NHS Data Model and Dictionary

NHS Digital

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 010 - ACCIDENT AND EMERGENCY CDS (RETIRED) renamed from CDS V6-2 TYPE 010 - ACCIDENT AND EMERGENCY CDS	Changed Name, status to Retired, Description

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

ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT (RETIRED) renamed from ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT	Changed Name, status to Retired, Description
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 Name, status to Retired, Description
CDS VERSION 6-2 MENU	Changed Description
CLINICAL CODING INTRODUCTION	Changed Description
CODING AND CLASSIFICATIONS MENU	Changed Description
COMMISSIONING DATA SET DATA DUPLICATION	Changed Description
COMMISSIONING DATA SET MANDATED DATA FLOWS	Changed Description
COMMISSIONING DATA SET NOTATION	Changed Description
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
URGENT TREATMENT CENTRE	Changed Description
XML SCHEMA TRUD DOWNLOAD	Changed Description

Class Definitions

ACTIVITY GROUP	Changed Attributes
CARE CONTACT	Changed Attributes
CARE PROFESSIONAL ORGANISATION	Changed Attributes
CLINICAL INTERVENTION	Changed Attributes
CRITICAL CARE PERIOD	Changed Description
LOCATION	Changed Attributes
LODGED PATIENT	Changed Description

PATIENT DIAGNOSIS	Changed Attributes
PERSON PROPERTY QUALIFIER	Changed Attributes
PLANNED ACTIVITY DATE TIME	Changed Attributes
REFERRAL REQUEST	Changed Attributes

Attribute Definitions

A AND E ATTENDANCE CATEGORY (RETIRED) renamed from A AND E ATTENDANCE CATEGORY	Changed Name, status to Retired, Description
A AND E INITIAL ASSESSMENT TRIAGE CATEGORY (RETIRED) renamed from A AND E INITIAL ASSESSMENT TRIAGE CATEGORY	Changed Name, status to Retired, Description
A AND E PATIENT GROUP (RETIRED) renamed from A AND E PATIENT GROUP	Changed Name, status to Retired, Description
A AND E STREAM (RETIRED) renamed from A AND E STREAM	Changed Name, status to Retired, Description
ACCIDENT AND EMERGENCY ARRIVAL MODE (RETIRED) renamed from ACCIDENT AND EMERGENCY ARRIVAL MODE	Changed Name, status to Retired, Description
ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL (RETIRED) renamed from ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL	Changed Name, status to Retired, Description
ACCIDENT AND EMERGENCY DEPARTMENT TYPE (RETIRED) renamed from ACCIDENT AND EMERGENCY DEPARTMENT TYPE	Changed Name, status to Retired, Description
ACCIDENT AND EMERGENCY DIAGNOSIS (RETIRED) renamed from ACCIDENT AND EMERGENCY DIAGNOSIS	Changed Name, status to Retired, Description
ACCIDENT AND EMERGENCY INCIDENT LOCATION TYPE (RETIRED) renamed from ACCIDENT AND EMERGENCY INCIDENT LOCATION TYPE	Changed Name, status to Retired, Description
ACCIDENT AND EMERGENCY INVESTIGATION (RETIRED) renamed from ACCIDENT AND EMERGENCY INVESTIGATION	Changed Name, status to Retired, Description
ACCIDENT AND EMERGENCY TREATMENT (RETIRED) renamed from ACCIDENT AND EMERGENCY TREATMENT	Changed Name, status to Retired, Description
ACTIVITY DATE AND TIME TYPE	Changed Description
ACTIVITY DATE TYPE	Changed Description
ACTIVITY GROUP TYPE	Changed Description
ACTIVITY TIME	Changed Description
ACTIVITY TIME TYPE	Changed Description
ADMISSION METHOD	Changed Description
ANATOMICAL AREA (RETIRED) renamed from ANATOMICAL AREA	Changed Name, status to Retired, Description
CANCER SURGICAL ADMISSION TYPE	Changed Description
CARE CONTACT TYPE	Changed Description
CDS BULK REPLACEMENT GROUP CODE	Changed Description
CDS MESSAGE VERSION NUMBER	Changed Description
CDS TYPE CODE	Changed Description
DIAGNOSIS SCHEME IN USE	Changed Description
EMERGENCY CARE DEPARTMENT TYPE	Changed Description
EVENT TIME	Changed Description
INITIAL DIAGNOSIS CARE SETTING OR SERVICE FOR HIV	Changed Description
INVESTIGATION SCHEME IN USE (RETIRED) renamed from INVESTIGATION SCHEME IN USE	Changed Name, status to Retired, Description
LOCAL CARE PROFESSIONAL IDENTIFIER (RETIRED) renamed from LOCAL CARE PROFESSIONAL IDENTIFIER	Changed Name, status to Retired, Description
LODGING END TIME	Changed Description
LODGING START TIME	Changed Description
NHS NUMBER	Changed Description
PATIENT SOURCE SETTING TYPE FOR DIAGNOSTIC IMAGING	Changed Description
PERSON PROPERTY RECORDED TIME	Changed Description
PLANNED ACTIVITY DATE AND TIME TYPE	New Attribute
PLANNED ACTIVITY TIME	New Attribute
REFERRAL TO TREATMENT PERIOD START DATE	Changed Description
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 Name, status to Retired, Description
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

Data Elements

A AND E ATTENDANCE CONCLUSION TIME (RETIRED) renamed from A AND E ATTENDANCE CONCLUSION TIME	Changed Name, status to Retired, linked Attribute, Description
A AND E ATTENDANCE NUMBER (RETIRED) renamed from A AND E ATTENDANCE NUMBER	Changed Name, status to Retired, linked Attribute, Description
A AND E DEPARTMENT TYPE (RETIRED) renamed from A AND E DEPARTMENT TYPE	Changed Name, status to Retired, linked Attribute, Description
A AND E DEPARTURE TIME (RETIRED) renamed from A AND E DEPARTURE TIME	Changed Name, status to Retired, linked Attribute, Description
A AND E INCIDENT LOCATION TYPE (RETIRED) renamed from A AND E INCIDENT LOCATION TYPE	Changed Name, status to Retired, linked Attribute, Description
A AND E INITIAL ASSESSMENT TIME (RETIRED) renamed from A AND E INITIAL ASSESSMENT TIME	Changed Name, status to Retired, linked Attribute, Description
A AND E PATIENT GROUP (RETIRED) renamed from A AND E PATIENT GROUP	Changed Name, status to Retired, linked Attribute, Description
A AND E STAFF MEMBER CODE (RETIRED) renamed from A AND E STAFF MEMBER CODE	Changed Name, status to Retired, linked Attribute, Description
A AND E TIME SEEN FOR TREATMENT (RETIRED) renamed from A AND E TIME SEEN FOR TREATMENT	Changed Name, status to Retired, linked Attribute, Description
ACCIDENT AND EMERGENCY ARRIVAL MODE CODE (RETIRED) renamed from ACCIDENT AND EMERGENCY ARRIVAL MODE CODE	Changed Name, status to Retired, linked Attribute, Description
ACCIDENT AND EMERGENCY ATTENDANCE CATEGORY CODE (RETIRED) renamed from ACCIDENT AND EMERGENCY ATTENDANCE CATEGORY CODE	Changed Name, status to Retired, linked Attribute, Description
ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE (RETIRED) renamed from ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE	Changed Name, status to Retired, linked Attribute, Description
ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL CODE (RETIRED) renamed from ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL CODE	Changed Name, status to Retired, linked Attribute, Description
ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT (RETIRED) renamed from ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT	Changed Name, status to Retired, linked Attribute, Description
ACCIDENT AND EMERGENCY DEPARTURE DATE (RETIRED) renamed from ACCIDENT AND EMERGENCY DEPARTURE DATE	Changed Name, status to Retired, linked Attribute, Description
ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST (RETIRED) renamed from ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST	Changed Name, status to Retired, linked Attribute, Description
ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND (RETIRED) renamed from ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND	Changed Name, status to Retired, linked Attribute, Description
ACCIDENT AND EMERGENCY INITIAL ASSESSMENT DATE (RETIRED) renamed from ACCIDENT AND EMERGENCY INITIAL ASSESSMENT DATE	Changed Name, status to Retired, linked Attribute, Description
ACCIDENT AND EMERGENCY INVESTIGATION - FIRST (RETIRED) renamed from ACCIDENT AND EMERGENCY INVESTIGATION - FIRST	

	Changed Name, status to Retired, linked Attribute, Description
ACCIDENT AND EMERGENCY INVESTIGATION - SECOND (RETIRED) renamed from ACCIDENT AND EMERGENCY INVESTIGATION - SECOND	Changed Name, status to Retired, linked Attribute, Description
ACCIDENT AND EMERGENCY TREATMENT - FIRST (RETIRED) renamed from ACCIDENT AND EMERGENCY TREATMENT - FIRST	Changed Name, status to Retired, linked Attribute, Description
ACCIDENT AND EMERGENCY TREATMENT - SECOND (RETIRED) renamed from ACCIDENT AND EMERGENCY TREATMENT - SECOND	Changed Name, status to Retired, linked Attribute, Description
AMBULANCE INCIDENT NUMBER	Changed Description
ARRIVAL DATE (RETIRED) renamed from ARRIVAL DATE	Changed Name, status to Retired, linked Attribute, Description
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 Name, status to Retired, linked Attribute, Description
ASSAULT LOCATION DESCRIPTION	Changed Description
ASSESSMENT TOOL VALIDATION TIMESTAMP	New Data Element
ATTENDANCE DATE	Changed Description
CARE PROFESSIONAL CLINICAL RESPONSIBILITY TIMESTAMP	New Data Element
CDS ACTIVITY DATE	Changed Description
CDS RECORD IDENTIFIER	Changed Description
CDS SENDER IDENTITY	Changed Description
CLINICAL TRIAL IDENTIFIER	Changed Description
CODED FINDING (SNOMED CT)	New Data Element
CODED FINDING TIMESTAMP	New Data Element
CODED OBSERVATION TIMESTAMP	New Data Element
DATE FIRST SEEN	Changed Description
DISEASE OUTBREAK NOTIFICATION	Changed Description
DISEASE OUTBREAK NOTIFICATION (SNOMED CT)	New Data Element
DISEASE OUTBREAK NOTIFICATION DESCRIPTION	New Data Element
EMERGENCY CARE CLINICALLY READY TO PROCEED TIMESTAMP	New Data Element
EMERGENCY CARE DEPARTMENT TYPE	Changed Description
EMERGENCY CARE EXPECTED DATE AND TIMESTAMP OF TREATMENT	New Data Element
EMERGENCY CARE TREATMENT ALLOCATION TIMESTAMP	New Data Element
INVESTIGATION SCHEME IN USE (RETIRED) renamed from INVESTIGATION SCHEME IN USE	Changed Name, status to Retired, linked Attribute, Description
ORGANISATION SITE IDENTIFIER (OF PROVIDER FIRST SEEN)	Changed Description
PROFESSIONAL REGISTRATION ISSUER CODE	Changed Description
SOURCE OF REFERRAL FOR A AND E (RETIRED) renamed from SOURCE OF REFERRAL FOR A AND E	Changed Name, status to Retired, linked Attribute, Description

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

CDS V6-2-3 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 Status	Group Repeats	FUNCTION:			
M	1..1	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	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 Status	**Group Repeats**	**FUNCTION:** **To carry the details of the mandatory Commissioning Data Set Submission Protocol controls for when using the Net Change mechanism.** **One per Commissioning Data Set Message submitted to the Secondary Uses Service.** **Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange.**			
M	**1..1**	**Data Element Components**			**Rules**
		M	**1..1**	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

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

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 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 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 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 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 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 V6-2-3 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 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 V6-2-3 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 Status	Group Repeats	FUNCTION:	
		To carry the details of the Patient Pathway.	
O	0..1		
M	1..1	DATA GROUP: PATIENT PATHWAY IDENTITY	Rules
M *Or* M	1..1 1..1	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) *Or* PATIENT PATHWAY IDENTIFIER	F F I2
M	1..1	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	F I2
M	1..1	DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS	Rules
M	1..1	REFERRAL TO TREATMENT PERIOD STATUS	V
M	1..1	WAITING TIME MEASUREMENT TYPE	V
O	0..1	REFERRAL TO TREATMENT PERIOD START DATE	F S13
O	0..1	REFERRAL TO TREATMENT PERIOD END DATE	F S13

Notation		DATA GROUP: PATIENT IDENTITY
Group Status	Group Repeats	FUNCTION:
		To carry the Identity of the Patient.
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	NHS NUMBER STATUS INDICATOR CODE	V
	R	0..1	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	F
	R	0..1	WITHHELD IDENTITY REASON	V

OR

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

OR

1..1	

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

Notation		**DATA GROUP: PATIENT CHARACTERISTICS (EMERGENCY CARE)**			
Group Status	**Group Repeats**	**FUNCTION:**			
R	**0..1**	**To carry the characteristics of the Patient for an Emergency Care Attendance.**			
R	0..1	Data Element Components			**Rules**
		R	0..1	PERSON STATED GENDER CODE	V
		R	0..1	ETHNIC CATEGORY	V
		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:**			
R	**0..***	**To carry the patients Mental Health Act Legal Status.**			
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:**			
R	**0..1**	**To carry the Patient's General Medical Practitioner and the General Practice details.**			
R	0..1	Data Element Components			**Rules**
		O	0..1	GENERAL MEDICAL PRACTITIONER (SPECIFIED)	F

		R	0..1	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	F

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

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

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

Notation		DATA GROUP: CODED SCORED ASSESSMENT			
		FUNCTION:			
		To carry the details of the SNOMED CT coded scores.			

Group Status	Group Repeats	
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 Status: R	Group Repeats: 0..*
	FUNCTION: To carry the details of the SNOMED CT coded clinical observations.

		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 Status: R	Group Repeats: 0..*
	FUNCTION: To carry the details of the SNOMED CT coded clinical findings.

		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 Status: R	Group Repeats: 0..1
	FUNCTION: To carry the details of injuries.

		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: R	Group Repeats: 0..1
	FUNCTION: To carry patient clinical history details.

		Data Element Components	Rules
R	0..*	COMORBIDITY (SNOMED CT)	F

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

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

Notation		DATA GROUP: CARE PROFESSIONALS (EMERGENCY CARE)			
Group Status	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 Status	**Group Repeats**	**FUNCTION:**
O	**0..1**	**To carry details of any Research and/or Disease Outbreak Notifications.**

O	0..1	Data Element Components			Rules
		O	0..1	CLINICAL TRIAL IDENTIFIER	F
		O *Or* O	0..1 0..1	DISEASE OUTBREAK NOTIFICATION (SNOMED CT) *Or* DISEASE OUTBREAK NOTIFICATION DESCRIPTION	F F

Notation		DATA GROUP: 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..1**	**DATA GROUP: CDS V6-2-3 Type 004 - CDS Message Trailer** One per Commissioning Data Set Message submitted to the Secondary Uses Service. Multiple Commissioning Data Set Messages may be submitted in a single Commissioning Data Set Interchange

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

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

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.	
O	0..1			
M	1..1		DATA GROUP: PATIENT PATHWAY IDENTITY	Rules
	M Or M	1..1 1..1	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) Or PATIENT PATHWAY IDENTIFIER	F F I2
	M	1..1	ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	F I2
M	1..1		DATA GROUP: REFERRAL TO TREATMENT PERIOD CHARACTERISTICS	Rules
	M	1..1	REFERRAL TO TREATMENT PERIOD STATUS	V
	M	1..1	WAITING TIME MEASUREMENT TYPE	V
	O	0..1	REFERRAL TO TREATMENT PERIOD START DATE	F S13
	O	0..1	REFERRAL TO TREATMENT PERIOD END DATE	F S13

Notation	DATA GROUP: PATIENT IDENTITY
Group Status M	Group Repeats 1..1	FUNCTION: To carry the Identity of the Patient. 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	NHS NUMBER STATUS INDICATOR CODE	V
	R	0..1	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	F
	R	0..1	WITHHELD IDENTITY REASON	V

OR

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

OR

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

Notation	DATA GROUP: PATIENT CHARACTERISTICS (A AND E)
Group Status R	Group Repeats 0..1	FUNCTION: To carry the characteristics of the Patient for an Accident and Emergency Attendance.

R	1..1	Data Element Components		Rules
	R	0..1	PERSON GENDER CODE CURRENT	V

		O	0..1	CARER SUPPORT INDICATOR	V
		R	0..1	ETHNIC CATEGORY	V

Notation		DATA GROUP: GP REGISTRATION			
Group Status R	Group Repeats 0..1	FUNCTION: To carry the Patient's General Medical Practitioner and the General Practice details.			
R	1..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: LOCATION GROUP - ATTENDANCE			
Group Status R	Group Repeats 0..1	FUNCTION: To carry the details of the Accident and Emergency Attendance location.			
M	1..1	Data Element Components			Rules
		M	1..1	SITE CODE (OF TREATMENT)	F

Notation		DATA GROUP: ATTENDANCE OCCURRENCE - ACTIVITY CHARACTERISTICS			
Group Status M	Group Repeats 1..1	FUNCTION: To carry the characteristics of the Accident and Emergency Attendance.			
M	1..1	Data Element Components			Rules
		R	0..1	A and E ATTENDANCE NUMBER	F
		R	0..1	ACCIDENT AND EMERGENCY ARRIVAL MODE CODE	V
		R	0..1	ACCIDENT AND EMERGENCY ATTENDANCE CATEGORY CODE	V
		R	0..1	ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL CODE	V
		R	0..1	A and E INCIDENT LOCATION TYPE	V
		R	0..1	A and E PATIENT GROUP	V
		R	0..1	SOURCE OF REFERRAL FOR A and E	V
		R	0..1	A and E DEPARTMENT TYPE	V
		M	1..1	ARRIVAL DATE	F S1 S13
		M	1..1	ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT	F S14
		M	1..1	AGE AT CDS ACTIVITY DATE	F S8
		O	0..1	OVERSEAS VISITOR STATUS CLASSIFICATION AT CDS ACTIVITY DATE	V
		O	0..1	ACCIDENT AND EMERGENCY INITIAL ASSESSMENT DATE	F S13
		R	0..1	A and E INITIAL ASSESSMENT TIME	F S14
		O	0..1	ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT	F S13
		R	0..1	A and E TIME SEEN FOR TREATMENT	F S14
		O	0..1	ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE	F S13
		R	0..1	A and E ATTENDANCE CONCLUSION TIME	F S14
		O	0..1	ACCIDENT AND EMERGENCY DEPARTURE DATE	F S13
		R	0..1	A and E DEPARTURE TIME	F S14
		O	0..1	AMBULANCE INCIDENT NUMBER	F
		O	0..1	ORGANISATION CODE (CONVEYING AMBULANCE TRUST)	F

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

		Data Element Components		Rules
M	1..1			
		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 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 R	Group Repeats 0..1	FUNCTION: To carry the details of the Responsible Clinician.

		Data Element Components		Rules
R	0..1			
		R	0..1	A and E STAFF MEMBER CODE	F

Notation	DATA GROUP: CLINICAL DIAGNOSIS GROUP (ICD)
Group Status O	Group Repeats 0..1	FUNCTION: To carry the details of the ICD coded Clinical Diagnoses.

		Data Element Components		Rules
M	1..1			
		M	1..1	DIAGNOSIS SCHEME IN USE	V
M	1..1	DATA GROUP: PRIMARY DIAGNOSIS		Rules
		M	1..1	PRIMARY DIAGNOSIS (ICD)	F
		O	0..1	PRESENT ON ADMISSION INDICATOR	V
O	0..*	DATA GROUP: SECONDARY DIAGNOSES		Rules
		M	1..1	SECONDARY DIAGNOSIS (ICD)	F
		O	0..1	PRESENT ON ADMISSION INDICATOR	V

Notation	DATA GROUP: CLINICAL DIAGNOSIS GROUP (READ)
Group Status O	Group Repeats 0..1	FUNCTION: To carry the details of the READ coded Clinical Diagnoses.

		Data Element Components		Rules
M	1..1			
		M	1..1	DIAGNOSIS SCHEME IN USE	V
M	1..1	DATA GROUP: PRIMARY DIAGNOSIS		Rules
		M	1..1	PRIMARY DIAGNOSIS (READ)	F
O	0..*	DATA GROUP: SECONDARY DIAGNOSES		Rules
		M	1..1	SECONDARY DIAGNOSIS (READ)	F

Notation	DATA GROUP: CLINICAL DIAGNOSIS GROUP (A AND E)
Group Status R	Group Repeats 0..1	FUNCTION: To carry the details of the Accident and Emergency coded Clinical Diagnoses.

		Data Element Components		Rules
M	1..1			
		M	1..1	DIAGNOSIS SCHEME IN USE	V
M	1..1	DATA GROUP: PRIMARY DIAGNOSIS		Rules
		M	1..1	ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST	F
O	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 R	Group Repeats 0..1	FUNCTION: To carry the details of the Accident and Emergency coded Investigations undertaken.			
M	1..1	Data Element Components			Rules
		M	1..1	INVESTIGATION SCHEME IN USE	V
M	1..1	DATA GROUP: PRIMARY INVESTIGATION			Rules
		M	1..1	ACCIDENT AND EMERGENCY INVESTIGATION - FIRST	F H4
O	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 O	Group Repeats 0..1	FUNCTION: To carry the details of the OPCS coded Clinical Activities and Treatments undertaken.			
M	1..1	Data Element Components			Rules
		M	1..1	PROCEDURE SCHEME IN USE	V
M	1..1	DATA GROUP: PRIMARY PROCEDURE			Rules
		M	1..1	PRIMARY PROCEDURE (OPCS)	F
		R	1..1	PROCEDURE DATE	F S13
O	0..1	DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL			Rules
		M	1..1	PROFESSIONAL REGISTRATION ISSUER CODE	V
		M	1..1	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)	F
O	0..1	DATA GROUP: RESPONSIBLE ANAESTHETIST			Rules
		M	1..1	PROFESSIONAL REGISTRATION ISSUER CODE	V
		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
O	0..1	DATA GROUP: MAIN OPERATING HEALTHCARE PROFESSIONAL			Rules
		M	1..1	PROFESSIONAL REGISTRATION ISSUER CODE	V
		M	1..1	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL)	F
O	0..1	DATA GROUP: RESPONSIBLE ANAESTHETIST			Rules
		M	1..1	PROFESSIONAL REGISTRATION ISSUER CODE	V
		M	1..1	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST)	F

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

Group Status R	Group Repeats 0..1			
M	1..1	Data Element Components		Rules
	M	1..1	PROCEDURE SCHEME IN USE	V
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
O	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 Name, status to Retired, 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
- Changed Description

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

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

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 Name, status to Retired, 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
- Changed Description

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

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

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 Name, status to Retired, 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
- Changed Description

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

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

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 Name, status to Retired, 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
- Changed Description

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

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

The Accident and Emergency Commissioning Data Set identified the need for a national set of codes to 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 Name, status to Retired, 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
- Changed Description

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

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

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 Name, status to Retired, 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
- Changed Description

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

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

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 Name, status to Retired, 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
- Changed Description

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

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

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 Name, status to Retired, 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
- Changed Description

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

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

~~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 Name, status to Retired, 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
- Changed Description

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

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

- ~~A broad classification of types of diagnoses which may be made as a result of Accident and Emergency Attendance. The full description is made up of codes from three tables – ACCIDENT AND EMERGENCY DIAGNOSIS, Accident and Emergency Attendance: ANATOMICAL AREAS and Accident and Emergency Attendance: ANATOMICAL SIDE. ANATOMICAL AREA (a classification of parts of the human body) and ANATOMICAL SIDE (an indication of the side of the human body) together give the Anatomical Site of clinical problems presented at an Accident and Emergency Attendance.~~

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

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

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

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

Accident and Emergency Diagnosis - Diagnosis Condition

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

*Item sub-analysed

Accident and Emergency Diagnosis - Sub-analysis

Sub-analysis		Code
Contusion/abrasion		

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

Anatomical Site

Accident And Emergency Anatomical Area - Area

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

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

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 Name, status to Retired, 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
- Changed Description

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

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

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 Name, status to Retired, 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
- Changed Description

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

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

~~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 Name, status to Retired, 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
- Changed Description

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

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

~~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 Name, status to Retired, 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
- Changed Description

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

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

- ~~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 2006-04-01~~	~~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 Name, status to Retired, 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
- Changed Description

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

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

~~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 Name, status to Retired, 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
- Changed Description

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

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

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

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

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

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

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

~~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 Name, status to Retired, 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
- Changed Description

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

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

~~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 Name, status to Retired, 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
- Changed Description

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

CDS V6-2-3 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

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 Name, status to Retired, Description

~~**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

O	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)
		O	0..1	DATA GROUP: CLINICAL DIAGNOSIS GROUP (ICD)
		O	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)
		O	0..1	DATA GROUP: CLINICAL ACTIVITY GROUP (OPCS)
		O	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 Name, status to Retired, 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
- Changed Description

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~~

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 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 010~~	~~Accident And Emergency~~	~~Monthly~~	~~Accident and Emergency Attendances were mandated to flow nationally from 1st April 2005, see DSCN 32/2004~~	~~All Accident and Emergency Attendances occurring during the time period being reported and defined by the Commissioning Data Set Submission Protocol being used.~~
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 Measurement standard must be submitted to the Secondary Uses Service (in accordance with ISN ISB0092 Amd 06/2011, and must include the PATIENT PATHWAY data group data items. Note that this is only supported in Commissioning Data Set version 6-2 onwards, with the introduction of data element WAITING TIME MEASUREMENT TYPE.	Due to the high volumes involved, these are often submitted on a weekly basis.
CDS 021	Future Out-Patients	As Required for piloting	From 01/01/2008, submissions to support local activities and commissioning will be supported for piloting purposes only.	
CDS 030	Elective Admission List End of Period (Standard)	Monthly if used	All Providers should endeavour to support this data flow. Elective Admission List End of Period Census (Standard) Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led	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

			Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	the ELECTIVE ADMISSION LIST may be included.
CDS 040	Elective Admission List End of Period (New)	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
CDS 050	Elective Admission List End of Period (Old)	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
CDS 060	Elective Admission List Event During Period (Add)	Monthly if used	Optional Elective Admission List Event During Period (Add) Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	May be submitted where an entry has been added to the ELECTIVE ADMISSION LIST during the time period reported.
CDS 070	Elective Admission List Event During Period (Remove)	Monthly if used	Optional Elective Admission List Event During Period (Remove) Commissioning Data Set records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	May be submitted where an entry has been removed from the ELECTIVE ADMISSION LIST during the time period reported.
CDS 080	Elective Admission List Event During Period (Offer)	Monthly if used	Optional Elective Admission List Event During Period (Offer) CDS records where the activity relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement must include the PATIENT PATHWAY data group items, from 1st October 2009.	May be submitted where an offer has been made during the time period reported.
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	All Episodes that have finished relevant to the time period defined by the Commissioning Data Set Submission Protocol being used.

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

COMMISSIONING DATA SET NOTATION

Change to Supporting Information: Changed Description

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

Repeats Column Notation

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

REPEATS	DESCRIPTION

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

Rules Column Notation

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

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

Notation Examples

The following are examples of some common scenarios.

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

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

When a Data Group is used:

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

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

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

EXPLANATION:

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

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

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

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

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

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

When the Data Group is used:

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

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

Change to Supporting Information: Changed Description

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

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

- **CDS XML Schema:**
- CDS XML Schema Overview
- CDS XML Schema Design
- CDS XML Schema Version Numbering

- CDS XML Schema Documentation
- XML Schema TRUD Download

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

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
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 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

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EMERGENCY CARE INITIAL ASSESSMENT DATE

Change to Supporting Information: Changed Description

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

~~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: • 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

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

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.

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
REPLOGLE 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 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 Name, status to Retired, Description

~~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 Name, status to Retired, Description

- 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
- Changed Description

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

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

~~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 Name, status to Retired, 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
- Changed Description

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

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

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	Road 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 Name, status to Retired, Description

- 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
- Changed Description

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

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

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 Name, status to Retired, 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
- Changed Description

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

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

~~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 Name, status to Retired, Description

- 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
- Changed Description

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

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

~~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 Name, status to Retired, Description

- 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
- Changed Description

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

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

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 Name, status to Retired, Description

- 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
- Changed Description

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

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

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 Name, status to Retired, Description

- 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
- Changed Description

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

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

~~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 Name, status to Retired, Description

- 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
- Changed Description

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

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

~~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 Name, status to Retired, Description

- 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
- Changed Description

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

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

~~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 Name, status to Retired, Description

- 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
- Changed Description

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~~
111 Accident and Emergency Initial Assessment Date (Retired 01 November 2020)
112 Accident and Emergency Date Seen For Treatment (Retired 01 November 2020)
113 Accident and Emergency Attendance Conclusion Date (Retired 01 November 2020)
114 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:

~~01~~ ~~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 TIME

Change to Attribute: Changed Description

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~~
~~51~~ ~~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

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
~~21~~	~~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

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ANATOMICAL AREA (RETIRED), renamed from ANATOMICAL AREA

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

~~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 Name, status to Retired, Description

- Changed Name from Data_Dictionary.Attributes.A.Ana.ANATOMICAL_AREA to Retired.Data_Dictionary.Attributes.A.ANATOMICAL_AREA
- Retired ANATOMICAL AREA
- Changed Description

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:

~~01~~	~~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

CDS BULK REPLACEMENT GROUP CODE

Change to Attribute: Changed Description

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

~~Note:~~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 MESSAGE VERSION NUMBER

Change to Attribute: Changed Description

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

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

National Codes:

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

Change to Attribute: Changed Description

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

DIAGNOSIS SCHEME IN USE

Change to Attribute: Changed Description

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:

01	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 DEPARTMENT TYPE

Change to Attribute: Changed Description

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:

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
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.

EVENT TIME

Change to Attribute: Changed Description

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.

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 Name, status to Retired, Description

~~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.**

~~01~~	~~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 Name, status to Retired, Description

- 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
- Changed Description

LOCAL CARE PROFESSIONAL IDENTIFIER (RETIRED) renamed from LOCAL CARE PROFESSIONAL IDENTIFIER

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

~~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 Name, status to Retired, Description

- Changed Name from Data_Dictionary.Attributes.L.Lo.LOCAL_CARE_PROFESSIONAL_IDENTIFIER to Retired.Data_Dictionary.Attributes.L.LOCAL_CARE_PROFESSIONAL_IDENTIFIER
- Retired LOCAL CARE PROFESSIONAL IDENTIFIER
- Changed Description

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.

NHS NUMBER

Change to Attribute: Changed Description

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.

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 PROPERTY RECORDED TIME

Change to Attribute: Changed Description

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.

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

REFERRAL TO TREATMENT PERIOD START DATE

Change to Attribute: Changed Description

The start date of a REFERRAL TO TREATMENT PERIOD.

This is a specific type of the attribute ACTIVITY DATE.

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

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

Referral To Treatment Consultant Led Waiting Times:

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

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

A REFERRAL TO TREATMENT PERIOD may also start from SERVICE REQUESTS to CONSULTANTS from GENERAL DENTAL PRACTITIONERS, 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.

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.~~
~~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 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 Name, status to Retired, Description

~~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 Name, status to Retired, Description

- 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
- Changed Description

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
~~10~~	~~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)

A AND E ATTENDANCE CONCLUSION TIME (RETIRED) renamed from A AND E ATTENDANCE CONCLUSION TIME

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

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 Name, status to Retired, linked Attribute, Description

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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

A AND E ATTENDANCE NUMBER (RETIRED) renamed from A AND E ATTENDANCE NUMBER

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

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 Name, status to Retired, linked Attribute, Description

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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

A AND E DEPARTMENT TYPE (RETIRED) renamed from A AND E DEPARTMENT TYPE

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

A AND E DEPARTURE TIME (RETIRED) renamed from A AND E DEPARTURE TIME

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

~~A and E DEPARTURE TIME~~

~~**Attribute:**~~

~~ACTIVITY TIME~~

A AND E DEPARTURE TIME (RETIRED) renamed from A AND E DEPARTURE TIME

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

A AND E INCIDENT LOCATION TYPE (RETIRED) renamed from A AND E INCIDENT LOCATION TYPE

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

A AND E INITIAL ASSESSMENT TIME (RETIRED) renamed from A AND E INITIAL ASSESSMENT TIME

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

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

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

A AND E STAFF MEMBER CODE (RETIRED) renamed from A AND E STAFF MEMBER CODE

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

A AND E TIME SEEN FOR TREATMENT (RETIRED) renamed from A AND E TIME SEEN FOR TREATMENT

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

ACCIDENT AND EMERGENCY ARRIVAL MODE CODE (RETIRED) renamed from ACCIDENT AND EMERGENCY ARRIVAL MODE CODE

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

~~Format/Length:~~	~~an1~~
~~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 Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

ACCIDENT AND EMERGENCY ATTENDANCE CATEGORY CODE (RETIRED) renamed from ACCIDENT AND EMERGENCY ATTENDANCE CATEGORY CODE

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

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 Name, status to Retired, linked Attribute, Description

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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

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

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

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 Name, status to Retired, linked Attribute, Description

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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

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

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

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

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

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

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST (RETIRED) renamed from ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

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 Name, status to Retired, linked Attribute, Description

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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND (RETIRED) renamed from ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

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 Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

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

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

ACCIDENT AND EMERGENCY INVESTIGATION - FIRST (RETIRED) renamed from **ACCIDENT AND EMERGENCY INVESTIGATION - FIRST**

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

ACCIDENT AND EMERGENCY INVESTIGATION - SECOND (RETIRED) **renamed from ACCIDENT AND EMERGENCY INVESTIGATION - SECOND**

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

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 Name, status to Retired, linked Attribute, Description

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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

ACCIDENT AND EMERGENCY TREATMENT - FIRST (RETIRED) renamed from ACCIDENT AND EMERGENCY TREATMENT - FIRST

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

Format/Length:	an6
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 Name, status to Retired, linked Attribute, Description

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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

ACCIDENT AND EMERGENCY TREATMENT - SECOND (RETIRED) renamed from ACCIDENT AND EMERGENCY TREATMENT - SECOND

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

AMBULANCE INCIDENT NUMBER

Change to Data Element: Changed Description

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 Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

~~ARRIVAL DATE~~

~~**Attribute:**~~

~~ACTIVITY DATE~~

ARRIVAL DATE (RETIRED) renamed from ARRIVAL DATE

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

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 Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

ASSAULT LOCATION DESCRIPTION

Change to Data Element: Changed Description

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

Notes:
ASSAULT LOCATION DESCRIPTION is the same as attribute PERSON OBSERVATION TEXT STRING.

ASSAULT LOCATION DESCRIPTION provides further comment and/or details of the LOCATION where an assault took place. ~~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 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

CDS ACTIVITY DATE

Change to Data Element: Changed Description

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 RECORD IDENTIFIER

Change to Data Element: Changed Description

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 SENDER IDENTITY

Change to Data Element: Changed Description

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.

CLINICAL TRIAL IDENTIFIER

Change to Data Element: Changed Description

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

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

~~Use in the CDS V6-2-1 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 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 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

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.

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 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 DEPARTMENT TYPE

Change to Data Element: Changed Description

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 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 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

INVESTIGATION SCHEME IN USE (RETIRED) renamed from INVESTIGATION SCHEME IN USE

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

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.

PROFESSIONAL REGISTRATION ISSUER CODE

Change to Data Element: Changed Description

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

SOURCE OF REFERRAL FOR A AND E (RETIRED) renamed from SOURCE OF REFERRAL FOR A AND E

Change to Data Element: Changed Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

~~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 Name, status to Retired, linked Attribute, Description

- 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
- null
- Changed Description

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
NHS SERVICE AGREEMENT LINE NUMBER	max an10	None	None	None	Existing Format/Length states an10 - XML Schema allows max an10
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION IDENTIFIER (CODE OF PROVIDER)	min an3 max an5	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE)	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE)	None	Removed	None	None	Default codes not enumerated in the XML Schema
ORGANISATION SITE IDENTIFIER (OF TREATMENT)	None	Removed	None	None	Default codes not enumerated in the XML Schema
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 (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 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 (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 V6-2-3 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	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,	None	None	National Code 500 removed (not allowed in XML Schema)

MAIN SPECIALTY CODE		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			
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	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

CODE (AT CENSUS DATE)					
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)	None	01,02,03,04,05,06,07,08,09,10,11,12,13,14, 15,16,17,18,19,20,31,32,34,35,36,37,38	None	None	Additional National Codes 37 and 38 added
NEUROLOGICAL SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
NHS SERVICE AGREEMENT LINE NUMBER	max an10	None	None	None	Existing Format/Length states an10 - XML Schema allows max an10
ORGAN SUPPORT MAXIMUM	None	None	00-06	None	Range 00-06 allowed
ORGANISATION CODE (CODE OF COMMISSIONER)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
ORGANISATION CODE (CODE OF PROVIDER)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION SITE CODE changes
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (BABY))	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION SITE CODE changes
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (MOTHER))	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION SITE CODE changes
ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
PERSON WEIGHT	n3.n3	None	None	None	Existing Format/Length states max n3.max n3 - XML Schema enforces 3 digits before and after the decimal point - max removed
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