thoracic Surgery Service
174	Cardiothoracic Transplantation Service
191	Pain Management Service
142	Paediatric Dentistry Service
171	Paediatric Surgery Service
211	Paediatric Urology Service
212	Paediatric Transplantation Surgery Service
213	Paediatric Gastrointestinal Surgery Service
214	Paediatric Trauma and Orthopaedic Service
215	Paediatric Ear Nose and Throat Service
216	Paediatric Ophthalmology Service
217	Paediatric Oral and Maxillofacial Surgery Service
218	Paediatric Neurosurgery Service
219	Paediatric Plastic Surgery Service
220	Paediatric Burns Care Service

221 Paediatric Cardiac Surgery Service
222 Paediatric Thoracic Surgery Service
223 Paediatric Epilepsy Service
230 Paediatric Clinical Pharmacology Service
240 Paediatric Palliative Medicine Service
241 Paediatric Pain Management Service
242 Paediatric Intensive Care Service
250 Paediatric Hepatology Service
251 Paediatric Gastroenterology Service
252 Paediatric Endocrinology Service
253 Paediatric Clinical Haematology Service
254 Paediatric Audio Vestibular Medicine Service
255 Paediatric Clinical Immunology and Allergy Service
256 Paediatric Infectious Diseases Service
257 Paediatric Dermatology Service
258 Paediatric Respiratory Medicine Service
259 Paediatric Nephrology Service
260 Paediatric Medical Oncology Service
261 Paediatric Inherited Metabolic Medicine Service
262 Paediatric Rheumatology Service
263 Paediatric Diabetes Service
264 Paediatric Cystic Fibrosis Service
270 Paediatric Emergency Medicine Service
280 Paediatric Interventional Radiology Service
290 Community Paediatric Service
291 Paediatric Neurodisability Service
321 Paediatric Cardiology Service
421 Paediatric Neurology Service
180 Emergency Medicine Service
190 Anaesthetic Service
192 Intensive Care Medicine Service
200 Aviation and Space Medicine Service
300 General Internal Medicine Service
301 Gastroenterology Service
302 Endocrinology Service
303 Clinical Haematology Service
304 Clinical Physiology Service
305 Clinical Pharmacology Service
306 Hepatology Service
307 Diabetes Service
308 Blood and Marrow Transplantation Service
309 Haemophilia Service
310 Audio Vestibular Medicine Service
311 Clinical Genetics Service
312 not a Treatment Function
313 Clinical Immunology and Allergy Service
314 Rehabilitation Medicine Service
315 Palliative Medicine Service
316 Clinical Immunology Service
317 Allergy Service
318 Intermediate Care Service
319 Respite Care Service
320 Cardiology Service
322 Clinical Microbiology Service
323 Spinal Injuries Service
324 Anticoagulant Service
325 Sport and Exercise Medicine Service
326 Acute Internal Medicine Service
327 Cardiac Rehabilitation Service
328 Stroke Medicine Service

329 Transient Ischaemic Attack Service
330 Dermatology Service
331 Congenital Heart Disease Service
333 Rare Disease Service
335 Inherited Metabolic Medicine Service
340 Respiratory Medicine Service
341 Respiratory Physiology Service
342 Pulmonary Rehabilitation Service
343 Adult Cystic Fibrosis Service
344 Complex Specialised Rehabilitation Service
345 Specialist Rehabilitation Service
346 Local Specialist Rehabilitation Service
347 Sleep Medicine Service
350 Infectious Diseases Service
352 Tropical Medicine Service
360 Genitourinary Medicine Service
361 Renal Medicine Service
370 Medical Oncology Service
371 Nuclear Medicine Service
400 Neurology Service
401 Clinical Neurophysiology Service
410 Rheumatology Service
420 Paediatric Service
422 Neonatal Critical Care Service
424 Well Baby Service
430 Elderly Medicine Service
431 Orthogeriatric Medicine Service
450 Dental Medicine Service
451 Special Care Dentistry Service
460 Medical Ophthalmology Service
461 Ophthalmic and Vision Science Service
500 not a Treatment Function
501 Obstetrics Service
502 Gynaecology Service
503 Gynaecological Oncology Service
504 Community Sexual and Reproductive Health Service
505 Fetal Medicine Service
510 Retired
520 Retired
560 Midwifery Service
600 not a Treatment Function
601 not a Treatment Function
610 Retired
620 Retired
656 Clinical Psychology Service
700 Intellectual Disability Service
710 Adult Mental Health Service
711 Child and Adolescent Psychiatry Service
712 Forensic Psychiatry Service
713 Medical Psychotherapy Service
715 Old Age Psychiatry Service
720 Eating Disorders Service
721 Addiction Service
722 Liaison Psychiatry Service
723 Psychiatric Intensive Care Service
724 Perinatal Mental Health Service
725 Mental Health Recovery and Rehabilitation Service
726 Mental Health Dual Diagnosis Service
727 Dementia Assessment Service
730 Neuropsychiatry Service

800 Clinical Oncology Service
810 not a Treatment Function
811 Interventional Radiology Service
812 Diagnostic Imaging Service
820 not a Treatment Function
821 not a Treatment Function
822 Chemical Pathology Service
823 not a Treatment Function
824 not a Treatment Function
830 not a Treatment Function
831 not a Treatment Function
832 Retired
834 Medical Virology Service
650 Physiotherapy Service
651 Occupational Therapy Service
652 Speech and Language Therapy Service
653 Podiatry Service
654 Dietetics Service
655 Orthoptics Service
657 Prosthetics Service
658 Orthotics Service
659 Dramatherapy Service
660 Art Therapy Service
661 Music Therapy Service
662 Optometry Service
663 Podiatric Surgery Service
670 Urological Physiology Service
673 Vascular Physiology Service
675 Cardiac Physiology Service
677 Gastrointestinal Physiology Service
840 Audiology Service
900 not a Treatment Function
901 not a Treatment Function
902 not a Treatment Function
903 not a Treatment Function
904 not a Treatment Function
920 Diabetic Education Service
950 not a Treatment Function
960 not a Treatment Function
990 Retired

UCUM UNIT OF MEASUREMENT

Change to Attribute: Changed Dataset

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

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

UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)

Change to Attribute: Changed Dataset

The unique booking reference number assigned by the [Choose and Book](#) system when a [PATIENT](#) accepts an [APPOINTMENT DATE OFFERED](#) of an [APPOINTMENT OFFER](#) where the offer was made via the [Choose and Book](#) system.

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

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

WAITING TIME MEASUREMENT TYPE

Change to Attribute: Changed Dataset

The type of waiting time measurement methodology which may be applied during a [PATIENT PATHWAY](#).

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

Notes:

- National Code 01 '[Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#)' is **not** valid for the [Mental Health Services Data Set](#)
- The following National Codes are **only** valid for the [Community Services Data Set](#):
 - National Code 05 '[Crisis Response Intermediate Care Within 2 Hours Waiting Time Measurement](#)'
 - National Code 06 '[Other Intermediate Care Within 2 Days Waiting Time Measurement](#)'
 - National Code 07 '[Crisis Response Intermediate Care Waiting Time Measurement](#)'
 - National Code 08 '[Other Intermediate Care Waiting Time Measurement](#)'.

National Codes:

- 01 [Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#)
- 02 [Allied Health Professional Referral To Treatment Measurement](#)
- 03 Improving Access to Psychological Therapies Referral To Treatment Measurement (Retired 1 April 2020)
- 04 Early Intervention in Psychosis Waiting Time Measurement (Retired 1 April 2020)
- 05 [Crisis Response Intermediate Care Within 2 Hours Waiting Time Measurement](#)
- 06 [Other Intermediate Care Within 2 Days Waiting Time Measurement](#)
- 07 [Crisis Response Intermediate Care Waiting Time Measurement](#)
- 08 [Other Intermediate Care Waiting Time Measurement](#)
- 09 Other Referral To Treatment Measurement Type (not listed)

WITHHELD IDENTITY REASON

Change to Attribute: Changed Dataset

A code used in the Data Group 'Withheld Identity Structure' in the Commissioning Data Sets (version 6-2 onwards) to allow suppliers of [Commissioning Data Set](#) records to indicate to recipients of the record (for example, the Commissioner of the [ACTIVITY](#)) that the record has been purposely anonymised for a valid reason.

National Codes:

- 01 Record anonymised for legal/statutory reasons
- 02 Record anonymised at request of Caldicott Guardian
- 03 Record anonymised at request of [PATIENT](#)
- 97 Record anonymised for other reason

A AND E ATTENDANCE CONCLUSION TIME (RETIRED), renamed from A AND E ATTENDANCE CONCLUSION TIME

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

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

Notes:

[A and E ATTENDANCE CONCLUSION TIME](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Accident and Emergency Attendance Conclusion Time](#)'. **This item has been retired from the NHS Data Model and Dictionary.**

The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

A AND E ATTENDANCE CONCLUSION TIME (RETIRED), renamed from A AND E ATTENDANCE CONCLUSION TIME

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

A and E ATTENDANCE CONCLUSION TIME

Attribute:

[ACTIVITY TIME](#)

A AND E ATTENDANCE CONCLUSION TIME (RETIRED), renamed from A AND E ATTENDANCE CONCLUSION TIME

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.A_and_E_ATTENDANCE_CONCLUSION_TIME to Retired.Data_Dictionary.Data_Field_Notes.A.A_and_E_ATTENDANCE_CONCLUSION_TIME
- Retired A and E ATTENDANCE CONCLUSION TIME

A AND E ATTENDANCE NUMBER (RETIRED), renamed from A AND E ATTENDANCE NUMBER

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

Format/Length:	an12
National Codes:	
Default Codes:	

Notes:

[A and E ATTENDANCE NUMBER](#) is same as attribute [ACTIVITY IDENTIFIER](#).

[A and E ATTENDANCE NUMBER](#) is a number allocated by an [Accident and Emergency Department](#) to provide a unique identifier for each [Accident and Emergency Attendance](#). This item has been retired from the NHS Data Model and Dictionary.

The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

A AND E ATTENDANCE NUMBER (RETIRED), renamed from A AND E ATTENDANCE NUMBER

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

A and E ATTENDANCE NUMBER

Attribute:

[ACTIVITY IDENTIFIER](#)

A AND E ATTENDANCE NUMBER (RETIRED), renamed from A AND E ATTENDANCE NUMBER

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.A_and_E_ATTENDANCE_NUMBER to Retired.Data_Dictionary.Data_Field_Notes.A.A_and_E_ATTENDANCE_NUMBER
- Retired A and E ATTENDANCE NUMBER

A AND E DEPARTMENT TYPE (RETIRED), renamed from A AND E DEPARTMENT TYPE

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

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

Notes:

[A and E DEPARTMENT TYPE](#) is the same as attribute [ACCIDENT AND EMERGENCY DEPARTMENT TYPE](#). This item has been retired from the NHS Data Model and Dictionary.

The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

A AND E DEPARTMENT TYPE (RETIRED), renamed from A AND E DEPARTMENT TYPE

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

A and E DEPARTMENT TYPE

Attribute:

ACCIDENT AND EMERGENCY DEPARTMENT TYPE

A AND E DEPARTMENT TYPE (RETIRED), renamed from A AND E DEPARTMENT TYPE

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.A_and_E_DEPARTMENT_TYPE to Retired.Data_Dictionary.Data_Field_Notes.A.A_and_E_DEPARTMENT_TYPE
- Retired A and E DEPARTMENT TYPE

A AND E DEPARTURE TIME (RETIRED), renamed from A AND E DEPARTURE TIME

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

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

Notes:

[A and E DEPARTURE TIME](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Accident and Emergency Departure Time](#)'. This item has been retired from the NHS Data Model and Dictionary.

The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

A AND E DEPARTURE TIME (RETIRED), renamed from A AND E DEPARTURE TIME

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

A and E DEPARTURE TIME

Attribute:

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ACTIVITY TIME

A AND E DEPARTURE TIME (RETIRED), renamed from A AND E DEPARTURE TIME

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.A_and_E_DEPARTURE_TIME to Retired.Data_Dictionary.Data_Field_Notes.A.A_and_E_DEPARTURE_TIME
- Retired A and E DEPARTURE TIME

A AND E INCIDENT LOCATION TYPE (RETIRED), renamed from A AND E INCIDENT LOCATION TYPE

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

Format/Length:	an2
National Codes:	See ACCIDENT AND EMERGENCY INCIDENT LOCATION TYPE
Default Codes:	

Notes:

~~A and E INCIDENT LOCATION TYPE is the same as attribute ACCIDENT AND EMERGENCY INCIDENT LOCATION TYPE.~~

The National Codes are not mutually exclusive; for example, an accident could happen at work which is also a [School](#). **This item has been retired from the NHS Data Model and Dictionary.**

In such cases, the selection of the National Code should be based on the status of the [PATIENT](#). **The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.**

If the [PATIENT](#): **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.**

- is a member of staff of the school, the [A and E INCIDENT LOCATION TYPE](#) would be *Work*;
- is a student, the [A and E INCIDENT LOCATION TYPE](#) would be *Educational Establishment*.

A AND E INCIDENT LOCATION TYPE (RETIRED), renamed from A AND E INCIDENT LOCATION TYPE

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

A and E INCIDENT LOCATION TYPE

Attribute:

ACCIDENT AND EMERGENCY INCIDENT LOCATION TYPE

A AND E INCIDENT LOCATION TYPE (RETIRED), renamed from A AND E INCIDENT LOCATION TYPE

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.A_and_E_INCIDENT_LOCATION_TYPE to Retired.Data_Dictionary.Data_Field_Notes.A.A_and_E_INCIDENT_LOCATION_TYPE
- Retired A and E INCIDENT LOCATION TYPE

A AND E INITIAL ASSESSMENT TIME (RETIRED), renamed from A AND E INITIAL ASSESSMENT TIME

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

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

Notes:

~~[A and E INITIAL ASSESSMENT TIME](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Accident and Emergency Initial Assessment Time](#)'.~~

This item has been retired from the NHS Data Model and Dictionary.

The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

A AND E INITIAL ASSESSMENT TIME (RETIRED) renamed from A AND E INITIAL ASSESSMENT TIME

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

A and E INITIAL ASSESSMENT TIME

Attribute:

[ACTIVITY TIME](#)

A AND E INITIAL ASSESSMENT TIME (RETIRED) renamed from A AND E INITIAL ASSESSMENT TIME

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.A_and_E_INITIAL_ASSESSMENT_TIME to Retired.Data_Dictionary.Data_Field_Notes.A.A_and_E_INITIAL_ASSESSMENT_TIME
- Retired A and E INITIAL ASSESSMENT TIME

A AND E PATIENT GROUP (RETIRED) renamed from A AND E PATIENT GROUP

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

Format/Length:	an2
National Codes:	See A AND E PATIENT GROUP
Default Codes:	

Notes:

~~[A and E PATIENT GROUP](#) is the same as attribute [A AND E PATIENT GROUP](#).~~ **This item has been retired from the NHS Data Model and Dictionary.**

The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

A AND E PATIENT GROUP (RETIRED) renamed from A AND E PATIENT GROUP

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

A and E PATIENT GROUP

Attribute:

[A AND E PATIENT GROUP](#)

A AND E PATIENT GROUP (RETIRED) renamed from A AND E PATIENT GROUP

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.A_and_E_PATIENT_GROUP to Retired.Data_Dictionary.Data_Field_Notes.A.A_and_E_PATIENT_GROUP
- Retired A and E PATIENT GROUP

A AND E STAFF MEMBER CODE (RETIRED), renamed from A AND E STAFF MEMBER CODE

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

Format/Length:	an3
National Codes:	
Default Codes:	

Notes:

~~A and E STAFF MEMBER CODE is the same as attribute [CARE PROFESSIONAL IDENTIFIER](#).~~

~~A and E STAFF MEMBER CODE is a locally determined code used to identify the [PERSON](#) principally responsible for the care of a [PATIENT](#) during an [Accident and Emergency Attendance](#). This item has been retired from the NHS Data Model and Dictionary.~~

The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

A AND E STAFF MEMBER CODE (RETIRED), renamed from A AND E STAFF MEMBER CODE

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

A and E STAFF MEMBER CODE

Attribute:

LOCAL CARE PROFESSIONAL IDENTIFIER

A AND E STAFF MEMBER CODE (RETIRED), renamed from A AND E STAFF MEMBER CODE

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.A_and_E_STAFF_MEMBER_CODE to Retired.Data_Dictionary.Data_Field_Notes.A.A_and_E_STAFF_MEMBER_CODE
- Retired A and E STAFF MEMBER CODE

A AND E TIME SEEN FOR TREATMENT (RETIRED), renamed from A AND E TIME SEEN FOR TREATMENT

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

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

Notes:

~~A and E TIME SEEN FOR TREATMENT is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code [Accident and Emergency Time Seen For Treatment](#). This item has been retired from the NHS Data Model and Dictionary.~~

The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

A AND E TIME SEEN FOR TREATMENT (RETIRED), renamed from **A AND E TIME SEEN FOR TREATMENT**

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

A and E TIME SEEN FOR TREATMENT

Attribute:

[ACTIVITY TIME](#)

A AND E TIME SEEN FOR TREATMENT (RETIRED), renamed from **A AND E TIME SEEN FOR TREATMENT**

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
 - null
 - null
 - Changed Name from Data_Dictionary.Data_Field_Notes.A.A_and_E_TIME_SEEN_FOR_TREATMENT to Retired.Data_Dictionary.Data_Field_Notes.A.A_and_E_TIME_SEEN_FOR_TREATMENT
 - Retired A and E TIME SEEN FOR TREATMENT
-

ACCESSIBLE INFORMATION PROFESSIONAL REQUIRED CODE (SNOMED CT)

Change to Data Element: Changed Dataset

Format/Length: See [SNOMED CT CODE](#)
National Codes:
Default Codes:

Notes:

[ACCESSIBLE INFORMATION PROFESSIONAL REQUIRED CODE \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

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

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Accessible information - requires communication professional simple reference set (foundation metadata concept)
- [Refset](#) Id: 99900215100000104

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

ACCIDENT AND EMERGENCY ARRIVAL MODE CODE (RETIRED), renamed from **ACCIDENT AND EMERGENCY ARRIVAL MODE CODE**

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

Format/Length: an4
National Codes: See [ACCIDENT AND EMERGENCY ARRIVAL MODE](#)
Default Codes:

Notes:

[ACCIDENT AND EMERGENCY ARRIVAL MODE CODE](#) is the same as attribute [ACCIDENT AND EMERGENCY ARRIVAL MODE](#). **This item has been retired from the NHS Data Model and Dictionary.**

The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ACCIDENT AND EMERGENCY ARRIVAL MODE CODE (RETIRED), renamed from **ACCIDENT AND EMERGENCY ARRIVAL MODE CODE**

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

ACCIDENT AND EMERGENCY ARRIVAL MODE CODE

Attribute:

[ACCIDENT AND EMERGENCY ARRIVAL MODE](#)

ACCIDENT AND EMERGENCY ARRIVAL MODE CODE (RETIRED), renamed from ACCIDENT AND EMERGENCY ARRIVAL MODE CODE

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_ARRIVAL_MODE_CODE to Retired.Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_ARRIVAL_MODE_CODE
- Retired ACCIDENT AND EMERGENCY ARRIVAL MODE CODE

ACCIDENT AND EMERGENCY ATTENDANCE CATEGORY CODE (RETIRED), renamed from ACCIDENT AND EMERGENCY ATTENDANCE CATEGORY CODE

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

Format/Length:	an1
National Codes:	See A AND E ATTENDANCE CATEGORY
Default Codes:	

Notes:

[ACCIDENT AND EMERGENCY ATTENDANCE CATEGORY CODE](#) is the same as attribute [A AND E ATTENDANCE CATEGORY](#).

A [FIRST ATTENDANCE](#) is the first or only attendance for the same incident, which may be an injury or occurrence of a condition; a follow up attendance is a visit to the same department for the same incident as the first visit within the episode. If a [PATIENT](#) has a recurring condition, such as epilepsy, or a tendency for joints to dislocate, there would be a new [FIRST ATTENDANCE](#) each time that the [PATIENT](#) presents with the condition. **This item has been retired from the NHS Data Model and Dictionary.**

A subsequent attendance may not always be a follow up attendance. It could qualify as an attendance at a consultant out patient clinic and if so, it needs to be recorded appropriately. **The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.**

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ACCIDENT AND EMERGENCY ATTENDANCE CATEGORY CODE (RETIRED), renamed from ACCIDENT AND EMERGENCY ATTENDANCE CATEGORY CODE

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

ACCIDENT AND EMERGENCY ATTENDANCE CATEGORY CODE

Attribute:

[A AND E ATTENDANCE CATEGORY](#)

ACCIDENT AND EMERGENCY ATTENDANCE CATEGORY CODE (RETIRED), renamed from ACCIDENT AND EMERGENCY ATTENDANCE CATEGORY CODE

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_ATTENDANCE_CATEGORY_CODE to Retired.Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_ATTENDANCE_CATEGORY_CODE
- Retired ACCIDENT AND EMERGENCY ATTENDANCE CATEGORY CODE

ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE (RETIRED), renamed from ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

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

Notes:

~~ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE~~ is the same as attribute ~~ACTIVITY DATE~~ where the ~~ACTIVITY DATE TYPE~~ is National Code '~~Accident and Emergency Attendance Conclusion Date~~'. This item has been retired from the NHS Data Model and Dictionary.

The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

~~ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE (RETIRED)~~, renamed from ~~ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE~~

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE

Attribute:

[ACTIVITY DATE](#)

~~ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE (RETIRED)~~, renamed from ~~ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE~~

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_ATTENDANCE_CONCLUSION_DATE to Retired.Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_ATTENDANCE_CONCLUSION_DATE
- Retired ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE

~~ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL CODE (RETIRED)~~, renamed from ~~ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL CODE~~

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

Format/Length:	an2
National Codes:	See ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL
Default Codes:	

Notes:

~~ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL CODE~~ is the same as attribute ~~ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL~~. This item has been retired from the NHS Data Model and Dictionary.

The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

~~ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL CODE (RETIRED)~~, renamed from ~~ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL CODE~~

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL CODE

Attribute:

[ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL](#)

ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL CODE (RETIRED), renamed from ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL CODE

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_ATTENDANCE DISPOSAL_CODE to Retired.Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_ATTENDANCE DISPOSAL_CODE
- Retired ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL CODE

ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT (RETIRED), renamed from ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

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

Notes:

[ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Accident and Emergency Date Seen For Treatment](#)'. **This item has been retired from the NHS Data Model and Dictionary.**

The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT (RETIRED), renamed from ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT

Attribute:

ACTIVITY DATE

ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT (RETIRED), renamed from ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_DATE_SEEN_FOR_TREATMENT to Retired.Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_DATE_SEEN_FOR_TREATMENT
- Retired ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT

ACCIDENT AND EMERGENCY DEPARTURE DATE (RETIRED), renamed from ACCIDENT AND EMERGENCY DEPARTURE DATE

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

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

Notes:

[ACCIDENT AND EMERGENCY DEPARTURE DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Accident and Emergency Departure Date](#)'. **This item has been retired from the NHS Data Model and Dictionary.**

The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ACCIDENT AND EMERGENCY DEPARTURE DATE (RETIRED), renamed from ACCIDENT AND EMERGENCY DEPARTURE DATE

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

ACCIDENT AND EMERGENCY DEPARTURE DATE

Attribute:

[ACTIVITY DATE](#)

ACCIDENT AND EMERGENCY DEPARTURE DATE (RETIRED), renamed from ACCIDENT AND EMERGENCY DEPARTURE DATE

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_DEPARTURE_DATE to Retired.Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_DEPARTURE_DATE
- Retired ACCIDENT AND EMERGENCY DEPARTURE DATE

ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST (RETIRED), renamed from ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

Format/Length:	an6
National Codes:	See Accident and Emergency Diagnosis Tables
Default Codes:	

Notes:

[ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST](#) is the same as attribute [ACCIDENT AND EMERGENCY DIAGNOSIS](#).

[ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST](#) is the first recorded [PATIENT DIAGNOSIS](#) for an [Accident and Emergency Attendance](#). This item has been retired from the NHS Data Model and Dictionary.

[ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST](#) is required for recording within an Accident and Emergency Attendance Commissioning Data Set. The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

For Commissioning Data Set and XML schema version 6 onwards, [ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST](#) will be recognised as Primary Diagnosis (Accident and Emergency). 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.

ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST (RETIRED), renamed from ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST

Attribute:

[ACCIDENT AND EMERGENCY DIAGNOSIS](#)

ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST (RETIRED), renamed from ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_DIAGNOSIS_-_FIRST to Retired.Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_DIAGNOSIS_-_FIRST

- Retired ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST

ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND (RETIRED), renamed from **ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND**

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

Format/Length:	an6
National Codes:	See Accident and Emergency Diagnosis Tables
Default Codes:	

Notes:

[ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND](#) is the same as attribute [ACCIDENT AND EMERGENCY DIAGNOSIS](#).

[ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND](#) is the second or subsequent recorded [PATIENT DIAGNOSIS](#) for an [Accident and Emergency Attendance](#). **This item has been retired from the NHS Data Model and Dictionary.**

[ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND](#) is required for recording within an Accident and Emergency Attendance Commissioning Data Set. **The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.**

For Commissioning Data Set and XML Schema version 6 onwards, [ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND](#) will be recognised as Secondary Diagnosis (Accident and Emergency). **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.**

For Commissioning Data Set version 6 onwards, there are no restrictions on the number of Secondary Diagnoses (Accident and Emergency) recorded.

ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND (RETIRED), renamed from **ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND**

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND

Attribute:

ACCIDENT AND EMERGENCY DIAGNOSIS

ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND (RETIRED), renamed from **ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND**

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_DIAGNOSIS_-_SECOND to Retired.Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_DIAGNOSIS_-_SECOND
- Retired ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND

ACCIDENT AND EMERGENCY INITIAL ASSESSMENT DATE (RETIRED), renamed from **ACCIDENT AND EMERGENCY INITIAL ASSESSMENT DATE**

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

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

Notes:

[ACCIDENT AND EMERGENCY INITIAL ASSESSMENT DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code [Accident and Emergency Initial Assessment Date](#). **This item has been retired from the NHS Data Model and Dictionary.**

The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ACCIDENT AND EMERGENCY INITIAL ASSESSMENT DATE (RETIRED), renamed from ACCIDENT AND EMERGENCY INITIAL ASSESSMENT DATE

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

ACCIDENT AND EMERGENCY INITIAL ASSESSMENT DATE

Attribute:

[ACTIVITY DATE](#)

ACCIDENT AND EMERGENCY INITIAL ASSESSMENT DATE (RETIRED), renamed from ACCIDENT AND EMERGENCY INITIAL ASSESSMENT DATE

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_INITIAL_ASSESSMENT_DATE to Retired.Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_INITIAL_ASSESSMENT_DATE
- Retired ACCIDENT AND EMERGENCY INITIAL ASSESSMENT DATE

ACCIDENT AND EMERGENCY INVESTIGATION - FIRST (RETIRED), renamed from ACCIDENT AND EMERGENCY INVESTIGATION - FIRST

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

Format/Length:	an6
National Codes:	See Accident and Emergency Investigation Table
Default Codes:	

Notes:

~~[ACCIDENT AND EMERGENCY INVESTIGATION - FIRST](#) is the same as attribute [ACCIDENT AND EMERGENCY INVESTIGATION](#).~~

~~[ACCIDENT AND EMERGENCY INVESTIGATION - FIRST](#) is the first recorded [CLINICAL INTERVENTION](#) for an [Accident and Emergency Attendance](#). This item has been retired from the NHS Data Model and Dictionary.~~

~~[ACCIDENT AND EMERGENCY INVESTIGATION - FIRST](#) is required for recording within an Accident and Emergency Attendance Commissioning Data Set. The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.~~

~~For Commissioning Data Set and XML Schema version 6 onwards, [ACCIDENT AND EMERGENCY INVESTIGATION - FIRST](#) will be recognised as Primary Investigation (Accident and Emergency). 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.~~

~~[ACCIDENT AND EMERGENCY INVESTIGATION - FIRST](#) 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](#).~~

ACCIDENT AND EMERGENCY INVESTIGATION - FIRST (RETIRED), renamed from ACCIDENT AND EMERGENCY INVESTIGATION - FIRST

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

ACCIDENT AND EMERGENCY INVESTIGATION - FIRST

Attribute:

[ACCIDENT AND EMERGENCY INVESTIGATION](#)

ACCIDENT AND EMERGENCY INVESTIGATION - FIRST (RETIRED), renamed from ACCIDENT AND EMERGENCY INVESTIGATION - FIRST

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_INVESTIGATION_-_FIRST to Retired.Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_INVESTIGATION_-_FIRST
- Retired ACCIDENT AND EMERGENCY INVESTIGATION - FIRST

ACCIDENT AND EMERGENCY INVESTIGATION - SECOND (RETIRED), renamed from ACCIDENT AND EMERGENCY INVESTIGATION - SECOND

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

Format/Length:	an6
National Codes:	See Accident and Emergency Investigation Table
Default Codes:	

Notes:

~~ACCIDENT AND EMERGENCY INVESTIGATION - SECOND~~ is the same as attribute ~~ACCIDENT AND EMERGENCY INVESTIGATION -~~

~~ACCIDENT AND EMERGENCY INVESTIGATION - SECOND~~ is the second or subsequent ~~CLINICAL INTERVENTION~~ for an ~~Accident and Emergency Attendance~~. **This item has been retired from the NHS Data Model and Dictionary.**

~~ACCIDENT AND EMERGENCY INVESTIGATION - SECOND~~ is required for recording within an Accident and Emergency Attendance Commissioning Data Set. **The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.**

For Commissioning Data Set and Schema version 6 onwards, ~~ACCIDENT AND EMERGENCY INVESTIGATION - SECOND~~ will be recognised as ~~Secondary Investigation (Accident and Emergency)~~. **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.**

For Commissioning Data Set version 6 onwards there are no restrictions on the number of Secondary Investigations (Accident and Emergency) recorded.

~~ACCIDENT AND EMERGENCY INVESTIGATION - SECOND~~ 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~~.

ACCIDENT AND EMERGENCY INVESTIGATION - SECOND (RETIRED), renamed from ACCIDENT AND EMERGENCY INVESTIGATION - SECOND

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

ACCIDENT AND EMERGENCY INVESTIGATION - SECOND

Attribute:

ACCIDENT AND EMERGENCY INVESTIGATION

ACCIDENT AND EMERGENCY INVESTIGATION - SECOND (RETIRED), renamed from ACCIDENT AND EMERGENCY INVESTIGATION - SECOND

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_INVESTIGATION_-_SECOND to Retired.Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_INVESTIGATION_-_SECOND
- Retired ACCIDENT AND EMERGENCY INVESTIGATION - SECOND

ACCIDENT AND EMERGENCY TREATMENT - FIRST (RETIRED), renamed from ACCIDENT AND EMERGENCY TREATMENT - FIRST

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

Format/Length:	an6
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National Codes: See [Accident and Emergency Treatment Tables](#)
Default Codes:

Notes:

~~[ACCIDENT AND EMERGENCY TREATMENT - FIRST](#) is the same as attribute [ACCIDENT AND EMERGENCY TREATMENT](#).~~

~~[ACCIDENT AND EMERGENCY TREATMENT - FIRST](#) is the first recorded [CLINICAL INTERVENTION](#) for an [Accident and Emergency Attendance](#). This item has been retired from the NHS Data Model and Dictionary.~~

~~[ACCIDENT AND EMERGENCY TREATMENT - FIRST](#) is required for recording within an Accident and Emergency Attendance Commissioning Data Set. The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.~~

~~For Commissioning Data Set and XML Schema version 6 onwards, [ACCIDENT AND EMERGENCY TREATMENT - FIRST](#) will be recognised as Primary Treatment (Accident and Emergency). 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.~~

~~[ACCIDENT AND EMERGENCY TREATMENT - FIRST](#) 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](#).~~

~~ACCIDENT AND EMERGENCY TREATMENT - FIRST (RETIRED), renamed from ACCIDENT AND EMERGENCY TREATMENT - FIRST~~

~~Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired~~

~~ACCIDENT AND EMERGENCY TREATMENT - FIRST~~

~~Attribute:~~

~~[ACCIDENT AND EMERGENCY TREATMENT](#)~~

~~ACCIDENT AND EMERGENCY TREATMENT - FIRST (RETIRED), renamed from ACCIDENT AND EMERGENCY TREATMENT - FIRST~~

~~Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired~~

- ~~• Changed Description~~
- ~~• null~~
- ~~• null~~
- ~~• Changed Name from Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_TREATMENT_-_FIRST to Retired.Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_TREATMENT_-_FIRST~~
- ~~• Retired ACCIDENT AND EMERGENCY TREATMENT - FIRST~~

~~ACCIDENT AND EMERGENCY TREATMENT - SECOND (RETIRED), renamed from ACCIDENT AND EMERGENCY TREATMENT - SECOND~~

~~Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired~~

Format/Length:	an6
National Codes:	See Accident and Emergency Treatment Tables
Default Codes:	

Notes:

~~[ACCIDENT AND EMERGENCY TREATMENT - SECOND](#) is the same as attribute [ACCIDENT AND EMERGENCY TREATMENT](#).~~

~~[ACCIDENT AND EMERGENCY TREATMENT - SECOND](#) is the second or subsequent recorded [CLINICAL INTERVENTION](#) for an [Accident and Emergency Attendance](#). This item has been retired from the NHS Data Model and Dictionary.~~

~~[ACCIDENT AND EMERGENCY TREATMENT - SECOND](#) is required for recording within an Accident and Emergency Attendance Commissioning Data Set. The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.~~

~~For Commissioning Data Set and XML Schema version 6 onwards, [ACCIDENT AND EMERGENCY TREATMENT - SECOND](#) will be recognised as Secondary Treatment (Accident and Emergency). 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.~~

For Commissioning Data Set version 6 onwards there are no restrictions on the number of Secondary Treatment (Accident and Emergency) recorded.

~~ACCIDENT AND EMERGENCY TREATMENT - SECOND~~ 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~~.

ACCIDENT AND EMERGENCY TREATMENT - SECOND (RETIRED) renamed from **ACCIDENT AND EMERGENCY TREATMENT - SECOND**

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

ACCIDENT AND EMERGENCY TREATMENT - SECOND

Attribute:

[ACCIDENT AND EMERGENCY TREATMENT](#)

ACCIDENT AND EMERGENCY TREATMENT - SECOND (RETIRED) renamed from **ACCIDENT AND EMERGENCY TREATMENT - SECOND**

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_TREATMENT_-_SECOND to Retired.Data_Dictionary.Data_Field_Notes.A.ACCIDENT_AND_EMERGENCY_TREATMENT_-_SECOND
- Retired ACCIDENT AND EMERGENCY TREATMENT - SECOND

ACCOMMODATION STATUS (SNOMED CT)

Change to Data Element: Changed Dataset

Format/Length: See [SNOMED CT CODE](#)
National Codes:
Default Codes:

Notes:

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

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

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Emergency care usual residence type simple reference set (foundation metadata concept)
- [Refset](#) Id: 99900305100000109

For further details relating to the [SNOMED CT Refset](#) Metadata, see the [Data Dictionary for Care \(DD4C\)](#) website at: [Emergency care usual residence type](#).

ACTIVITY SERVICE REQUEST DATE (EMERGENCY CARE)

Change to Data Element: Changed Dataset

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

Notes:

[ACTIVITY SERVICE REQUEST DATE \(EMERGENCY CARE\)](#) is the same as attribute [ACTIVITY SERVICE REQUEST DATE](#).

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

ACTIVITY SERVICE REQUEST TIME (EMERGENCY CARE)

Change to Data Element: Changed Dataset

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

Notes:

[ACTIVITY SERVICE REQUEST TIME \(EMERGENCY CARE\)](#) is the same as attribute [ACTIVITY SERVICE REQUEST TIME](#).

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

ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT)

Change to Data Element: Changed Dataset

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

Notes:

[ACTIVITY TREATMENT FUNCTION CODE \(DECISION TO ADMIT\)](#) is the same as attribute [TREATMENT FUNCTION CODE](#).

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

AGE AT CDS ACTIVITY DATE

Change to Data Element: Changed Dataset

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

Notes:

[AGE AT CDS ACTIVITY DATE](#) is derived as the number of completed years between the [PERSON BIRTH DATE](#) of the [PATIENT](#) and the [CDS ACTIVITY DATE](#).

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

For further information, please refer to the [NHS Digital](#) website at: [Payment by Results Guidance](#).

AMBULANCE CALL IDENTIFIER

Change to Data Element: Changed Dataset

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

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

Notes:

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

AMBULANCE INCIDENT NUMBER

Change to Data Element: Changed Description, Dataset

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

Notes:

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

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

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

ARRIVAL DATE (RETIRED), renamed from ARRIVAL DATE

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

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

Notes:

[ARRIVAL DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Arrival Date At Accident and Emergency Department](#)'. **This item has been retired from the NHS Data Model and Dictionary.**

The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ARRIVAL DATE (RETIRED), renamed from ARRIVAL DATE

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

ARRIVAL DATE

Attribute:

ACTIVITY DATE

ARRIVAL DATE (RETIRED), renamed from ARRIVAL DATE

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.Ap.ARRIVAL_DATE to Retired.Data_Dictionary.Data_Field_Notes.A.ARRIVAL_DATE
- Retired ARRIVAL DATE

ARRIVAL DATE AND TIME AT ACCIDENT AND EMERGENCY DEPARTMENT (RETIRED)

Change to Data Element: Changed Description

This item has been retired from the NHS Data Model and Dictionary.

The last live version of this item is available in the August 2020 release of the NHS Data Model and Dictionary. The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT (RETIRED), renamed from ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

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

Notes:

~~[ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Arrival Time At Accident and Emergency Department](#)'. This item has been retired from the NHS Data Model and Dictionary.~~

The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT (RETIRED), renamed from ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT

Attribute:

ACTIVITY TIME

ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT (RETIRED), renamed from ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.Ap.ARRIVAL_TIME_AT_ACCIDENT_AND_EMERGENCY_DEPARTMENT to Retired.Data_Dictionary.Data_Field_Notes.A.ARRIVAL_TIME_AT_ACCIDENT_AND_EMERGENCY_DEPARTMENT
- Retired ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT

ASSAULT LOCATION DESCRIPTION

Change to Data Element: Changed Description, Dataset

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. This data element may only be completed when the [ASSAULT LOCATION TYPE](#) is 'Other location (specify)'.

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

ASSESSMENT TOOL VALIDATION TIMESTAMP

Change to Data Element: New Data Element

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

Notes:

ASSESSMENT TOOL VALIDATION TIMESTAMP is the same as attribute ACTIVITY DATE and ACTIVITY TIME where the ACTIVITY DATE AND TIME TYPE is National Code 'Assessment Tool Validation Timestamp'.

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

For the CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set, 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.

This data element is also known by these names:

Context	Alias
plural	ASSESSMENT TOOL VALIDATION TIMESTAMPS

ASSESSMENT TOOL VALIDATION TIMESTAMP

Change to Data Element: New Data Element

ASSESSMENT TOOL VALIDATION TIMESTAMP

Attribute:

ACTIVITY DATE
ACTIVITY TIME

ATTENDANCE DATE

Change to Data Element: Changed Description

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

Notes:

ATTENDANCE DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Care Contact Date'.

ATTENDANCE DATE is the date of an attendance or contact, for example at a Consultant Clinic, Nurse Clinic, Accident and Emergency Department or by a Ward Attender. ATTENDANCE DATE is the date of an attendance or contact, for example at a Consultant Clinic, Nurse Clinic, Emergency Care Department or by a Ward Attender.

CARE CONTACT IDENTIFIER (AMBULANCE SERVICE)

Change to Data Element: Changed Dataset

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

Notes:

CARE CONTACT IDENTIFIER (AMBULANCE SERVICE) is the ACTIVITY IDENTIFIER for a CARE CONTACT allocated by the Ambulance Service.

~~This item is being used for development purposes and has not yet been approved.~~ CARE CONTACT IDENTIFIER (AMBULANCE SERVICE) is an identifier allocated to each Ambulance Incident for each PATIENT.

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

CARE PROFESSIONAL CLINICAL RESPONSIBILITY TIMESTAMP

Change to Data Element: New Data Element

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

Notes:

CARE PROFESSIONAL CLINICAL RESPONSIBILITY TIMESTAMP is the same as attribute ACTIVITY DATE and ACTIVITY TIME where the ACTIVITY DATE AND TIME TYPE is National Code '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.

For the CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set, 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.

This data element is also known by these names:

Context	Alias
plural	CARE PROFESSIONAL CLINICAL RESPONSIBILITY TIMESTAMPS

CARE PROFESSIONAL CLINICAL RESPONSIBILITY TIMESTAMP

Change to Data Element: New Data Element

CARE PROFESSIONAL CLINICAL RESPONSIBILITY TIMESTAMP

Attribute:

ACTIVITY DATE
ACTIVITY TIME

CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR (EMERGENCY CARE)

Change to Data Element: Changed Dataset

Format/Length:	an1
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National Codes: See [CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR FOR EMERGENCY CARE](#)
Default Codes:

Notes:

[CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR \(EMERGENCY CARE\)](#) is the same as attribute [CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR FOR EMERGENCY CARE](#).

CARE PROFESSIONAL TIER (EMERGENCY CARE)

Change to Data Element: Changed Dataset

Format/Length: an2
National Codes: See [CARE PROFESSIONAL TIER FOR EMERGENCY CARE](#)
Default Codes:

Notes:

[CARE PROFESSIONAL TIER \(EMERGENCY CARE\)](#) is the same as attribute [CARE PROFESSIONAL TIER FOR EMERGENCY CARE](#).

CARER SUPPORT INDICATOR

Change to Data Element: Changed Dataset

Format/Length: an2
National Codes: See [CARER SUPPORT INDICATOR](#)
Default Codes:

Notes:

[CARER SUPPORT INDICATOR](#) is the same as attribute [CARER SUPPORT INDICATOR](#).

CDS ACTIVITY DATE

Change to Data Element: Changed Description, Dataset

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

Notes:

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

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

For Bulk Update use, see:

- [CDS V6-2 Type 005B - Commissioning Data Set Transaction Header Group - Bulk Update Protocol](#)
- [CDS V6-2-1 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](#)

For Net Change Use, see:

- [CDS V6-2 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#)
- [CDS V6-2-1 Type 005N - Commissioning Data Set Transaction Header Group - Net Change Protocol](#)
- [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](#)

Note:

- [CDS Type 010 'Accident and Emergency Attendance'](#) will no longer be accepted from 01 November 2020.

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

CDS TYPE	DESCRIPTION	CDS ORIGINATING DATE (used to populate the CDS ACTIVITY DATE)
----------	-------------	------------------------------------------------------------------

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

Usage:

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

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

CDS APPLICABLE DATE

Change to Data Element: Changed Dataset

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

Notes:

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

Usage:

[CDS APPLICABLE DATE](#) is mandatory when used with the Commissioning Data Set Net Change Update Mechanism. It is not required when the Commissioning Data Set Bulk Replacement Update Mechanism is used. See the [Commissioning Data Set Submission Protocol](#).

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

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

CDS APPLICABLE TIME

Change to Data Element: Changed Dataset

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

Notes:

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

Usage:

[CDS APPLICABLE TIME](#) is mandatory when used with the Commissioning Data Set Net Change Update Mechanism. It is not required when the CDS Bulk Replacement Update Mechanism is used. See the [Commissioning Data Set Submission Protocol](#).

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

CDS BULK REPLACEMENT GROUP CODE

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	See CDS BULK REPLACEMENT GROUP CODE
Default Codes:	

Notes:

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

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

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

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

For submissions of [CDS V6-2](#), [CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set](#) 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](#).

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

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

CDS COPY RECIPIENT IDENTITY

Change to Data Element: Changed Dataset

Format/Length:	an3 or an5
National Codes:	
ODS Default Codes:	VPP00 - Private PATIENTS / Overseas Visitor liable for charges YDD82 - Episodes funded directly by the National Commissioning Group for England (Retired September 2018)

Notes:

[CDS COPY RECIPIENT IDENTITY](#) is the same as attribute [ORGANISATION CODE](#).

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

Usage:

A Recipient may be an agency or [SERVICE](#) provider that carries out the receiving (and perhaps other) processes on behalf of the NHS [ORGANISATION](#) that ultimately uses the data. There may be multiple recipients for Commissioning data.

[Organisation Data Service Default Codes](#) for [CDS COPY RECIPIENT IDENTITIES](#) are detailed in the [Commissioning Data Set Addressing Grid](#).

Where [NHS England](#) is the responsible commissioner for a specialised [SERVICE](#), based on the [NHS England Commissioner Assignment Method \(CAM\)](#), one of the [Specialised Commissioning Hub ORGANISATION CODES](#) should be used depending on which [Health Care Provider](#) delivered the [SERVICE](#), e.g. [NHS Trust](#), [Independent Sector Healthcare Provider](#).

The [NHS Digital](#) website provides a mapping list of which [Health Care Providers](#) map to which [Specialised Commissioning Hub](#). The mapping can be found on the [Organisation Data Service](#) web pages at: [Provider to Commissioning Hub Mapping](#).

[CDS COPY RECIPIENT IDENTITY](#) will be replaced with [ORGANISATION IDENTIFIER \(CDS RECIPIENT\)](#), when it has been approved for use in national information standards.

CDS EXTRACT DATE

Change to Data Element: Changed Dataset

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

Notes:

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

Usage:

[CDS EXTRACT DATE](#) is mandatory when used with the Commissioning Data Set Bulk Replacement Update Mechanism. It is not required when the Commissioning Data Set Net Change Update Mechanism is used, see the [Commissioning Data Set Submission Protocol](#).

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

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

CDS EXTRACT TIME

Change to Data Element: Changed Dataset

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

Notes:

[CDS EXTRACT TIME](#) is the time (with an associated [CDS EXTRACT DATE](#)) at which the Commissioning data extract was undertaken.

Usage:

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

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

CDS INTERCHANGE APPLICATION REFERENCE

Change to Data Element: Changed Dataset

Format/Length:	an14
National Codes:	
Default Codes:	

Notes:

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

Usage:

This facility enables submitted interchanges to be marked to enable interchange content to be identified and recorded. All [Commissioning Data Set](#) Interchanges must contain this data element.

CDS XML Schema Interchanges:

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

CDS INTERCHANGE CONTROL COUNT

Change to Data Element: Changed Dataset

Format/Length:	n7
National Codes:	
Default Codes:	

Notes:

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

Usage:

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

CDS INTERCHANGE CONTROL REFERENCE

Change to Data Element: Changed Dataset

Format/Length:	an14
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.

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

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

CDS XML Schema Interchanges:

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

CDS INTERCHANGE DATE OF PREPARATION

Change to Data Element: Changed Dataset

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

Notes:

[CDS INTERCHANGE DATE OF PREPARATION](#) is the date when the [Commissioning Data Set](#) Interchange data was created.

Usage:

[CDS INTERCHANGE DATE OF PREPARATION](#) is a mandatory data element when submitting Commissioning data.

CDS XML Schema Interchanges:

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

CDS INTERCHANGE RECEIVER IDENTITY

Change to Data Element: Changed Dataset

Format/Length: an15
National Codes:
Default Codes:

Notes:

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

Usage:

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

CDS XML Schema Interchanges:

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

CDS INTERCHANGE SENDER IDENTITY

Change to Data Element: Changed Dataset

Format/Length: an15
National Codes:
Default Codes:

Notes:

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

Usage:

[CDS INTERCHANGE SENDER IDENTITY](#) is a mandatory data element when submitting Commissioning Data Set interchanges. Every [ORGANISATION](#) must register its [CDS INTERCHANGE SENDER IDENTITY](#) for use with the [Secondary Uses Service](#).

Where an [ORGANISATION](#) acts on behalf of another NHS [ORGANISATION](#), care must be taken to ensure the correct use of the identity. For data submitted to the service, the [CDS INTERCHANGE SENDER IDENTITY](#) is the Electronic Data Interchange (EDI) address of the sending site.

CDS XML Schema Interchanges:

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

CDS INTERCHANGE TEST INDICATOR

Change to Data Element: Changed Dataset

Format/Length: an1
National Codes: See [CDS INTERCHANGE TEST INDICATOR](#)
Default Codes:

Notes:

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

Usage:

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

Whilst [CDS INTERCHANGE TEST INDICATOR](#) is optional it is highly recommended that correct values be completed in the data.

On receipt of a Test Interchange, the processes are as follows:

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

CDS XML Schema Interchanges:

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

CDS INTERCHANGE TIME OF PREPARATION

Change to Data Element: Changed Dataset

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

Notes:

[CDS INTERCHANGE TIME OF PREPARATION](#) is the time when the [Commissioning Data Set](#) Interchange data was created.

Usage:

[CDS INTERCHANGE TIME OF PREPARATION](#) is a mandatory data element when submitting Commissioning Data Set Interchanges.

CDS XML Schema Interchanges:

All [Commissioning Data Set](#) XML Schema interchanges submitted to the service must contain a [CDS INTERCHANGE TIME OF PREPARATION](#).

CDS MESSAGE REFERENCE

Change to Data Element: Changed Dataset

Format/Length:	an14
National Codes:	
Default Codes:	

Notes:

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

Usage:

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

CDS MESSAGE TYPE

Change to Data Element: Changed Dataset

Format/Length:	an6
National Codes:	See CDS MESSAGE TYPE
Default Codes:	

Notes:

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

Usage:

[Commissioning Data Set](#) XML Schema interchanges should only contain multiple message of the same [CDS MESSAGE TYPE](#).

CDS MESSAGE VERSION NUMBER

Change to Data Element: Changed Dataset

Format/Length:	an8
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National Codes:
Default Codes:

Notes:

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

Usage:

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

CDS PRIME RECIPIENT IDENTITY

Change to Data Element: Changed Dataset

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

Notes:

[CDS PRIME RECIPIENT IDENTITY](#) is the same as attribute [ORGANISATION CODE](#).

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

Usage:

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

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

[Organisation Data Service Default Codes](#) for [CDS PRIME RECIPIENT IDENTITIES](#) are detailed in the [Commissioning Data Set Addressing Grid](#).

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

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

[CDS PRIME RECIPIENT IDENTITY](#) will be replaced with [ORGANISATION IDENTIFIER \(CDS RECIPIENT\)](#), when it has been approved for use in national information standards.

CDS PROTOCOL IDENTIFIER CODE

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	See CDS PROTOCOL IDENTIFIER CODE
Default Codes:	

Notes:

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

CDS RECORD IDENTIFIER

Change to Data Element: Changed Description, Dataset

Format/Length: an35
National Codes:
Default Codes:

Notes:

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

When exchanging Commissioning Data Set data, [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	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 V6-2-1 Type 005B - CDS Transaction Header Group - Bulk Update Protocol or the CDS V6-2-1 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
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 V6-2-1 Type 005B - CDS Transaction Header Group - Bulk Update Protocol or the CDS V6-2-1 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 V6-2-3 Type 005B - CDS Transaction Header Group - Bulk Update Protocol or the CDS V6-2-3 Type 005N - CDS Transaction Header Group - Net Change Protocol
2	Not Used	an2	Set = Blank
3	CDS INTERCHANGE CONTROL REFERENCE	an14 (n7) *	As generated in the CDS V6-2 Type 001 - CDS Interchange Header
4	CDS MESSAGE REFERENCE	an14 (n7) *	As generated in the CDS V6-2 Type 003 - CDS Message Header

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

Usage:

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

CDS XML Schema Interchanges:

The [CDS-RID](#) data element is carried in the CDS Message Header ([CDS V6-2 Type 003 - CDS Message Header](#)). The [CDS-RID](#) data element is carried in the CDS Message Headers:

- [CDS V6-2 Type 003 - CDS Message Header](#)
- [CDS V6-2-1 Type 003 - CDS Message Header](#)
- [CDS V6-2-2 Type 003 - CDS Message Header](#)
- [CDS V6-2-3 Type 003 - CDS Message Header](#).

CDS REPORT PERIOD END DATE

Change to Data Element: Changed Dataset

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

Notes:

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

Usage:

[CDS REPORT PERIOD END DATE](#) is a mandatory data item when the Commissioning Data Set Bulk Replacement Update Mechanism is used. It is not required when the Commissioning Data Set Net Change Update Mechanism is used.

The [CDS REPORT PERIOD END DATE](#) must be a valid date and must not be before the [CDS REPORT PERIOD START DATE](#).

See the supporting information in the [Commissioning Data Set Submission Protocol](#) for further details.

CDS REPORT PERIOD START DATE

Change to Data Element: Changed Dataset

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

Notes:

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

Usage:

[CDS REPORT PERIOD START DATE](#) is a mandatory data item when the Commissioning Data Set Bulk Replacement Update Mechanism is used. It is not required when the Commissioning Data Set Net Change Update Mechanism is used.

The [CDS REPORT PERIOD START DATE](#) must be a valid date and cannot be after the [CDS REPORT PERIOD END DATE](#).

See the supporting information in the [Commissioning Data Set Submission Protocol](#) for further details.

CDS SENDER IDENTITY

Change to Data Element: Changed Description, Dataset

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

Notes:

[CDS SENDER IDENTITY](#) is the mandatory NHS [ORGANISATION CODE](#) of the [ORGANISATION](#) acting as the physical Sender of Commissioning Data Set submissions.

Usage:

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

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

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

Usually, the [CDS SENDER IDENTITY](#) is never altered once assigned.

[CDS SENDER IDENTITY](#) will be replaced with [ORGANISATION IDENTIFIER \(CDS SENDER\)](#), when it has been approved for use in national information standards.

CDS TYPE CODE

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	See CDS TYPE CODE
Default Codes:	

Notes:

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

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

CDS UNIQUE IDENTIFIER

Change to Data Element: Changed Dataset

Format/Length:	an35
National Codes:	
Default Codes:	

Notes:

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

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

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

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

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

For All CDS Types EXCEPT the EAL CDS Types:

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

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

REF	UID	FORMAT	CODES / VALUES	COMMENT
1	NHS Organisation Code Type	an1	A = Pre 1996 ORGANISATION CODE B = Post 1996 NHS ORGANISATION CODE / ORGANISATION IDENTIFIER	Mandatory For all CDS Types
2	Provider Code	an5		Mandatory for all CDS Types

			The NHS ORGANISATION CODE / ORGANISATION IDENTIFIER of the Provider at the time of, or at the start of, the period covered by the activity reported by the CDS Message.	
3b	Application Specific CDS Identity	an9	A code of up to 9 alpha-numeric characters generated by the Sender's application to uniquely identify the EAL End Of period census CDS Types with the same Admission List Entry. Additional data positions must be left blank.	Mandatory for all EAL EOP CDS Types
3c	Filler	an20	Additional data positions must be left blank.	

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

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

Usage:

[CDS UNIQUE IDENTIFIER](#) is a mandatory data item when the Net Change Update Mechanism is used and strongly recommended for use with the Bulk Replacement Update Mechanism.

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

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

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

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

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

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

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

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

CDS UPDATE TYPE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See CDS UPDATE TYPE
Default Codes:	

Notes:

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

Usage:

[CDS UPDATE TYPE](#) is a mandatory data item when using the Net Change Update Mechanism. It is not required when using the Bulk Replacement Update Mechanism.

CLINICAL TRIAL IDENTIFIER

Change to Data Element: Changed Description, Dataset

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

Notes:

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

~~Use in the [CDS V6-2-1 Type 011 – Emergency Care Commissioning Data Set](#) / [CDS V6-2-2 Type 011 – Emergency Care Commissioning Data Set](#); Use in the [CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set](#) / [CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set](#) / [CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set](#);~~

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

CODED ASSESSMENT TOOL TYPE (SNOMED CT)

Change to Data Element: Changed Dataset

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

Notes:

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

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

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

CODED CLINICAL ENTRY SEQUENCE NUMBER

Change to Data Element: Changed Dataset

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

Notes:

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

CODED FINDING (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:

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

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

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

This data element is also known by these names:

Context	Alias
plural	CODED FINDINGS (SNOMED CT)

CODED FINDING (SNOMED CT)

Change to Data Element: New Data Element

CODED FINDING (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

CODED FINDING TIMESTAMP

Change to Data Element: New Data Element

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 [CODED FINDING \(SNOMED CT\)](#) 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.

For the [CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set](#), 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.

This data element is also known by these names:

Context	Alias
plural	CODED FINDING TIMESTAMPS

CODED FINDING TIMESTAMP

Change to Data Element: New Data Element

CODED FINDING TIMESTAMP

Attribute:

PERSON PROPERTY RECORDED DATE
PERSON PROPERTY RECORDED TIME

CODED OBSERVATION (SNOMED CT)

Change to Data Element: Changed Dataset

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

Notes:

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

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

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

CODED OBSERVATION TIMESTAMP

Change to Data Element: New Data Element

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 [CODED OBSERVATION \(SNOMED CT\)](#) 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.

For the [CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set](#), 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.

This data element is also known by these names:

Context	Alias
plural	CODED OBSERVATION TIMESTAMPS

CODED OBSERVATION TIMESTAMP

Change to Data Element: New Data Element

CODED OBSERVATION TIMESTAMP

Attribute:

PERSON PROPERTY RECORDED DATE
PERSON PROPERTY RECORDED TIME

COMMISSIONER REFERENCE NUMBER

Change to Data Element: Changed Dataset

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

Notes:

[COMMISSIONER REFERENCE NUMBER](#) is the same as attribute [COMMISSIONER REFERENCE NUMBER](#).

COMMISSIONING SERIAL NUMBER

Change to Data Element: Changed Dataset

Format/Length:	an6
National Codes:	
Default Codes:	

Notes:

[COMMISSIONING SERIAL NUMBER](#) is the same as attribute [NHS SERVICE AGREEMENT NUMBER](#).

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

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

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

COMORBIDITY (SNOMED CT)

Change to Data Element: Changed Dataset

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

Notes:

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

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

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Comorbid conditions for selection simple reference set (foundation metadata concept)

- [Refset](#) Id: 991381000000107

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

DATE FIRST SEEN

Change to Data Element: Changed Description

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

Notes:

[DATE FIRST SEEN](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Care Contact Date](#)'.

[DATE FIRST SEEN](#) is the date that the [PATIENT](#) is first seen in the Trust that receives the first referral.

[DATE FIRST SEEN](#) will be one of the following, whichever is the earliest [SERVICE](#) relating to the [REFERRAL REQUEST](#):

- first [Out-Patient Appointment](#); this is the [ATTENDANCE DATE](#) of the first [Out-Patient Attendance Consultant](#)
- first diagnostic procedure if this precedes the first [Out-Patient Appointment](#); this is the first [Clinical Intervention Date](#) of the [Imaging or Radiodiagnostic Event](#) or [CLINICAL INTERVENTION](#)
- ~~first seen as an emergency; this is the [Start Date](#) of the [Hospital Provider Spell](#) or the [Arrival Date At Accident and Emergency Department](#) of the [Accident and Emergency Attendance](#)~~
- first seen as an emergency; this is the [Start Date](#) of the [Hospital Provider Spell](#) or the [Emergency Care Arrival Date](#) of the [Emergency Care Attendance](#)
- the date the [PATIENT](#) was first seen following referral (or recall) from (or by) a Screening Unit.

[DATE FIRST SEEN](#) for the:

- [National Cancer Waiting Times Monitoring Data Set](#) is:
 - the date when the [PATIENT](#) is seen for the first time by a [CONSULTANT](#) (or member of their team) or in a clinic following receipt of the [REFERRAL REQUEST](#).
- [HIV and AIDS Reporting Data Set](#) is:
 - the date the [PATIENT](#) was first seen for Human Immunodeficiency Virus (HIV) care at a [HIV Clinic Attendance](#) at the current [Health Care Provider](#).

DECIDED TO ADMIT DATE

Change to Data Element: Changed Dataset

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

Notes:

[DECIDED TO ADMIT DATE](#) is the same as attribute [DECIDED TO ADMIT DATE](#).

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

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

DECIDED TO ADMIT TIME

Change to Data Element: Changed Dataset

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

Notes:

[DECIDED TO ADMIT TIME](#) is the same as attribute [DECIDED TO ADMIT TIME](#).

DIAGNOSIS SCHEME IN USE

Change to Data Element: Changed Dataset

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

Notes:

[DIAGNOSIS SCHEME IN USE](#) is the same as attribute [DIAGNOSIS SCHEME IN USE](#).

For specific National Code usage in different data sets, see [DIAGNOSIS SCHEME IN USE](#).

DISEASE OUTBREAK NOTIFICATION

Change to Data Element: Changed Description

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

Notes:

[DISEASE OUTBREAK NOTIFICATION](#) is the same as attribute [PERSON OBSERVATION TEXT STRING](#).

~~[DISEASE OUTBREAK NOTIFICATION](#) is used in the [CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set](#) / [CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set](#) to support collection of nationally notifiable data relating to outbreaks of disease which are identified in [Emergency Care Departments](#).~~ [DISEASE OUTBREAK NOTIFICATION](#) is used in:

- [CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set](#)
- [CDS V6-2-2 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 available, the [DISEASE OUTBREAK NOTIFICATION](#) field should contain this. If a [SNOMED CT CODE](#) is NOT available, then it is permissible to submit free-text detail of the disease.

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

DISEASE OUTBREAK NOTIFICATION (SNOMED CT)

Change to Data Element: New Data Element

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

Notes:

[DISEASE OUTBREAK NOTIFICATION \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

[DISEASE OUTBREAK NOTIFICATION \(SNOMED CT\)](#) is the SNOMED CT® concept ID describing nationally-notifiable outbreaks of disease.

[DISEASE OUTBREAK NOTIFICATION \(SNOMED CT\)](#) is collected for a specified purpose at national level only and will not be available from the [Secondary Uses Service](#) for use by unauthorised [ORGANISATIONS](#) or individuals.

DISEASE OUTBREAK NOTIFICATION (SNOMED CT)

Change to Data Element: New Data Element

DISEASE OUTBREAK NOTIFICATION (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

DISEASE OUTBREAK NOTIFICATION DESCRIPTION

Change to Data Element: New Data Element

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 collected for a specified purpose at national level only and will not be available from the [Secondary Uses Service](#) for use by unauthorised [ORGANISATIONS](#) or individuals.

DISEASE OUTBREAK NOTIFICATION DESCRIPTION

Change to Data Element: New Data Element

DISEASE OUTBREAK NOTIFICATION DESCRIPTION

Attribute:

PERSON OBSERVATION TEXT STRING

EMERGENCY CARE ACUITY (SNOMED CT)

Change to Data Element: Changed Dataset

Format/Length: See [SNOMED CT CODE](#)
National Codes:
Default Codes:

Notes:

[EMERGENCY CARE ACUITY \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

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

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

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Emergency care acuity simple reference set (foundation metadata concept)
- [Refset](#) Id: 99900306100000107

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

EMERGENCY CARE ARRIVAL DATE

Change to Data Element: Changed Dataset

Format/Length: an10 CCYY-MM-DD

National Codes:
Default Codes:

Notes:

[EMERGENCY CARE ARRIVAL DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Emergency Care Arrival Date](#)'.

EMERGENCY CARE ARRIVAL MODE (SNOMED CT)

Change to Data Element: Changed Dataset

Format/Length: See [SNOMED CT CODE](#)
National Codes:
Default Codes:

Notes:

[EMERGENCY CARE ARRIVAL MODE \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

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

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Emergency care arrival mode simple reference set (foundation metadata concept)
- [Refset](#) Id: 99900298100000107

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

EMERGENCY CARE ARRIVAL TIME

Change to Data Element: Changed Dataset

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

Notes:

[EMERGENCY CARE ARRIVAL TIME](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Emergency Care Arrival Time](#)'.

EMERGENCY CARE ATTENDANCE CATEGORY

Change to Data Element: Changed Dataset

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

Notes:

[EMERGENCY CARE ATTENDANCE CATEGORY](#) is the same as attribute [EMERGENCY CARE ATTENDANCE CATEGORY](#).

EMERGENCY CARE ATTENDANCE IDENTIFIER

Change to Data Element: Changed Dataset

Format/Length: min an1 max an12
National Codes:
Default Codes:

Notes:

[EMERGENCY CARE ATTENDANCE IDENTIFIER](#) is same as attribute [ACTIVITY IDENTIFIER](#).

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

EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT)

Change to Data Element: Changed Dataset

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

Notes:

[EMERGENCY CARE ATTENDANCE SOURCE \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

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

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Emergency care source of attendance findings simple reference set (foundation metadata concept)
- [Refset](#) Id: 99900299100000109

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

EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT)

Change to Data Element: Changed Dataset

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

Notes:

[EMERGENCY CARE CHIEF COMPLAINT \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

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

[SNOMED CT Refset](#) Metadata:

- [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](#) Metadata, see the [Data Dictionary for Care \(DD4C\)](#) website at: [Emergency care presenting complaints or issues](#).

EMERGENCY CARE CLINICAL INVESTIGATION (SNOMED CT)

Change to Data Element: Changed Dataset

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

Notes:

[EMERGENCY CARE CLINICAL INVESTIGATION \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

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

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Emergency care investigations simple reference set (foundation metadata concept)
- [Refset](#) Id: 991261000000107

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

EMERGENCY CARE CLINICALLY READY TO PROCEED TIMESTAMP

Change to Data Element: New Data Element

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

Notes:

EMERGENCY CARE CLINICALLY READY TO PROCEED TIMESTAMP is the same as attribute **ACTIVITY DATE** and **ACTIVITY TIME** where the **ACTIVITY DATE AND TIME TYPE** is National Code '*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.

For the **CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set**, 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.

This data element is also known by these names:

Context	Alias
plural	EMERGENCY CARE CLINICALLY READY TO PROCEED TIMESTAMPS

EMERGENCY CARE CLINICALLY READY TO PROCEED TIMESTAMP

Change to Data Element: New Data Element

EMERGENCY CARE CLINICALLY READY TO PROCEED TIMESTAMP**Attribute:**

ACTIVITY DATE
ACTIVITY TIME

EMERGENCY CARE DATE SEEN FOR TREATMENT

Change to Data Element: Changed Dataset

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

Notes:

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

EMERGENCY CARE DEPARTMENT TYPE

Change to Data Element: Changed Description, Dataset

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

Notes:

[EMERGENCY CARE DEPARTMENT TYPE](#) is the same as attribute [EMERGENCY CARE DEPARTMENT TYPE](#).

The [EMERGENCY CARE DEPARTMENT TYPE](#) definitions will be updated at the next iteration of [DCB0092-2062: Commissioning Data Sets: Emergency Care Data Set](#), to amend the National Code values to support the introduction of [Urgent Treatment Centres](#).

EMERGENCY CARE DEPARTURE DATE

Change to Data Element: Changed Dataset

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

Notes:

[EMERGENCY CARE DEPARTURE DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Emergency Care Departure Date](#)'.

EMERGENCY CARE DEPARTURE TIME

Change to Data Element: Changed Dataset

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

Notes:

[EMERGENCY CARE DEPARTURE TIME](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Emergency Care Departure Time](#)'.

EMERGENCY CARE DIAGNOSIS (SNOMED CT)

Change to Data Element: Changed Dataset

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

Notes:

[EMERGENCY CARE DIAGNOSIS \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

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

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Emergency care diagnosis simple reference set (foundation metadata concept)
- [Refset](#) Id: 991411000000109

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

EMERGENCY CARE DIAGNOSIS QUALIFIER (SNOMED CT)

Change to Data Element: Changed Dataset

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

Notes:

[EMERGENCY CARE DIAGNOSIS QUALIFIER \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

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

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Emergency care diagnosis qualifier simple reference set (foundation metadata concept)
- [Refset](#) Id: 999003001000000108

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

EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT)

Change to Data Element: Changed Dataset

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

Notes:

[EMERGENCY CARE DISCHARGE DESTINATION \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

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

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Emergency care discharge destination simple reference set (foundation metadata concept)
- [Refset](#) Id: 999003011000000105

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

EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT)

Change to Data Element: Changed Dataset

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

Notes:

[EMERGENCY CARE DISCHARGE FOLLOW UP \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

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

[SNOMED CT Refset](#) Metadata:

- [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](#) Metadata, see the [Data Dictionary for Care \(DD4C\)](#) website at: [Emergency care follow-up procedures](#).

EMERGENCY CARE DISCHARGE INFORMATION GIVEN (SNOMED CT)

Change to Data Element: Changed Dataset

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

Notes:

[EMERGENCY CARE DISCHARGE INFORMATION GIVEN \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

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

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Emergency care notification to general practitioner simple reference set (foundation metadata concept)
- [Refset](#) Id: 991241000000106

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

EMERGENCY CARE DISCHARGE STATUS (SNOMED CT)

Change to Data Element: Changed Dataset

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

Notes:

[EMERGENCY CARE DISCHARGE STATUS \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

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

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Emergency care discharge status simple reference set (foundation metadata concept)
- [Refset](#) Id: 999003021000000104

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

EMERGENCY CARE EXPECTED DATE AND TIMESTAMP OF TREATMENT

Change to Data Element: New Data Element

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

Notes:

[EMERGENCY CARE EXPECTED DATE AND TIMESTAMP OF TREATMENT](#) is the same as attribute [PLANNED ACTIVITY DATE](#) and [PLANNED ACTIVITY TIME](#) where the [PLANNED ACTIVITY DATE AND TIME TYPE](#) is National Code '[Emergency Care Expected Date and Timestamp of Treatment](#)'.

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

For the [CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set](#), 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.

This data element is also known by these names:

Context	Alias
plural	EMERGENCY CARE EXPECTED DATES AND TIMESTAMPS OF TREATMENTS

EMERGENCY CARE EXPECTED DATE AND TIMESTAMP OF TREATMENT

Change to Data Element: New Data Element

EMERGENCY CARE EXPECTED DATE AND TIMESTAMP OF TREATMENT

Attribute:

PLANNED ACTIVITY DATE
PLANNED ACTIVITY TIME

EMERGENCY CARE INITIAL ASSESSMENT DATE

Change to Data Element: Changed Dataset

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

Notes:

[EMERGENCY CARE INITIAL ASSESSMENT DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Emergency Care Initial Assessment Date](#)'.

EMERGENCY CARE INITIAL ASSESSMENT TIME

Change to Data Element: Changed Dataset

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

Notes:

[EMERGENCY CARE INITIAL ASSESSMENT TIME](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Emergency Care Initial Assessment Time](#)'.

EMERGENCY CARE INJURY ACTIVITY STATUS (SNOMED CT)

Change to Data Element: Changed Dataset

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

Notes:

[EMERGENCY CARE INJURY ACTIVITY STATUS \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

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

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Emergency care injury activity status simple reference set (foundation metadata concept)
- [Refset](#) Id: 99900303100000102

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

EMERGENCY CARE INJURY ACTIVITY TYPE (SNOMED CT)

Change to Data Element: Changed Dataset

Format/Length:	See SNOMED CT CODE
National Codes:	

Default Codes:

Notes:

[EMERGENCY CARE INJURY ACTIVITY TYPE \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

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

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Emergency care injury activity type simple reference set (foundation metadata concept)
- [Refset](#) Id: 1024501000000108

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

EMERGENCY CARE INJURY ALCOHOL OR DRUG INVOLVEMENT (SNOMED CT)

Change to Data Element: Changed Dataset

Format/Length: See [SNOMED CT CODE](#)
National Codes:
Default Codes:

Notes:

[EMERGENCY CARE INJURY ALCOHOL OR DRUG INVOLVEMENT \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

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

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Emergency care drug or alcohol use related to injury simple reference set (foundation metadata concept)
- [Refset](#) Id: 991421000000103

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

EMERGENCY CARE INJURY INTENT (SNOMED CT)

Change to Data Element: Changed Dataset

Format/Length: See [SNOMED CT CODE](#)
National Codes:
Default Codes:

Notes:

[EMERGENCY CARE INJURY INTENT \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

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

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Emergency care injury intent type simple reference set (foundation metadata concept)
- [Refset](#) Id: 991431000000101

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

EMERGENCY CARE INJURY MECHANISM (SNOMED CT)

Change to Data Element: Changed Dataset

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

Notes:

[EMERGENCY CARE INJURY MECHANISM \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

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

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Emergency care mechanism of injury simple reference set (foundation metadata concept)
- [Refset](#) Id: 99128100000103

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

EMERGENCY CARE PLACE OF INJURY (LATITUDE)

Change to Data Element: Changed Dataset

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

Notes:

[EMERGENCY CARE PLACE OF INJURY \(LATITUDE\)](#) is the same as attribute [GEOGRAPHIC CO-ORDINATE](#).

[EMERGENCY CARE PLACE OF INJURY \(LATITUDE\)](#) is the latitude of the [EMERGENCY CARE PLACE OF INJURY \(SNOMED CT\)](#), expressed in decimal degrees.

EMERGENCY CARE PLACE OF INJURY (LONGITUDE)

Change to Data Element: Changed Dataset

Format/Length:	max n3.n6
National Codes:	
Default Codes:	

Notes:

[EMERGENCY CARE PLACE OF INJURY \(LONGITUDE\)](#) is the same as attribute [GEOGRAPHIC CO-ORDINATE](#).

[EMERGENCY CARE PLACE OF INJURY \(LONGITUDE\)](#) is the longitude of the [EMERGENCY CARE PLACE OF INJURY \(SNOMED CT\)](#), expressed in decimal degrees.

EMERGENCY CARE PLACE OF INJURY (SNOMED CT)

Change to Data Element: Changed Dataset

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

Notes:

[EMERGENCY CARE PLACE OF INJURY \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

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

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Emergency care place of injury type simple reference set (foundation metadata concept)
- [Refset](#) Id: 991291000000101

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

EMERGENCY CARE PROCEDURE (SNOMED CT)

Change to Data Element: Changed Dataset

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

Notes:

[EMERGENCY CARE PROCEDURE \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

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

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Emergency care treatments simple reference set (foundation metadata concept)
- [Refset](#) Id: 991271000000100

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

EMERGENCY CARE TIME SEEN FOR TREATMENT

Change to Data Element: Changed Dataset

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

Notes:

[EMERGENCY CARE TIME SEEN FOR TREATMENT](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Emergency Care Time Seen For Treatment](#)'.

EMERGENCY CARE TREATMENT ALLOCATION TIMESTAMP

Change to Data Element: New Data Element

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.

For the [CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set](#), 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.

This data element is also known by these names:

Context	Alias
plural	EMERGENCY CARE TREATMENT ALLOCATION TIMESTAMPS

EMERGENCY CARE TREATMENT ALLOCATION TIMESTAMP

Change to Data Element: New Data Element

EMERGENCY CARE TREATMENT ALLOCATION TIMESTAMP

Attribute:

EVENT DATE
EVENT TIME

ETHNIC CATEGORY

Change to Data Element: Changed Dataset

Format/Length:	an2
NWDS ID:	PETH
NWDS Field Name:	Ethnic Category
ESR Field Name:	Ethnic Origin
National Codes:	See ETHNIC CATEGORY CODE 2001
Default Codes:	99 - Not known

Notes:

[ETHNIC CATEGORY](#) is the same as attribute [ETHNIC CATEGORY CODE 2001](#).

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

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

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

Note: for the [Stop Smoking Services Quarterly Data Set](#) default code 99 'Not Known' is **not** valid.

ETHNIC CATEGORY 2021

Change to Data Element: Changed Dataset

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

Notes:

[ETHNIC CATEGORY 2021](#) is the same as attribute [ETHNIC CATEGORY 2021](#).

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

EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Dataset

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

Notes:

[EXPIRY DATE \(MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION\)](#) is the same as attribute [PERSON PROPERTY EFFECTIVE END DATE](#).

[EXPIRY DATE \(MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION\)](#) is the date when a [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION](#) for a [PATIENT](#) expires.

EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Dataset

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

Notes:

[END TIME \(MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD\)](#) is the same as attribute [PERSON PROPERTY EFFECTIVE END TIME](#).

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

GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)

Change to Data Element: Changed Dataset

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

Notes:

[GENERAL MEDICAL PRACTICE CODE \(PATIENT REGISTRATION\)](#) is the same as attribute [ORGANISATION CODE](#).

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

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

Use of [Organisation Data Service Default Codes](#)

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

GENERAL MEDICAL PRACTITIONER (SPECIFIED)

Change to Data Element: Changed Dataset

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

Notes:

[GENERAL MEDICAL PRACTITIONER \(SPECIFIED\)](#) is the [GENERAL MEDICAL PRACTITIONER PPD CODE](#) of the [GENERAL MEDICAL PRACTITIONER](#) specified by the [PATIENT](#).

This [GENERAL MEDICAL PRACTITIONER](#) works within the [General Medical Practitioner Practice](#) with which the [PATIENT](#) is registered.

A [GENERAL MEDICAL PRACTITIONER](#) will have at least one of the following:

- [GENERAL MEDICAL COUNCIL REFERENCE NUMBER](#)
- [DOCTOR INDEX NUMBER](#)
- [GENERAL MEDICAL PRACTITIONER PPD CODE](#).

Ministry of Defence Doctors:

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

INJURY DATE

Change to Data Element: Changed Dataset

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

Notes:

[INJURY DATE](#) is the same as attribute [PERSON PROPERTY EFFECTIVE START DATE](#).

[INJURY DATE](#) is the date the [PATIENT](#) was injured.

Where this information cannot be obtained directly from the [PATIENT](#) (or [Patient Proxy](#)), the [INJURY DATE](#) should be estimated.

INJURY TIME

Change to Data Element: Changed Dataset

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

Notes:

[INJURY TIME](#) is the same as attribute [PERSON PROPERTY EFFECTIVE START TIME](#).

[INJURY TIME](#) is the time the [PATIENT](#) was injured.

Where this information cannot be obtained directly from the [PATIENT](#) (or [Patient Proxy](#)), the [INJURY TIME](#) should be estimated.

INTERPRETER LANGUAGE (SNOMED CT)

Change to Data Element: Changed Dataset

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

Notes:

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

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

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Interpreter type findings simple reference set
- [Refset](#) Id: 991231000000102

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

INVESTIGATION SCHEME IN USE (RETIRED), renamed from **INVESTIGATION SCHEME IN USE**

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

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

Notes:

[INVESTIGATION SCHEME IN USE](#) is the same as attribute [INVESTIGATION SCHEME IN USE](#).

[INVESTIGATION SCHEME IN USE](#) is used in the Clinical Activity Group of the [Commissioning Data Set](#) to denote the scheme basis of an investigation. **This item has been retired from the NHS Data Model and Dictionary.**

The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

INVESTIGATION SCHEME IN USE (RETIRED), renamed from **INVESTIGATION SCHEME IN USE**

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

INVESTIGATION SCHEME IN USE

Attribute:

INVESTIGATION SCHEME IN USE

INVESTIGATION SCHEME IN USE (RETIRED), renamed from **INVESTIGATION SCHEME IN USE**

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from `Data_Dictionary.Data_Field_Notes.I.Inv.INVESTIGATION_SCHEME_IN_USE` to `Retired.Data_Dictionary.Data_Field_Notes.I.INVESTIGATION_SCHEME_IN_USE`
- Retired INVESTIGATION SCHEME IN USE

LOCAL PATIENT IDENTIFIER

Change to Data Element: Changed Dataset

Format/Length:	an10
National Codes:	
Default Codes:	

Notes:

[LOCAL PATIENT IDENTIFIER](#) is the same as attribute [LOCAL PATIENT IDENTIFIER](#).

LOCAL PATIENT IDENTIFIER (EXTENDED)

Change to Data Element: Changed Dataset

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

Notes:

[LOCAL PATIENT IDENTIFIER \(EXTENDED\)](#) is the same as attribute [LOCAL PATIENT IDENTIFIER](#).

[LOCAL PATIENT IDENTIFIER \(EXTENDED\)](#) is used where IT systems have a [LOCAL PATIENT IDENTIFIER](#) which is longer than 10 characters and [LOCAL PATIENT IDENTIFIER](#) cannot be used for data submission.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE

Change to Data Element: Changed Dataset

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

Notes:

[MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE](#) is the same as attribute [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE](#).

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

Note: for the [Mental Health Services Data Set](#), 'Not Known' indicates 'Not Recorded'.

NHS NUMBER

Change to Data Element: Changed Dataset

Format/Length:	n10
National Codes:	
Default Codes:	

Notes:

[NHS NUMBER](#) is the same as attribute [NHS NUMBER](#).

For the [AIDC for Patient Identification Data Set](#) further guidance can be found on the [NHS Digital](#) website at: [DCB1077: AIDC for Patient Identification](#).

NHS NUMBER STATUS INDICATOR CODE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See NHS NUMBER STATUS INDICATOR CODE
Default Codes:	

Notes:

[NHS NUMBER STATUS INDICATOR CODE](#) is the same as attribute [NHS NUMBER STATUS INDICATOR CODE](#).

For specific National Code usage in different data sets, see [NHS NUMBER STATUS INDICATOR CODE](#).

NHS SERVICE AGREEMENT LINE NUMBER

Change to Data Element: Changed Dataset

Format/Length:	an10
National Codes:	
Default Codes:	

Notes:

[NHS SERVICE AGREEMENT LINE NUMBER](#) is the same as attribute [NHS SERVICE AGREEMENT LINE NUMBER](#).

The [NHS SERVICE AGREEMENT LINE NUMBERS](#) may be used to identify a specific [NHS SERVICE AGREEMENT](#) reference where the main identifier refers to a general omnibus agreement.

OBSERVATION VALUE

Change to Data Element: Changed Dataset

Format/Length:	max an10
National Codes:	
Default Codes:	

Notes:

[OBSERVATION VALUE](#) is the same as attribute [OBSERVATION VALUE](#).

ORGANISATION CODE (CODE OF COMMISSIONER)

Change to Data Element: Changed Dataset

Format/Length:	an3 or an5
National Codes:	
ODS Default Codes:	VPP00 - Private PATIENTS / Overseas Visitor liable for charge XMD00 - Commissioner Code for Ministry of Defence (MoD) Healthcare YDD82 - Episodes funded directly by the National Commissioning Group for England (Retired September 2018)

Notes:

[ORGANISATION CODE \(CODE OF COMMISSIONER\)](#) is the same as attribute [ORGANISATION CODE](#).

[ORGANISATION CODE \(CODE OF COMMISSIONER\)](#) is the [ORGANISATION CODE](#) of the [ORGANISATION](#) commissioning health care.

For [Commissioning Data Sets](#), the [ORGANISATION CODE \(CODE OF COMMISSIONER\)](#) should always be the [ORGANISATION CODE](#) of the original commissioner to support the [National Tariff Payment System](#).

The [NHS England](#) document "[Who pays? Determining responsibility for payments to providers](#)" sets out a framework for establishing responsibility for commissioning an individual's care within the NHS, (i.e. determining who pays for a [PATIENT](#)'s care.)

The document includes information on the following:

- General Rules
- Applying the rules to [Clinical Commissioning Group](#) and [NHS England](#) commissioned services
- Exceptions to the general rules
- Examples to help clarify the boundaries of responsibility between commissioning [ORGANISATIONS](#).

For further information on this document contact [NHS England](#) at "[Contact us](#)".

Where [NHS England](#) is the responsible commissioner for a specialised [SERVICE](#), based on the [NHS England Commissioner Assignment Method \(CAM\)](#), one of the [Specialised Commissioning Hub ORGANISATION CODES](#) should be used depending on which [Health Care Provider](#) delivered the [SERVICE](#), e.g. [NHS Trust](#), [Independent Sector Healthcare Provider](#).

The [NHS Digital](#) website provides a mapping list of which [Health Care Providers](#) map to which [Specialised Commissioning Hub](#). The mapping can be found on the [Organisation Data Service](#) web pages at: [Provider to Commissioning Hub Mapping](#).

[ORGANISATION CODE \(CODE OF COMMISSIONER\)](#) will be replaced with [ORGANISATION IDENTIFIER \(CODE OF COMMISSIONER\)](#), when it has been approved for use in national information standards.

ORGANISATION CODE (CODE OF PROVIDER)

Change to Data Element: Changed Dataset

Format/Length:	an3, an5 or an6
National Codes:	
ODS Default Codes:	89997 - Non-UK provider where no ORGANISATION CODE has been issued 89999 - Non-NHS UK provider where no ORGANISATION CODE has been issued

Notes:

[ORGANISATION CODE \(CODE OF PROVIDER\)](#) is the same as the attribute [ORGANISATION CODE](#).

[ORGANISATION CODE \(CODE OF PROVIDER\)](#) is the [ORGANISATION CODE](#) of the [ORGANISATION](#) acting as a [Health Care Provider](#).

For [Commissioning Data Sets](#), the [ORGANISATION CODE \(CODE OF PROVIDER\)](#) should always be the [ORGANISATION CODE](#) of the [Health Care Provider](#) receiving the [National Tariff Payment System](#) income.

[ORGANISATION CODE \(CODE OF PROVIDER\)](#) is used by the [Secondary Uses Service](#) to derive the [Healthcare Resource Group](#) 4. Failure to correctly populate this data element is likely to result in an incorrect [Healthcare Resource Group](#), usually associated with lower levels of healthcare resource.

For further information, please refer to the [NHS Digital](#) website at: [Payment by Results Guidance](#).

[ORGANISATION CODE \(CODE OF PROVIDER\)](#) will be replaced with [ORGANISATION IDENTIFIER \(CODE OF PROVIDER\)](#), when it has been approved for use in national information standards.

ORGANISATION CODE (CONVEYING AMBULANCE TRUST)

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	
Default Codes:	

Notes:

[ORGANISATION CODE \(CONVEYING AMBULANCE TRUST\)](#) is the same as attribute [ORGANISATION CODE](#).

[ORGANISATION CODE \(CONVEYING AMBULANCE TRUST\)](#) is the code of an [Ambulance Service](#) which conveys a [PATIENT](#).

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

ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)

Change to Data Element: Changed Dataset

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

Notes:

[ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#) is the same as attribute [ORGANISATION CODE](#).

[ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#) is the [ORGANISATION CODE](#) of the [ORGANISATION](#) that assigned the [LOCAL PATIENT IDENTIFIER](#).

[ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#) will be replaced with [ORGANISATION IDENTIFIER \(LOCAL PATIENT IDENTIFIER\)](#), when it has been approved for use in national information standards.

ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)

Change to Data Element: Changed Dataset

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

Notes:

[ORGANISATION CODE \(PATIENT PATHWAY IDENTIFIER ISSUER\)](#) is the same as attribute [ORGANISATION CODE](#).

[ORGANISATION CODE \(PATIENT PATHWAY IDENTIFIER ISSUER\)](#) is the [ORGANISATION CODE](#) of the [ORGANISATION](#) issuing the [PATIENT PATHWAY IDENTIFIER](#).

Where [Choose and Book](#) has been used, the [ORGANISATION CODE](#) X09 should be used.

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a [Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#), and is of the following Commissioning Data Set Types:

- [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#)
- [CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 030 - Elective Admission List - End of Period Census \(Standard\) Commissioning Data Set](#)
- [CDS V6-2 Type 060 - Elective Admission List - Event During Period \(Add\) Commissioning Data Set](#)
- [CDS V6-2 Type 070 - Elective Admission List - Event During Period \(Remove\) Commissioning Data Set](#)
- [CDS V6-2 Type 080 - Elective Admission List - Event During Period \(Offer\) Commissioning Data Set](#)

then [ORGANISATION CODE \(PATIENT PATHWAY IDENTIFIER ISSUER\)](#) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

[ORGANISATION CODE \(PATIENT PATHWAY IDENTIFIER ISSUER\)](#) will be replaced with [ORGANISATION IDENTIFIER \(PATIENT PATHWAY IDENTIFIER ISSUER\)](#), when it has been approved for use in national information standards.

ORGANISATION CODE (RESIDENCE RESPONSIBILITY)

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	
ODS Default Codes:	Q99 - High Level Health Geography/Primary Care ORGANISATION of Residence Not Known Note: This code must not be used in the Commissioning Data Set header. It is not a default commissioner code.
	X98 - Primary Care ORGANISATION Not Applicable (Overseas Visitors) Note: this code must not be used in the Commissioning Data Set (CDS) header. It is not a default Commissioner code.

Notes:

[ORGANISATION CODE \(RESIDENCE RESPONSIBILITY\)](#) is the same as attribute [ORGANISATION CODE](#).

[ORGANISATION CODE \(RESIDENCE RESPONSIBILITY\)](#) is the [ORGANISATION CODE](#) derived from the [PATIENT](#)'s [POSTCODE OF USUAL ADDRESS](#), where they reside within the boundary of a:

- [Clinical Commissioning Group](#)
- [Care Trust](#)
- [Local Health Board \(Wales\)](#)
- [Scottish Health Board](#)
- [Northern Ireland Local Commissioning Group](#): *Guidance on the use of Northern Ireland codes can be found in [Data Set Change Notice 19/2009](#)*
- [Primary Healthcare Directorate \(Isle of Man\)](#)
- [Local Authority](#).

[ORGANISATION CODES](#) can be downloaded from [Technology Reference Data Update Distribution \(TRUD\)](#). For further information, see [Organisation Data Service](#).

For [PATIENTS](#) who are [Overseas Visitors](#): [Organisation Data Service Default Code](#) X98 'Primary Care Organisation Not Applicable ([Overseas Visitors](#))' should be reported.

Note: A review of [Organisation Data Service Default Codes](#) is planned to be carried out and this default code will be updated as part of that.

For the purposes of sending Commissioning Data Set messages to the [Secondary Uses Service](#) (regardless of how local systems hold the data), it is essential at present to continue using a 3 character field, using the first 3 characters of the [ORGANISATION CODE \(RESIDENCE RESPONSIBILITY\)](#) and following the same update rules relating to Prime Recipient as are currently in place. This is necessary, primarily to preserve the integrity of the current Commissioning Data Set message and the [CDS PRIME RECIPIENT IDENTITY](#) which is derived from the [ORGANISATION CODE \(RESIDENCE RESPONSIBILITY\)](#).

The [Organisation Data Service](#) provides postcode files which link postcodes to the [Clinical Commissioning Group](#). See [NHS Postcode Directory](#).

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

ORGANISATION IDENTIFIER (CDS RECIPIENT)

Change to Data Element: Changed Dataset

Format/Length:	min an3 max an5
National Codes:	
ODS Default Codes:	TDH00 - Overseas Visitor exempt from charges VPP00 - Private PATIENTS / Overseas Visitor liable for charges

Notes:

ORGANISATION IDENTIFIER (CDS RECIPIENT) is the same as attribute ORGANISATION IDENTIFIER.

~~This item is being used for development purposes and has not yet been approved.~~ ORGANISATION IDENTIFIER (CDS RECIPIENT) is the NHS ORGANISATION IDENTIFIER (or valid Organisation Data Service Default Code) for an ORGANISATION identified as a recipient of the commissioning data set data.

Usage:

A maximum of 7 ORGANISATION IDENTIFIERS (CDS RECIPIENT) may be submitted. The submission order does not infer the primacy of one recipient over another.

A Recipient may be an agency or SERVICE provider that carries out the receiving (and perhaps other) processes on behalf of the NHS ORGANISATION that ultimately uses the data.

Where NHS England is the responsible Commissioner for a specialised SERVICE, based on the NHS England Commissioner Assignment Method (CAM), one of the Specialised Commissioning Hub ORGANISATION IDENTIFIERS should be used depending on which Health Care Provider delivered the SERVICE, e.g. NHS Trust, Independent Sector Healthcare Provider.

The NHS Digital website provides a mapping list of which Health Care Providers map to which Specialised Commissioning Hub. The mapping can be found on the Organisation Data Service web pages at: Provider to Commissioning Hub Mapping.

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

- Q99 - High Level Health Geography/Primary Care Organisation of Residence Not Known
 - a valid ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) must be reported where a recipient of commissioning data is specified
- X98 - Primary Care Organisation Not Applicable (Overseas Visitors).

CDS PRIME RECIPIENT IDENTITY and CDS COPY RECIPIENT IDENTITY will be replaced with ORGANISATION IDENTIFIER (CDS RECIPIENT), when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (CDS SENDER)

Change to Data Element: Changed Dataset

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

Notes:

ORGANISATION IDENTIFIER (CDS SENDER) is the mandatory ORGANISATION IDENTIFIER of the ORGANISATION acting as the physical Sender of Commissioning Data Set submissions.

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

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

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

For further guidance see the [Commissioning Data Set Submission Protocol](#).

[CDS SENDER IDENTITY](#) will be replaced with [ORGANISATION IDENTIFIER \(CDS SENDER\)](#), when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)

Change to Data Element: Changed Dataset

Format/Length:	min an3 max an5
National Codes:	
ODS Default Codes:	VPP00 - Private PATIENTS / Overseas Visitor liable for charge
	XMD00 - Commissioner Code for Ministry of Defence (MoD) Healthcare
	YDD82 - Episodes funded directly by the National Commissioning Group for England (Retired September 2018)

Notes:

[ORGANISATION IDENTIFIER \(CODE OF COMMISSIONER\)](#) is the same as attribute [ORGANISATION IDENTIFIER](#).

[ORGANISATION IDENTIFIER \(CODE OF COMMISSIONER\)](#) is the [ORGANISATION IDENTIFIER](#) of the [ORGANISATION](#) commissioning health care.

For [Commissioning Data Sets](#), the [ORGANISATION IDENTIFIER \(CODE OF COMMISSIONER\)](#) should always be the [ORGANISATION IDENTIFIER](#) of the original commissioner to support the [National Tariff Payment System](#).

The [NHS England](#) document "[Who pays? Determining responsibility for payments to providers](#)" sets out a framework for establishing responsibility for commissioning an individual's care within the NHS, (i.e. determining who pays for a [PATIENT](#)'s care.)

The document includes information on the following:

- General Rules
- Applying the rules to [Clinical Commissioning Group](#) and [NHS England](#) commissioned services
- Exceptions to the general rules
- Examples to help clarify the boundaries of responsibility between commissioning [ORGANISATIONS](#).

For further information on this document contact [NHS England](#) at "[Contact us](#)".

Where [NHS England](#) is the responsible commissioner for a specialised [SERVICE](#), based on the [NHS England Commissioner Assignment Method \(CAM\)](#), one of the [Specialised Commissioning Hub ORGANISATION IDENTIFIERS](#) should be used depending on which [Health Care Provider](#) delivered the [SERVICE](#), e.g. [NHS Trust](#), [Independent Sector Healthcare Provider](#).

The [NHS Digital](#) website provides a mapping list of which [Health Care Providers](#) map to which [Specialised Commissioning Hub](#). The mapping can be found on the [Organisation Data Service](#) web pages at: [Provider to Commissioning Hub Mapping](#).

[ORGANISATION CODE \(CODE OF COMMISSIONER\)](#) will be replaced with [ORGANISATION IDENTIFIER \(CODE OF COMMISSIONER\)](#), when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (CODE OF PROVIDER)

Change to Data Element: Changed Dataset

Format/Length:	min an3 max an6
National Codes:	
ODS Default Codes:	89997 - Non-UK provider where no ORGANISATION IDENTIFIER has been issued
	89999 - Non-NHS UK provider where no ORGANISATION IDENTIFIER has been issued

Notes:

[ORGANISATION IDENTIFIER \(CODE OF PROVIDER\)](#) is the same as the attribute [ORGANISATION IDENTIFIER](#).

[ORGANISATION IDENTIFIER \(CODE OF PROVIDER\)](#) is the [ORGANISATION IDENTIFIER](#) of the [ORGANISATION](#) acting as a [Health Care Provider](#).

For [Commissioning Data Sets](#), the [ORGANISATION IDENTIFIER \(CODE OF PROVIDER\)](#) should always be the [ORGANISATION IDENTIFIER](#) of the [Health Care Provider](#) receiving the [National Tariff Payment System](#) income.

[ORGANISATION CODE \(CODE OF PROVIDER\)](#) is used by the [Secondary Uses Service](#) to derive the [Healthcare Resource Group 4](#). Failure to correctly populate this data element is likely to result in an incorrect [Healthcare Resource Group](#), usually associated with lower levels of healthcare resource.

For further information, please refer to the [NHS Digital](#) website at: [Payment by Results Guidance](#).

[ORGANISATION CODE \(CODE OF PROVIDER\)](#) will be replaced with [ORGANISATION IDENTIFIER \(CODE OF PROVIDER\)](#), when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (CONVEYING AMBULANCE TRUST)

Change to Data Element: Changed Dataset

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

Notes:

[ORGANISATION IDENTIFIER \(CONVEYING AMBULANCE TRUST\)](#) is the same as attribute [ORGANISATION IDENTIFIER](#).

[ORGANISATION IDENTIFIER \(CONVEYING AMBULANCE TRUST\)](#) is the [ORGANISATION IDENTIFIER](#) of an [Ambulance Service](#) which conveys a [PATIENT](#).

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

ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)

Change to Data Element: Changed Dataset

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

Notes:

[ORGANISATION IDENTIFIER \(LOCAL PATIENT IDENTIFIER\)](#) is the same as attribute [ORGANISATION IDENTIFIER](#).

[ORGANISATION IDENTIFIER \(LOCAL PATIENT IDENTIFIER\)](#) is the [ORGANISATION IDENTIFIER](#) of the [ORGANISATION](#) that assigned the [LOCAL PATIENT IDENTIFIER](#).

[ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#) will be replaced with [ORGANISATION IDENTIFIER \(LOCAL PATIENT IDENTIFIER\)](#), when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)

Change to Data Element: Changed Dataset

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

Notes:

[ORGANISATION IDENTIFIER \(PATIENT PATHWAY IDENTIFIER ISSUER\)](#) is the same as attribute [ORGANISATION IDENTIFIER](#).

[ORGANISATION IDENTIFIER \(PATIENT PATHWAY IDENTIFIER ISSUER\)](#) is the [ORGANISATION IDENTIFIER](#) of the [ORGANISATION](#) issuing the [PATIENT PATHWAY IDENTIFIER](#).

Where [Choose and Book](#) has been used, the [ORGANISATION IDENTIFIER](#) X09 should be used.

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a [Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#), and is of the following Commissioning Data Set Types:

- [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#)
- [CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 030 - Elective Admission List - End of Period Census \(Standard\) Commissioning Data Set](#)
- [CDS V6-2 Type 060 - Elective Admission List - Event During Period \(Add\) Commissioning Data Set](#)
- [CDS V6-2 Type 070 - Elective Admission List - Event During Period \(Remove\) Commissioning Data Set](#)
- [CDS V6-2 Type 080 - Elective Admission List - Event During Period \(Offer\) Commissioning Data Set](#)

then [ORGANISATION CODE \(PATIENT PATHWAY IDENTIFIER ISSUER\)](#) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

[ORGANISATION CODE \(PATIENT PATHWAY IDENTIFIER ISSUER\)](#) will be replaced with [ORGANISATION IDENTIFIER \(PATIENT PATHWAY IDENTIFIER ISSUER\)](#), when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)

Change to Data Element: Changed Dataset

Format/Length:	min an3 max an5
National Codes:	
ODS Default Codes:	Q99 - High Level Health Geography/Primary Care ORGANISATION of Residence Not Known Note: This code must not be used in the Commissioning Data Set header. It is not a default commissioner code.
	X98 - Primary Care ORGANISATION Not Applicable (Overseas Visitors) Note: this code must not be used in the Commissioning Data Set (CDS) header. It is not a default Commissioner code.

Notes:

[ORGANISATION IDENTIFIER \(RESIDENCE RESPONSIBILITY\)](#) is the same as attribute [ORGANISATION IDENTIFIER](#).

[ORGANISATION IDENTIFIER \(RESIDENCE RESPONSIBILITY\)](#) is the [ORGANISATION IDENTIFIER](#) derived from the [PATIENT's POSTCODE OF USUAL ADDRESS](#), where they reside within the boundary of a:

- [Clinical Commissioning Group](#)
- [Care Trust](#)
- [Local Health Board \(Wales\)](#)
- [Scottish Health Board](#)
- [Northern Ireland Local Commissioning Group](#): *Guidance on the use of Northern Ireland codes can be found in [Data Set Change Notice 19/2009](#)*
- [Primary Healthcare Directorate \(Isle of Man\)](#)
- [Local Authority](#).

For [PATIENTS](#) who are [Overseas Visitors](#): [Organisation Data Service Default Code](#) X98 'Primary Care Organisation Not Applicable ([Overseas Visitors](#))' should be reported.

Note: A review of [Organisation Data Service Default Codes](#) is planned to be carried out and this default code will be updated as part of that.

For the purposes of sending Commissioning Data Set messages to the [Secondary Uses Service](#) (regardless of how local systems hold the data), it is essential at present to continue using a 3 character field, using the first 3 characters of the [ORGANISATION IDENTIFIER \(RESIDENCE RESPONSIBILITY\)](#) and following the same update rules relating to Prime Recipient as are currently in place. This is necessary, primarily to preserve the integrity of the current Commissioning Data Set message and the [CDS PRIME RECIPIENT IDENTITY](#) which is derived from the [ORGANISATION IDENTIFIER \(RESIDENCE RESPONSIBILITY\)](#).

[ORGANISATION CODE \(RESIDENCE RESPONSIBILITY\)](#) will be replaced with [ORGANISATION IDENTIFIER \(RESIDENCE RESPONSIBILITY\)](#), when it has been approved for use in national information standards.

ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE)

Change to Data Element: Changed Dataset

Format/Length:	min an5 max an9
National Codes:	
ODS 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](#).

ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE)

Change to Data Element: Changed Dataset

Format/Length:	min an5 max an9
National Codes:	
ODS 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](#).

ORGANISATION SITE IDENTIFIER (OF PROVIDER FIRST SEEN)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
ODS 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 \(OF PROVIDER FIRST SEEN\)](#) is the same as attribute [ORGANISATION SITE IDENTIFIER](#).

[ORGANISATION SITE IDENTIFIER \(OF PROVIDER FIRST SEEN\)](#) is the [ORGANISATION SITE IDENTIFIER](#) of the [ORGANISATION SITE](#) of the [Health Care Provider](#) at the first contact with the [PATIENT](#).

For the [National Cancer Waiting Times Monitoring Data Set](#) this may be the:

- [Out-Patient Attendance Consultant](#)
- [Imaging or Radiodiagnostic Event](#)
- [CLINICAL INTERVENTION](#)
- [Hospital Provider Spell](#)
- [Accident and Emergency Attendance](#) or
- [Emergency Care Attendance](#) or
- [Screening Test](#)

whichever is the earlier [SERVICE](#) related to the initial [REFERRAL REQUEST](#).

[ORGANISATION SITE IDENTIFIER \(OF PROVIDER FIRST SEEN\)](#) may be the same [Health Care Provider](#) as for [ORGANISATION SITE IDENTIFIER \(OF PROVIDER FIRST CANCER SPECIALIST\)](#) if the [PATIENT](#) was first seen by the appropriate specialist for cancer.

ORGANISATION SITE IDENTIFIER (OF TREATMENT)

Change to Data Element: Changed Dataset

Format/Length:	min an5 max an9
National Codes:	
ODS Default Codes:	R9998 - Not a hospital site 89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:

[ORGANISATION SITE IDENTIFIER \(OF TREATMENT\)](#) is the same as attribute [ORGANISATION SITE IDENTIFIER](#).

[ORGANISATION SITE IDENTIFIER \(OF TREATMENT\)](#) is the [ORGANISATION SITE IDENTIFIER](#) of the [ORGANISATION SITE](#) where the [PATIENT](#) was treated, i.e. it should enable the treating [ORGANISATION](#) to be identified.

[ORGANISATION SITE IDENTIFIER \(OF TREATMENT\)](#) identifies the [ORGANISATION SITE](#) within the [ORGANISATION](#) on which the [PATIENT](#) was treated, since facilities may vary on different hospital sites.

The code recorded should always be the national code; if the treatment is sub-commissioned to another NHS [Health Care Provider](#) or an independent UK provider, the [ORGANISATION SITE IDENTIFIER \(OF TREATMENT\)](#) used should be the [ORGANISATION SITE IDENTIFIER](#) of the [Health Care Provider](#) actually carrying out the work.

Where treatment is sub-commissioned to an overseas provider the [Organisation Data Service Default Code](#) 89997 'Non-UK Provider where no [ORGANISATION SITE IDENTIFIER](#) has been issued' is applicable.

Each [ORGANISATION](#) has a unique [ORGANISATION SITE IDENTIFIER](#). However, where an [ORGANISATION](#) has more than one site from which it provides [SERVICES](#), then each site is uniquely identified. These sites are [ORGANISATION SITES](#) and are uniquely identified by an [ORGANISATION SITE IDENTIFIER](#).

For out-patients, [ACTIVITY](#) may take place outside the hospital, such as in the [PATIENT'S](#) home; in such cases, raising a site code is impractical. Therefore, code R9998 'Not a hospital site' would be used in these circumstances.

Note: [LOCATION CLASS](#) is used in the Commissioning Data Set (CDS) message to indicate the physical [LOCATION](#) within which the [ACTIVITY](#) occurred.

Use in the Future Outpatient CDS:

If the [INTENDED SITE CODE \(OF TREATMENT\)](#) is not known, this data element should be omitted.

[SITE CODE \(OF TREATMENT\)](#) will be replaced with [ORGANISATION SITE IDENTIFIER \(OF TREATMENT\)](#), when it has been approved for use in national information standards.

OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See OVERSEAS VISITOR CHARGING CATEGORY
Default Codes:	9 - OVERSEAS VISITOR CHARGING CATEGORY Not Known (Not Recorded) X - Not Known (Decision pending on OVERSEAS VISITOR CHARGING CATEGORY): only valid for CDS V6-2-1 Type 011 - Emergency Care Commissioning Data Set

Notes:

[OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE](#) is the same as attribute [OVERSEAS VISITOR CHARGING CATEGORY](#), recorded at the [CDS ACTIVITY DATE](#).

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

OVERSEAS VISITOR STATUS CLASSIFICATION AT CDS ACTIVITY DATE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See OVERSEAS VISITOR STATUS CLASSIFICATION
Default Codes:	8 - Not applicable (not an Overseas Visitor)

Notes:

[OVERSEAS VISITOR STATUS CLASSIFICATION AT CDS ACTIVITY DATE](#) is the same as attribute [OVERSEAS VISITOR STATUS CLASSIFICATION](#), recorded at the [CDS ACTIVITY DATE](#).

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

PATIENT NAME

Change to Data Element: Changed Dataset

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

Notes:

[PATIENT NAME](#) is the preferred name of the [PATIENT](#).

For the [Commissioning Data Sets](#) it is necessary to identify whether the [PERSON NAME](#) is a [PERSON NAME STRUCTURED](#) or [PERSON NAME UNSTRUCTURED](#) using the following codes.

- | | |
|---|--------------------------------------------------------------------------------|
| 1 | Structured - two element name, forename followed by surname, each element an35 |
| 2 | Unstructured - an70 |
| 9 | Not known: a validation error |

The [PATIENT](#)'s name and [ADDRESS](#) should be withheld from any [Commissioning Data Set](#) that contains a valid [NHS NUMBER](#). For further information, see the [Security Issues and Patient Confidentiality](#).

PATIENT PATHWAY IDENTIFIER

Change to Data Element: Changed Dataset

Format/Length:	an20
National Codes:	
Default Codes:	

Notes:

[PATIENT PATHWAY IDENTIFIER](#) is the same as [PATIENT PATHWAY IDENTIFIER](#).

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a [Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#), and is of the following Commissioning Data Set Types:

- [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#)
- [CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 030 - Elective Admission List - End of Period Census \(Standard\) Commissioning Data Set](#)
- [CDS V6-2 Type 060 - Elective Admission List - Event During Period \(Add\) Commissioning Data Set](#)
- [CDS V6-2 Type 070 - Elective Admission List - Event During Period \(Remove\) Commissioning Data Set](#)
- [CDS V6-2 Type 080 - Elective Admission List - Event During Period \(Offer\) Commissioning Data Set](#)

then either [UNIQUE BOOKING REFERENCE NUMBER \(CONVERTED\)](#) or [PATIENT PATHWAY IDENTIFIER](#) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

PATIENT USUAL ADDRESS

Change to Data Element: Changed Dataset

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

Notes:

[PATIENT USUAL ADDRESS](#) is the same as attribute [ADDRESS](#).

[PATIENT USUAL ADDRESS](#) is the usual [ADDRESS](#) nominated by the [PATIENT](#), where the [ADDRESS ASSOCIATION TYPE](#) is National Code 'Main Permanent Residence' or 'Other Permanent Residence'.

For the [Commissioning Data Sets](#) it is necessary whenever an [ADDRESS](#) is included in a [Commissioning Data Set](#) message to allow correct interpretation by the recipient. The following values have been used in [Commissioning Data Set](#) message implementations and are recommended to be used.

- 1 or S To denote a "Label format" [ADDRESS](#), i.e. an [ADDRESS](#) consisting of up to five address lines of 35 characters where each line is left justified as a specific data element
- 2 or U To denote an unstructured [ADDRESS](#), i.e. an [ADDRESS](#) consisting of up to five contiguous data elements of 35 characters representing a 175 character string

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

Where [PATIENTS](#) are not capable of supplying this information, because of age or mental illness, for example, then the [PERSON](#) responsible for the [PATIENT](#), such as a parent or guardian, should nominate the [PATIENT USUAL ADDRESS](#).

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

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

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

```

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

```

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

PERSON BIRTH DATE

Change to Data Element: Changed Dataset

Format/Length:	an10 CCYY-MM-DD
NWDS ID:	PEBD
NWDS Field Name:	Date of Birth
National Codes:	
Default Codes:	

Notes:

[PERSON BIRTH DATE](#) is the same as attribute [PERSON BIRTH DATE](#).

PERSON GENDER CODE CURRENT

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See PERSON GENDER CODE
Default Codes:	

Notes:

[PERSON GENDER CODE CURRENT](#) is the same as attribute [PERSON GENDER CODE](#).

[PERSON GENDER CODE CURRENT](#) is a [PERSON](#)'s gender currently.

[PERSON GENDER CODE CURRENT](#) 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](#).

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

For specific National Code usage, see [PERSON GENDER CODE](#).

PERSON SCORE

Change to Data Element: Changed Dataset

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

Notes:

[PERSON SCORE](#) is the same as attribute [PERSON SCORE](#).

PERSON STATED GENDER CODE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See PERSON STATED GENDER CODE
Default Codes:	X - Not Known (PERSON STATED GENDER CODE not recorded)

Notes:

[PERSON STATED GENDER CODE](#) is the same as attribute [PERSON STATED GENDER CODE](#).

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

POSTCODE OF USUAL ADDRESS

Change to Data Element: Changed Dataset

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

Notes:

[POSTCODE OF USUAL ADDRESS](#) is the same as data element [POSTCODE](#).

[POSTCODE OF USUAL ADDRESS](#) is the [POSTCODE](#) of the [ADDRESS](#) nominated by the [PATIENT](#) where the [ADDRESS ASSOCIATION TYPE](#) is National Code 'Main Permanent Residence' or 'Other Permanent Residence'.

For further information on [POSTCODES](#), see [POSTCODE](#).

PREFERRED SPOKEN LANGUAGE (SNOMED CT)

Change to Data Element: Changed Dataset

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

Notes:

[PREFERRED SPOKEN LANGUAGE \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

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

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Preferred spoken language findings simple reference set
- [Refset](#) Id: 991181000000109

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

PRESENT ON ADMISSION INDICATOR

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See PRESENT ON ADMISSION INDICATOR
Default Codes:	8 - Not applicable (indication of this PATIENT DIAGNOSIS on admission not required nationally) 9 - Not known whether the PATIENT DIAGNOSIS was present on admission

Notes:

[PRESENT ON ADMISSION INDICATOR](#) is the same as attribute [PRESENT ON ADMISSION INDICATOR](#).

Note:

This data item is included in Commissioning Data Set version 6-2, but should not be submitted until further development by [NHS Digital](#) has been undertaken.

PRIMARY DIAGNOSIS (ICD)

Change to Data Element: Changed Dataset

Format/Length:	See ICD-10 CODE
National Codes:	
Default Codes:	

Notes:

[PRIMARY DIAGNOSIS \(ICD\)](#) is the same as attribute [CLINICAL CLASSIFICATION CODE](#).

[PRIMARY DIAGNOSIS \(ICD\)](#) is the [International Classification of Diseases \(ICD\)](#) code used to identify the [PRIMARY DIAGNOSIS](#).

[PRIMARY DIAGNOSIS \(ICD\)](#) is used by the [Secondary Uses Service](#) to derive the [Healthcare Resource Group 4](#). Failure to correctly populate this data element is likely to result in an incorrect [Healthcare Resource Group](#), usually associated with lower levels of healthcare resource.

For further information, please refer to the [NHS Digital](#) website at: [Payment by Results Guidance](#).

Note:

- The format/length of this Data Element has been corrected as a result of the work undertaken for the development of the Coding Strategy.
- The data set specifications of the data sets that contain this Data Element will be updated in the next version of the information standard where it is not already correct.

PRIMARY DIAGNOSIS (READ)

Change to Data Element: Changed Dataset

Format/Length:	See READ CODE
National Codes:	
Default Codes:	

Notes:

[PRIMARY DIAGNOSIS \(READ\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

[PRIMARY DIAGNOSIS \(READ\)](#) is the [Read Coded Clinical Terms](#) code to identify the [PRIMARY DIAGNOSIS](#).

Note: [Read Coded Clinical Terms](#) Version 3 (CTV3) with qualifiers is not supported in the Commissioning Data Sets. Therefore, the Commissioning Data Set Version 6-2 XML Schema has the format of this Data Element constrained to max an5.

PRIMARY PROCEDURE (OPCS)

Change to Data Element: Changed Dataset

Format/Length:	See OPCS-4 CODE
National Codes:	
Default Codes:	

Notes:

[PRIMARY PROCEDURE \(OPCS\)](#) is the same as attribute [CLINICAL CLASSIFICATION CODE](#).

[PRIMARY PROCEDURE \(OPCS\)](#) is the [OPCS Classification of Interventions and Procedures](#) code which is used to identify the primary [Patient Procedure](#) carried out.

PRIMARY PROCEDURE (READ)

Change to Data Element: Changed Dataset

Format/Length:	See READ CODE
National Codes:	
Default Codes:	

Notes:

[PRIMARY PROCEDURE \(READ\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

[PRIMARY PROCEDURE \(READ\)](#) is the [Read Coded Clinical Terms](#) code which is used to identify the primary [Patient Procedure](#) carried out.

Note: [Read Coded Clinical Terms](#) Version 3 (CTV3) with qualifiers is not supported in the Commissioning Data Sets. Therefore, the Commissioning Data Set Version 6-2 XML Schema has the format of this Data Element constrained to max an5.

PROCEDURE (OPCS)

Change to Data Element: Changed Dataset

Format/Length:	See OPCS-4 CODE
National Codes:	
Default Codes:	

Notes:

[PROCEDURE \(OPCS\)](#) is the same as attribute [CLINICAL CLASSIFICATION CODE](#).

[PROCEDURE \(OPCS\)](#) is a [Patient Procedure](#) other than the [PRIMARY PROCEDURE \(OPCS\)](#).

For [Commissioning Data Sets](#) purposes it is recommended that multiple [Patient Procedures](#) are recorded and the CDS XML Schema (CDS Version 6 onwards) has been designed to carry as many [Patient Procedures](#) as required.

PROCEDURE (READ)

Change to Data Element: Changed Dataset

Format/Length:	See READ CODE
National Codes:	
Default Codes:	

Notes:

[PROCEDURE \(READ\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

[PROCEDURE \(READ\)](#) is the [Read Coded Clinical Terms](#) for a [Patient Procedure](#) other than the [PRIMARY PROCEDURE \(READ\)](#).

For [Commissioning Data Sets](#) purposes it is recommended that multiple [Patient Procedures](#) are recorded and the CDS XML Schema (CDS Version 6 onwards) has been designed to carry as many [Patient Procedures](#) as required.

Note: [Read Coded Clinical Terms](#) Version 3 (CTV3) with qualifiers is not supported in the [Commissioning Data Sets](#). Therefore, the Commissioning Data Set Version 6-2 XML Schema has the format of this Data Element constrained to max an5.

PROCEDURE DATE

Change to Data Element: Changed Dataset

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

Notes:

[PROCEDURE DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Procedure Date](#)'.

PROCEDURE DATE (EMERGENCY CARE CLINICAL INVESTIGATION)

Change to Data Element: Changed Dataset

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

Notes:

[PROCEDURE DATE \(EMERGENCY CARE CLINICAL INVESTIGATION\)](#) is the same as data element [PROCEDURE DATE](#).

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

PROCEDURE DATE (EMERGENCY CARE PROCEDURE)

Change to Data Element: Changed Dataset

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

Notes:

[PROCEDURE DATE \(EMERGENCY CARE PROCEDURE\)](#) is the same as data element [PROCEDURE DATE](#).

[PROCEDURE DATE \(EMERGENCY CARE PROCEDURE\)](#) is the date a [Patient Procedure](#) was performed during an [Emergency Care Attendance](#).

PROCEDURE SCHEME IN USE

Change to Data Element: Changed Dataset

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

Notes:

[PROCEDURE SCHEME IN USE](#) is the same as attribute [PROCEDURE SCHEME IN USE](#).

For specific National Code usage in different data sets, see [PROCEDURE SCHEME IN USE](#).

PROCEDURE TIME (EMERGENCY CARE CLINICAL INVESTIGATION)

Change to Data Element: Changed Dataset

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

Default Codes:

Notes:

[PROCEDURE TIME \(EMERGENCY CARE CLINICAL INVESTIGATION\)](#) is the same as data element [PROCEDURE TIME](#).

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

PROCEDURE TIME (EMERGENCY CARE PROCEDURE)

Change to Data Element: Changed Dataset

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

Notes:

[PROCEDURE TIME \(EMERGENCY CARE PROCEDURE\)](#) is the same as data element [PROCEDURE TIME](#).

[PROCEDURE TIME \(EMERGENCY CARE PROCEDURE\)](#) is the time a [Patient Procedure](#) was performed during an [Emergency Care Attendance](#).

PROFESSIONAL REGISTRATION ENTRY IDENTIFIER

Change to Data Element: Changed Dataset

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

Notes:

[PROFESSIONAL REGISTRATION ENTRY IDENTIFIER](#) is the same as attribute [PROFESSIONAL REGISTRATION ENTRY IDENTIFIER](#).

PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)

Change to Data Element: Changed Dataset

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

Notes:

[PROFESSIONAL REGISTRATION ENTRY IDENTIFIER \(MAIN OPERATING CARE PROFESSIONAL\)](#) is the [PROFESSIONAL REGISTRATION ENTRY IDENTIFIER](#) of the [CARE PROFESSIONAL](#) carrying out a [Patient Procedure](#). Where more than one [CARE PROFESSIONAL](#) is involved in the [Patient Procedure](#), the [PROFESSIONAL REGISTRATION ENTRY IDENTIFIER](#) of the main/lead [CARE PROFESSIONAL](#) should be recorded.

In Commissioning Data Set version 6-2, [PROFESSIONAL REGISTRATION ENTRY IDENTIFIER \(MAIN OPERATING CARE PROFESSIONAL\)](#) must be accompanied by the [PROFESSIONAL REGISTRATION ISSUER CODE](#), which indicates the body which issued the [PROFESSIONAL REGISTRATION](#) of the main/lead [CARE PROFESSIONAL](#), where it is one of the following:

- [General Dental Council](#)
- [General Medical Council](#)
- [Health and Care Professions Council](#)
- [Nursing and Midwifery Council](#).

PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)

Change to Data Element: Changed Dataset

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

Notes:

[PROFESSIONAL REGISTRATION ENTRY IDENTIFIER \(RESPONSIBLE ANAESTHETIST\)](#) is the [PROFESSIONAL REGISTRATION ENTRY IDENTIFIER](#) of the [CARE PROFESSIONAL](#) providing anaesthesia during a [Patient Procedure](#). Where more than one [CARE PROFESSIONAL](#) is involved in providing anaesthesia during the [Patient Procedure](#), the [PROFESSIONAL REGISTRATION ENTRY IDENTIFIER](#) of the main/lead anaesthetist should be recorded.

In Commissioning Data Set version 6-2, [PROFESSIONAL REGISTRATION ENTRY IDENTIFIER \(RESPONSIBLE ANAESTHETIST\)](#) must be accompanied by the [PROFESSIONAL REGISTRATION ISSUER CODE](#), which indicates the body which issued the [PROFESSIONAL REGISTRATION](#) of the main/lead anaesthetist, where it is one of the following:

- [General Dental Council](#)
- [General Medical Council](#)
- [Health and Care Professions Council](#)
- [Nursing and Midwifery Council](#).

PROFESSIONAL REGISTRATION ISSUER CODE

Change to Data Element: Changed Description, Dataset

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:

[PROFESSIONAL REGISTRATION ISSUER CODE](#) is the same as attribute [PROFESSIONAL REGISTRATION BODY CODE](#) but only the following National Codes are permitted:

Notes:

- National Code 04 '[General Optical Council](#)' is only valid for [CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set](#) and must not be submitted in other [Commissioning Data Set](#) versions.
- National Code 04 '[General Optical Council](#)' is only valid for [CDS V6-2-2 Type 011 - Emergency Care Commissioning Data Set](#) / [CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set](#) and must not be submitted in other [Commissioning Data Set](#) versions
- National Code 16 '[General Pharmaceutical Council](#)' is only valid for [CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set](#) and must not be submitted in other [Commissioning Data Set](#) versions.

Permitted National Codes:

- 02 [General Dental Council](#)
- 03 [General Medical Council](#)
- 04 [General Optical Council](#)
- 08 [Health and Care Professions Council](#)
- 09 [Nursing and Midwifery Council](#)
- 16 [General Pharmaceutical Council](#)

PROVIDER REFERENCE NUMBER

Change to Data Element: Changed Dataset

Format/Length:	an17
National Codes:	
Default Codes:	

Notes:

[PROVIDER REFERENCE NUMBER](#) is the same as attribute [PROVIDER REFERENCE NUMBER](#).

REFERRAL TO TREATMENT PERIOD END DATE

Change to Data Element: Changed Dataset

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

Notes:

[REFERRAL TO TREATMENT PERIOD END DATE](#) is the same as attribute [REFERRAL TO TREATMENT PERIOD END DATE](#).

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a [Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#), and is of the following Commissioning Data Set Types:

- [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#)
- [CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 030 - Elective Admission List - End of Period Census \(Standard\) Commissioning Data Set](#)
- [CDS V6-2 Type 060 - Elective Admission List - Event During Period \(Add\) Commissioning Data Set](#)
- [CDS V6-2 Type 070 - Elective Admission List - Event During Period \(Remove\) Commissioning Data Set](#)
- [CDS V6-2 Type 080 - Elective Admission List - Event During Period \(Offer\) Commissioning Data Set](#)

then [REFERRAL TO TREATMENT PERIOD END DATE](#) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group, where the [REFERRAL TO TREATMENT PERIOD](#) has ended.

REFERRAL TO TREATMENT PERIOD START DATE

Change to Data Element: Changed Dataset

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

Notes:

[REFERRAL TO TREATMENT PERIOD START DATE](#) is the same as attribute [REFERRAL TO TREATMENT PERIOD START DATE](#).

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a [Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#), and is of the following Commissioning Data Set Types:

- [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#)
- [CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 030 - Elective Admission List - End of Period Census \(Standard\) Commissioning Data Set](#)
- [CDS V6-2 Type 060 - Elective Admission List - Event During Period \(Add\) Commissioning Data Set](#)
- [CDS V6-2 Type 070 - Elective Admission List - Event During Period \(Remove\) Commissioning Data Set](#)
- [CDS V6-2 Type 080 - Elective Admission List - Event During Period \(Offer\) Commissioning Data Set](#)

then [REFERRAL TO TREATMENT PERIOD START DATE](#) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

REFERRAL TO TREATMENT PERIOD STATUS

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See REFERRAL TO TREATMENT PERIOD STATUS
Default Codes:	

Notes:

[REFERRAL TO TREATMENT PERIOD STATUS](#) is the same as attribute [REFERRAL TO TREATMENT PERIOD STATUS](#).

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a [Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#), and is of the following Commissioning Data Set Types:

- [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#)
- [CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set](#)

- [CDS V6-2 Type 030 - Elective Admission List - End of Period Census \(Standard\) Commissioning Data Set](#)
- [CDS V6-2 Type 060 - Elective Admission List - Event During Period \(Add\) Commissioning Data Set](#)
- [CDS V6-2 Type 070 - Elective Admission List - Event During Period \(Remove\) Commissioning Data Set](#)
- [CDS V6-2 Type 080 - Elective Admission List - Event During Period \(Offer\) Commissioning Data Set](#)

then [REFERRAL TO TREATMENT PERIOD STATUS](#) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

For specific National Code usage, see [REFERRAL TO TREATMENT PERIOD STATUS](#).

REFERRED TO SERVICE (SNOMED CT)

Change to Data Element: Changed Dataset

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

Notes:

[REFERRED TO SERVICE \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

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

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Emergency care referral procedures simple reference set (foundation metadata concept)
- [Refset](#) Id: 991451000000108

For further details relating to the [SNOMED CT Refset](#) Metadata, see the [Data Dictionary for Care \(DD4C\)](#) website at: [Emergency care referral procedures](#).

REFERRED TO SERVICE ASSESSMENT DATE

Change to Data Element: Changed Dataset

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

Notes:

[REFERRED TO SERVICE ASSESSMENT DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) '[Clinical Intervention Date](#)'.

[REFERRED TO SERVICE ASSESSMENT DATE](#) is the date a [PATIENT](#) was assessed by a [CARE PROFESSIONAL](#) from a [SERVICE](#) which a [PATIENT](#) has been referred to.

REFERRED TO SERVICE ASSESSMENT TIME

Change to Data Element: Changed Dataset

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

Notes:

[REFERRED TO SERVICE ASSESSMENT TIME](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) '[Clinical Intervention Time](#)'.

[REFERRED TO SERVICE ASSESSMENT TIME](#) is the time a [PATIENT](#) was assessed by a [CARE PROFESSIONAL](#) from a [SERVICE](#) which a [PATIENT](#) has been referred to.

SAFEGUARDING CONCERN (SNOMED CT)

Change to Data Element: Changed Dataset

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

Notes:

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

[SAFEGUARDING CONCERN \(SNOMED CT\)](#) is the [SNOMED CT](#)® concept ID which is used to identify an unresolved issue or concern regarding adult and child safeguarding that requires communication to another [ORGANISATION](#) or care agency.

[SNOMED CT Refset](#) Metadata:

- [Refset](#) FSN: Safeguarding issues simple reference set (foundation metadata concept)
- [Refset](#) Id: 99900238100000108

For further details relating to the [SNOMED CT Refset](#) Metadata, see the [Data Dictionary for Care \(DD4C\)](#) website at: [Safeguarding issues](#).

SECONDARY DIAGNOSIS (ICD)

Change to Data Element: Changed Dataset

Format/Length:	See ICD-10 CODE
National Codes:	
Default Codes:	

Notes:

[SECONDARY DIAGNOSIS \(ICD\)](#) is the same as attribute [CLINICAL CLASSIFICATION CODE](#).

[SECONDARY DIAGNOSIS \(ICD\)](#) is the [International Classification of Diseases \(ICD\)](#) code used to identify the secondary [PATIENT DIAGNOSIS](#).

For [Commissioning Data Sets](#) (CDS) purposes it is recommended that multiple Diagnoses are recorded and the CDS XML Schema (CDS Version 6 onwards) has been designed to carry as many Diagnoses as required.

[SECONDARY DIAGNOSIS \(ICD\)](#) 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 resulting in lower levels of healthcare resource.

For further information, please refer to the [NHS Digital](#) website at: [Payment by Results Guidance](#).

Note:

- The format/length of this Data Element has been corrected as a result of the work undertaken for the development of the Coding Strategy.
- The data set specifications of the data sets that contain this Data Element will be updated in the next version of the information standard where it is not already correct.

SECONDARY DIAGNOSIS (READ)

Change to Data Element: Changed Dataset

Format/Length:	See READ CODE
National Codes:	
Default Codes:	

Notes:

[SECONDARY DIAGNOSIS \(READ\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

[SECONDARY DIAGNOSIS \(READ\)](#) is the [Read Coded Clinical Terms](#) used to identify the secondary [PATIENT DIAGNOSIS](#).

For Commissioning Data Set (CDS) purposes it is recommended that multiple Diagnoses are recorded and the CDS XML Schema (CDS Version 6 onwards) has been designed to carry as many Diagnoses as required.

Note: [Read Coded Clinical Terms](#) Version 3 (CTV3) with qualifiers is not supported in the [Commissioning Data Sets](#). Therefore, the Commissioning Data Set Version 6-2 XML Schema has the format of this Data Element constrained to max an5.

SITE CODE (OF TREATMENT)

Change to Data Element: Changed Dataset

Format/Length:	min an5 max an9
National Codes:	
ODS Default Codes:	R9998 - Not a hospital site
	89999 - Non-NHS UK Provider where no ORGANISATION SITE CODE has been issued
	89997 - Non-UK Provider where no ORGANISATION SITE CODE has been issued

Notes:

[SITE CODE \(OF TREATMENT\)](#) is the same as attribute [ORGANISATION SITE CODE](#).

[SITE CODE \(OF TREATMENT\)](#) is the [ORGANISATION SITE CODE](#) of the [ORGANISATION](#) where the [PATIENT](#) was treated, i.e. it should enable the treating [ORGANISATION](#) to be identified.

This identifies the [ORGANISATION SITE](#) within the [ORGANISATION](#) on which the [PATIENT](#) was treated, since facilities may vary on different hospital sites.

The code recorded should always be the national code; if the treatment is sub-commissioned to another NHS [Health Care Provider](#) or an independent UK provider, the [SITE CODE \(OF TREATMENT\)](#) used should be the [ORGANISATION SITE CODE](#) of the [Health Care Provider](#) actually carrying out the work.

Where treatment is sub-commissioned to an overseas provider the [Organisation Data Service Default Code](#) 89997 'Non-UK Provider where no [ORGANISATION SITE CODE](#) has been issued' is applicable.

Each [ORGANISATION](#) has a unique [ORGANISATION CODE](#). However, where an [ORGANISATION](#) has more than one site from which it provides [SERVICES](#), then each site is uniquely identified. These sites are [ORGANISATION SITES](#) and are uniquely identified by [ORGANISATION SITE CODE](#). The [ORGANISATION SITE CODE](#) contains the first 3 digits of the [ORGANISATION CODE](#) with the last two digits being the site identifier.

Example:

- RA700 [ORGANISATION CODE](#) of the [ORGANISATION](#)
- RA701 [ORGANISATION SITE CODE](#) of the first identified [ORGANISATION SITE](#) within the [ORGANISATION](#)
- RA702 [ORGANISATION SITE CODE](#) of the second identified [ORGANISATION SITE](#) within the [ORGANISATION](#)

For out-patients, [ACTIVITY](#) may take place outside the hospital, such as in the [PATIENT'S](#) home; in such cases, raising a site code is impractical. Therefore, code R9998 'Not a hospital site' would be used in these circumstances.

Note: [LOCATION CLASS](#) is used in the Commissioning Data Set (CDS) message to indicate the classification of the physical [LOCATION](#) within which the [ACTIVITY](#) occurred.

Use in the Future Outpatient CDS:

If the [INTENDED SITE CODE \(OF TREATMENT\)](#) is not known, this data element should be omitted.

[SITE CODE \(OF TREATMENT\)](#) will be replaced with [ORGANISATION SITE IDENTIFIER \(OF TREATMENT\)](#), when it has been approved for use in national information standards.

SOURCE OF REFERRAL FOR A AND E (RETIRED), renamed from SOURCE OF REFERRAL FOR A AND E

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

Format/Length:	an2
National Codes:	See SOURCE OF REFERRAL FOR A and E
Default Codes:	

Notes:

[SOURCE OF REFERRAL FOR A and E](#) is the same as attribute [SOURCE OF REFERRAL FOR A and E](#). **This item has been retired from the NHS Data Model and Dictionary.**

The last live version of this item is available in the September 2020 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

SOURCE OF REFERRAL FOR A AND E (RETIRED), renamed from SOURCE OF REFERRAL FOR A AND E

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

SOURCE OF REFERRAL FOR A and E

Attribute:

[SOURCE OF REFERRAL FOR A and E](#)

SOURCE OF REFERRAL FOR A AND E (RETIRED), renamed from SOURCE OF REFERRAL FOR A AND E

Change to Data Element: Changed Description, linked Attribute, Dataset, Name, status to Retired

- Changed Description
- null
- null
- Changed Name from Data Dictionary.Data_Field_Notes.S.So.SOURCE_OF_REFERRAL_FOR_A_and_E to Retired.Data_Dictionary.Data_Field_Notes.S.SOURCE_OF_REFERRAL_FOR_A_and_E
- Retired SOURCE OF REFERRAL FOR A and E

START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

Format/Length: an10 CCYY-MM-DD

National Codes:

Default Codes:

Notes:

[START DATE \(MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Mental Health Act Legal Status Classification Assignment Period](#).

START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

Format/Length: an8 HH:MM:SS

National Codes:

Default Codes:

Notes:

[START TIME \(MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Start Time](#)' of the [Mental Health Act Legal Status Classification Assignment Period](#).

UCUM UNIT OF MEASUREMENT

Change to Data Element: Changed Dataset

Format/Length: max an10

National Codes:

Default Codes:

Notes:

[UCUM UNIT OF MEASUREMENT](#) is the same as attribute [UCUM UNIT OF MEASUREMENT](#).

UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)

Change to Data Element: Changed Dataset

Format/Length: n12

National Codes:

Default Codes:

Notes:

[UNIQUE BOOKING REFERENCE NUMBER \(CONVERTED\)](#) is the same as attribute [UNIQUE BOOKING REFERENCE NUMBER \(CONVERTED\)](#).

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a [Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#), and is of the following Commissioning Data Set Types:

- [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#)
- [CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 030 - Elective Admission List - End of Period Census \(Standard\) Commissioning Data Set](#)
- [CDS V6-2 Type 060 - Elective Admission List - Event During Period \(Add\) Commissioning Data Set](#)
- [CDS V6-2 Type 070 - Elective Admission List - Event During Period \(Remove\) Commissioning Data Set](#)
- [CDS V6-2 Type 080 - Elective Admission List - Event During Period \(Offer\) Commissioning Data Set](#)

then either [UNIQUE BOOKING REFERENCE NUMBER \(CONVERTED\)](#) or [PATIENT PATHWAY IDENTIFIER](#) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

WAITING TIME MEASUREMENT TYPE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See WAITING TIME MEASUREMENT TYPE
Default Codes:	

Notes:

[WAITING TIME MEASUREMENT TYPE](#) is the same as attribute [WAITING TIME MEASUREMENT TYPE](#).

Note: National Codes 01, 03 and 04 are not valid for the Referral To Treatment (RTT) data group in the [Mental Health Services Data Set](#).

For specific National Code usage in different data sets, see [WAITING TIME MEASUREMENT TYPE](#).

WITHHELD IDENTITY REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See WITHHELD IDENTITY REASON
Default Codes:	99 - Identity withheld but reason not known

Notes:

[WITHHELD IDENTITY REASON](#) is the same as attribute [WITHHELD IDENTITY REASON](#).

COMMISSIONING DATA SET VERSION 6-2-2 XML SCHEMA CONSTRAINTS

Change to XML Schema Constraint: Changed Description

XML Schema constraints applied to the:

- [CDS V6-2-2 Type 011 - Emergency Care CDS](#)
- [CDS V6-2-2 Type 001 - CDS Interchange Header](#)
- [CDS V6-2-2 Type 011 - Emergency Care CDS](#)
- [CDS V6-2-2 Type 001 - CDS Interchange Header](#)
- [CDS V6-2-2 Type 002 - CDS Interchange Trailer](#)
- [CDS V6-2-2 Type 003 - CDS Message Header](#)
- [CDS V6-2-2 Type 004 - CDS Message Trailer](#)
- [CDS V6-2-2 Type 005B - CDS Transaction Header Group - Bulk Update Protocol](#)
- [CDS V6-2-2 Type 005N - CDS Transaction Header Group - Net Change Protocol](#)

The "Allowed Values" column indicates the NHS Data Model and Dictionary National Codes and Default Codes present in the XML Schema:

- None = The National Codes and Default Codes are included in the XML Schema
- Removed = The National Codes and Default Codes are not included in the XML Schema.

Data Element	XML Schema Format/Length	Allowed Values	Range	Pattern Match	Reason / Comment / XML Choice
ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT)	None	Removed	None	None	National Codes not enumerated in the XML Schema
AGE AT CDS ACTIVITY DATE	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
CDS COPY RECIPIENT IDENTITY	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
CDS INTERCHANGE APPLICATION REFERENCE	min an1 max an14	None	None	None	Existing Format/Length states an14 - XML Schema allows min an1 max an14
CDS INTERCHANGE CONTROL COUNT	max n7	None	None	None	Existing Format/Length states n7 - XML Schema allows max n7
CDS INTERCHANGE CONTROL REFERENCE	min an1 max an14	None	None	None	Existing Format/Length states an14 - XML Schema allows min an1 max an14
CDS INTERCHANGE SENDER IDENTITY	min an1 max an15	None	None	None	Existing Format/Length states an15 - XML Schema allows min an1 max an15
CDS INTERCHANGE RECEIVER IDENTITY	min an1 max an15	None	None	None	Existing Format/Length states an15 - XML Schema allows min an1 max an15
CDS INTERCHANGE TEST INDICATOR	None	0,1	None	None	Null value not allowed in XML Schema
CDS MESSAGE REFERENCE	max n7	None	None	None	Existing Format/Length states an14 - XML Schema allows max n7 to support SUS requirements
CDS MESSAGE VERSION NUMBER	an6	CDS062	None	None	Message version is hard coded in the XML Schema
CDS PRIME RECIPIENT IDENTITY	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
CDS RECORD IDENTIFIER	min an1 max an35	None	None	None	Existing Format/Length states an35 - XML Schema allows min an1 max an35
CDS SENDER IDENTITY	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
CDS UNIQUE IDENTIFIER	min an1 max an35	None	None	None	Existing Format/Length states an35 - XML Schema allows min an1 max an35
COMMISSIONER REFERENCE NUMBER	max an17	None	None	None	Existing Format/Length states an17 - XML Schema allows max an17
COMMISSIONING SERIAL NUMBER	max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows max an6
EMERGENCY CARE PLACE OF INJURY (LATITUDE)	None	None	-90.000000-90.000000	None	Range applied to allow correct reporting of EMERGENCY CARE PLACE OF INJURY (LATITUDE)
EMERGENCY CARE PLACE OF INJURY (LONGITUDE)	None	None	-180.000000-180.000000	None	Range applied to allow correct reporting of EMERGENCY CARE PLACE OF INJURY (LONGITUDE)
ETHNIC CATEGORY	max an2	None	None	None	Existing Format/Length means fixed length which is incorrect. Unable to change this as it is used in other data sets. Second character can be for local use. Format/Length amended to max an2
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	None	Removed	None	None	Default codes not enumerated in the XML Schema
GENERAL MEDICAL PRACTITIONER (SPECIFIED)	None	Removed	None	None	National Codes and default codes not enumerated in the XML Schema
	max an10	None	None	None	Existing Format/Length states an10 - XML Schema allows max an10

NHS SERVICE AGREEMENT LINE NUMBER					
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION IDENTIFIER (CODE OF PROVIDER)	min an3 max an5	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE)	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE)	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION SITE IDENTIFIER (OF TREATMENT)	None	Removed	None	None	Default codes not enumerated in the XML Schema
OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE	None	A,B,C,D,E,F,P,9	None	None	National Code X is not valid in CDS V6-2-2 Type 011 - Emergency Care CDS
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
PROVIDER REFERENCE NUMBER	max an17	None	None	None	Existing Format/Length states an17 - XML Schema allows max an17
WAITING TIME MEASUREMENT TYPE	None	01,02,09	None	None	National Codes 03 and 04 not valid in Commissioning Data Sets

COMMISSIONING DATA SET VERSION 6-2-3 XML SCHEMA CONSTRAINTS

Change to XML Schema Constraint: New XML Schema Constraint

XML Schema constraints applied to the:

- [CDS V6-2-3 Type 011 - Emergency Care CDS](#)
- [CDS V6-2-3 Type 001 - CDS Interchange Header](#)
- [CDS V6-2-3 Type 002 - CDS Interchange Trailer](#)
- [CDS V6-2-3 Type 003 - CDS Message Header](#)
- [CDS V6-2-3 Type 004 - CDS Message Trailer](#)
- [CDS V6-2-3 Type 005B - CDS Transaction Header Group - Bulk Update Protocol](#)
- [CDS V6-2-3 Type 005N - CDS Transaction Header Group - Net Change Protocol](#)

The "Allowed Values" column indicates the NHS Data Model and Dictionary National Codes and Default Codes present in the XML Schema:

- None = The National Codes and Default Codes are included in the XML Schema
- Removed = The National Codes and Default Codes are not included in the XML Schema.

Data Element	XML Schema Format/Length	Allowed Values	Range	Pattern Match	Reason / Comment / XML Choice
ACTIVITY TREATMENT FUNCTION CODE	None	Removed	None	None	National Codes not enumerated in the XML Schema

(DECISION TO ADMIT)					
AGE AT CDS ACTIVITY DATE	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
CDS INTERCHANGE APPLICATION REFERENCE	min an1 max an14	None	None	None	Existing Format/Length states an14 - XML Schema allows min an1 max an14
CDS INTERCHANGE CONTROL COUNT	max n7	None	None	None	Existing Format/Length states n7 - XML Schema allows max n7
CDS INTERCHANGE CONTROL REFERENCE	min an1 max an14	None	None	None	Existing Format/Length states an14 - XML Schema allows min an1 max an14
CDS INTERCHANGE SENDER IDENTITY	min an1 max an15	None	None	None	Existing Format/Length states an15 - XML Schema allows min an1 max an15
CDS INTERCHANGE RECEIVER IDENTITY	min an1 max an15	None	None	None	Existing Format/Length states an15 - XML Schema allows min an1 max an15
CDS INTERCHANGE TEST INDICATOR	None	0,1	None	None	Null value not allowed in XML Schema
CDS MESSAGE REFERENCE	max n7	None	None	None	Existing Format/Length states an14 - XML Schema allows max n7 to support SUS requirements
CDS MESSAGE VERSION NUMBER	an6	CDS062	None	None	Message version is hard coded in the XML Schema
CDS RECORD IDENTIFIER	min an1 max an35	None	None	None	Existing Format/Length states an35 - XML Schema allows min an1 max an35
CDS UNIQUE IDENTIFIER	min an1 max an35	None	None	None	Existing Format/Length states an35 - XML Schema allows min an1 max an35
COMMISSIONER REFERENCE NUMBER	max an17	None	None	None	Existing Format/Length states an17 - XML Schema allows max an17
COMMISSIONING SERIAL NUMBER	max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows max an6
EMERGENCY CARE DEPARTMENT TYPE	an2	Removed	None	None	National Codes not enumerated in the XML Schema
EMERGENCY CARE PLACE OF INJURY (LATITUDE)	None	None	-90.000000-90.000000	None	Range applied to allow correct reporting of EMERGENCY CARE PLACE OF INJURY (LATITUDE)
EMERGENCY CARE PLACE OF INJURY (LONGITUDE)	None	None	-180.000000-180.000000	None	Range applied to allow correct reporting of EMERGENCY CARE PLACE OF INJURY (LONGITUDE)
ETHNIC CATEGORY	max an2	None	None	None	Existing Format/Length means fixed length which is incorrect. Unable to change this as it is used in other data sets. Second character can be for local use. Format/Length amended to max an2
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	None	Removed	None	None	Default codes not enumerated in the XML Schema
GENERAL MEDICAL PRACTITIONER (SPECIFIED)	None	Removed	None	None	National Codes and default codes not enumerated in the XML Schema
NHS SERVICE AGREEMENT LINE NUMBER	max an10	None	None	None	Existing Format/Length states an10 - XML Schema allows max an10
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION IDENTIFIER (CODE OF PROVIDER)	min an3 max an5	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION IDENTIFIER	None	Removed	None	None	Default codes not enumerated in the XML Schema

(RESIDENCE RESPONSIBILITY)					
ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE)	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE)	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION SITE IDENTIFIER (OF TREATMENT)	None	Removed	None	None	Default codes not enumerated in the XML Schema
OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE	None	A,B,C,D,E,F,P,9	None	None	National Code X is not valid in CDS V6-2-3 Type 011 - Emergency Care CDS
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
PROVIDER REFERENCE NUMBER	max an17	None	None	None	Existing Format/Length states an17 - XML Schema allows max an17
WAITING TIME MEASUREMENT TYPE	None	01,02,09	None	None	National Codes 03 and 04 not valid in Commissioning Data Sets

COMMISSIONING DATA SET VERSION 6-2 XML SCHEMA CONSTRAINTS

Change to XML Schema Constraint: Changed Description

XML Schema constraints applied to the [Commissioning Data Sets](#) V6-2.

The "Allowed Values" column indicates the NHS Data Model and Dictionary National Codes and Default Codes present in the XML Schema:

- None = The National Codes and Default Codes are included in the XML Schema
- Removed = The National Codes and Default Codes are not included in the XML Schema.

Data Element	XML Schema Format/Length	Allowed Values	Range	Pattern Match	Reason / Comment / XML Choice
A and E ATTENDANCE NUMBER	max an12	None	None	None	Existing Format/Length states an12 - XML Schema allows max an12
ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST	min an2 max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows min an2 max an6
ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND	min an2 max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows min an2 max an6
ACCIDENT AND EMERGENCY INVESTIGATION - FIRST	min an2 max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows min an2 max an6
ACCIDENT AND EMERGENCY INVESTIGATION - SECOND	min an2 max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows min an2 max an6
ACCIDENT AND EMERGENCY TREATMENT - FIRST	min an2 max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows min an2 max an6

ACCIDENT AND EMERGENCY TREATMENT - SECOND	min an2 max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows min an2 max an6
ACTIVITY LOCATION TYPE CODE	None	A01,A02,A03,A04,B01,B02,C01,C02,C03,D01,D02,D03,			
ACTIVITY LOCATION TYPE CODE	None	A01,A02,A03,A04,B01,B02,C01,C02,C03,D01,D02,D03, E01,E02,E03,E04,E99,F01,G01,G02,G03,H01,J01,K01,K02, L01,L02,L03,L04,L05,L06,L99,M01,M02,M03,M04,M05, N01,N02,N03,N04,N05,X01	None	None	National Code G04 removed (not allowed in XML Schema)
ADVANCED CARDIOVASCULAR SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
ADVANCED RESPIRATORY SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
AGE AT CDS ACTIVITY DATE	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
AGE AT CENSUS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
AGE ON ADMISSION	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
ATTENDANCE IDENTIFIER	max an12	None	None	None	Existing Format/Length states an12 - XML Schema allows max an12
BASIC CARDIOVASCULAR SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
BASIC RESPIRATORY SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
BIRTH WEIGHT	max n4	None	None	None	Existing Format/Length states n4 - XML Schema allows max n4
CARE PROFESSIONAL MAIN SPECIALTY CODE	None	100,101,110,120,130,140,141,142,143,145,146,147,148,149, 150,160,170,171,180,190,192,300,301,302,303,304,305,310, 311,312,313,314,315,320,321,325,326,330,340,350,352,360, 361,370,371,400,401,410,420,421,430,450,451,460,501,502, 504,560,600,601,700,710,711,712,713,715,800,810,820,821, 822,823,824,830,831,833,834,900,901,902,903,904,950,960, 199,499	None	None	National Code 500 removed (not allowed in XML Schema)
CDS COPY RECIPIENT IDENTITY	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
CDS MESSAGE REFERENCE	max n7	None	None	None	Existing Format/Length states n7 - XML Schema allows max n14 but SUS accepts max n7
CDS MESSAGE VERSION NUMBER	None	CDS062	None	None	Message version is hard coded in the XML Schema
CDS PRIME RECIPIENT IDENTITY	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
CDS SENDER IDENTITY	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
CDS UNIQUE IDENTIFIER	max an35	None	None	None	

					Existing Format/Length states an35 - XML Schema allows max an35
COMMISSIONER REFERENCE NUMBER	max an17	None	None	None	Existing Format/Length states an17 - XML Schema allows max an17
COMMISSIONING SERIAL NUMBER	max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows max an6
CONSULTATION MEDIUM USED	None	01,02,03,04	None	None	National Codes 05, 06 and 98 are not used in CDS version 6-2
COUNT OF DAYS SUSPENDED	max n4	None	None	None	Existing Format/Length states n4 - XML Schema allows max n4
CRITICAL CARE ACTIVITY CODE	None	01,02,03,04,05,06,07,08,09,10,11,12,13,14,15,16,21,22,23,24,25,26,27,28,29,50,51,52,53,55,56,57,58,59,60,61,62,63,64,65,66,67,68,69,70,71,72,73,74,99	None	None	National Codes 80, 81, 82, 83, 84, 85, 94, 95, 96 and 97 removed (not allowed in the XML Schema)
CRITICAL CARE LEVEL 2 DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
CRITICAL CARE LEVEL 3 DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
CRITICAL CARE LOCAL IDENTIFIER	max an8	None	None	None	Existing Format/Length states an8 - XML Schema allows max an8
DERMATOLOGICAL SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL)	None	1,2,3,4,5,8,9	None	None	National Codes 6 and 7 are not used in CDS version 6-2
DURATION OF CARE TO PSYCHIATRIC CENSUS DATE	max n5	None	None	None	Existing Format/Length states n5 - XML Schema allows max n5
DURATION OF DETENTION	max n5	None	None	None	Existing Format/Length states n5 - XML Schema allows max n5
DURATION OF ELECTIVE WAIT	max n4	None	None	None	Existing Format/Length states n4 - XML Schema allows max n4
ELECTIVE ADMISSION LIST ENTRY NUMBER	max an12	None	None	None	Existing Format/Length states an12 - XML Schema allows max an12
EPISODE NUMBER	max an2	None	None	None	Existing Format/Length states an2 - XML Schema allows max an2
ETHNIC CATEGORY	max an2	None	None	None	Existing Format/Length means fixed length which is incorrect. Unable to change this as it is used in other data sets. Second character can be for local use. Format/Length amended to max an2
GASTRO-INTESTINAL SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3

GENERAL MEDICAL PRACTITIONER PRACTICE (ANTENATAL CARE)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE)	None	Removed	None	None	National Codes and default codes not enumerated in the XML Schema
GENERAL MEDICAL PRACTITIONER (SPECIFIED)	None	Removed	None	None	National Codes and default codes not enumerated in the XML Schema
HOSPITAL PROVIDER SPELL NUMBER	max an12	None	None	None	Existing Format/Length states an12 - XML Schema allows max an12
INTENDED SITE CODE (OF TREATMENT)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
LIVER SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
LOCAL PATIENT IDENTIFIER	max an10	None	None	None	Existing Format/Length states an10 - XML Schema allows max an10
LOCAL PATIENT IDENTIFIER (BABY)	max an10	None	None	None	Existing Format/Length states an10 - XML Schema allows max an10
LOCAL PATIENT IDENTIFIER (MOTHER)	max an10	None	None	None	Existing Format/Length states an10 - XML Schema allows max an10
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (AT CENSUS DATE)	None	01,02,03,04,05,06,07,08,09,10,11,12,13,14,15,16,17,18,19,20,31,32,34,35,36,37,38	None	None	Additional National Codes 37 and 38 added
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)	None	01,02,03,04,05,06,07,08,09,10,11,12,13,14,15,16,17,18,19,20,31,32,34,35,36,37,38	None	None	Additional National Codes 37 and 38 added
NEUROLOGICAL SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
NHS SERVICE AGREEMENT LINE NUMBER	max an10	None	None	None	Existing Format/Length states an10 - XML Schema allows max an10
ORGAN SUPPORT MAXIMUM	None	None	00-06	None	Range 00-06 allowed
ORGANISATION CODE (CODE OF COMMISSIONER)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS

ORGANISATION CODE (CODE OF PROVIDER)					ORGANISATION SITE CODE changes
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (BABY))	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION SITE CODE changes
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (MOTHER))	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION SITE CODE changes
ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
PERSON WEIGHT	n3.n3	None	None	None	Existing Format/Length states max n3.max n3 - XML Schema enforces 3 digits before and after the decimal point - max removed
PRIMARY DIAGNOSIS (READ)	max an5	None	None	None	Existing Format/Length allows for all clinical classifications -XML Schema allows max an5
PROVIDER REFERENCE NUMBER	max an17	None	None	None	Existing Format/Length states an17 - XML Schema allows max an17
REFERRER CODE	None	Removed	None	None	National Codes and default codes not enumerated in the XML Schema
REFERRING ORGANISATION CODE	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
RENAL SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
SECONDARY DIAGNOSIS (READ)	max an5	None	None	None	Existing Format/Length allows for all clinical classifications -XML Schema allows max an5
SITE CODE (OF TREATMENT)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION SITE CODE changes
SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL)	None	19,29,39,49,51,52,53,54,65,66,79,85,87,88	None	None	National Codes 40, 41 and 42 are not used in CDS version 6-2

For enquiries about this Change Request, please email information.standards@nhs.net

