



### NHS Connecting for Health

#### NHS Data Model and Dictionary Service

**Reference:** Change Request 1002  
**Version No:** 1.0  
**Subject:** Commissioning Data Set Version 6-1 Tables  
**Effective Date:** 29 November 2008  
**Reason for Change:** Change to Data Standards  
**Publication Date:** 5 November 2008

#### Background:

This change introduces Commissioning Data Set 6-1 from 1 November 2008. Commissioning Data Set 6-0 remains an approved standard until 1 April 2009. A single set of tables are maintained for both Commissioning Data Set version 6-0 and 6-1.

Commissioning Data Set 5 ceased being an approved Information Standard from use on 1st April 2008 (see DSCN 14/2007 and DSCN 35/2007). It is retired from the NHS Data Model and Dictionary from 29 November 2008. Release 4 of the Secondary Uses Service will only support Commissioning Data Set 6-0 and 6-1.

#### Ethnic Category

Ethnic Category is required in the following Commissioning Data Sets:

- CDS V6 TYPE 010 - ACCIDENT AND EMERGENCY CDS
- CDS V6 TYPE 020 - OUTPATIENT CDS
- CDS V6 TYPE 120 - ADMITTED PATIENT CARE - FINISHED BIRTH EPISODE CDS
- CDS V6 TYPE 130 - ADMITTED PATIENT CARE - FINISHED GENERAL EPISODE CDS
- CDS V6 TYPE 140 - ADMITTED PATIENT CARE - FINISHED DELIVERY EPISODE CDS
- CDS V6 TYPE 170 - ADMITTED PATIENT CARE - DETAINED AND/OR LONG TERM PSYCHIATRIC CENSUS CDS
- CDS V6 TYPE 180 - ADMITTED PATIENT CARE - UNFINISHED BIRTH EPISODE CDS
- CDS V6 TYPE 190 - ADMITTED PATIENT CARE - UNFINISHED GENERAL EPISODE CDS
- CDS V6 TYPE 200 - ADMITTED PATIENT CARE - UNFINISHED DELIVERY EPISODE CDS

The use of the not stated classification and not known default code has been clarified.

This change introduces the requirement to flow Ethnic Category in: -

- CDS V6 TYPE 010 - ACCIDENT AND EMERGENCY CDS
- CDS V6 TYPE 020 - OUTPATIENT CDS
- CDS V6 TYPE 120 - ADMITTED PATIENT CARE - FINISHED BIRTH EPISODE CDS

Note that although the CDS V6 TYPE 021 - FUTURE OUTPATIENT CDS is identical in structure to CDS V6 TYPE 020 OUTPATIENT CDS, a placeholder for ETHNIC CATEGORY has been used in CDS TYPE 021 as the Information Standards Board have not approved the CDS type. CDS V6 TYPE 021 is only available for pilot implementation.

#### Mental Health Act 2007 Mental Category

Mental Health Act 2007 Mental Category is introduced into: -

- CDS V6 TYPE 170 - ADMITTED PATIENT CARE - DETAINED AND/OR LONG TERM PSYCHIATRIC CENSUS CDS

#### Person Birth Date

Person Birth Date has been moved from the Commissioning Data Set Group Patient Characteristics to the Commissioning Data Set Group Patient Identity. This reflects the use of Person Birth Date to identify patients. The schema for Commissioning Data Set 6-1 will enable providers to identify patients whose identity has been removed.

## Security and Confidentiality

The notes on Security and Confidentiality have been clarified.

## Commissioning Data Set Validation Table

The Commissioning Data Set Validation Table will be updated in a later Change Request.

### Summary of changes:

Data Set	
<a href="#">ACCIDENT AND EMERGENCY ATTENDANCE CDS TYPE (RETIRED)</a> renamed from <a href="#">ACCIDENT AND EMERGENCY ATTENDANCE CDS TYPE</a>	Changed status to Retired, Name
<a href="#">ADMITTED PATIENT CARE CDS TYPE - BIRTH EPISODE (RETIRED)</a> renamed from <a href="#">ADMITTED PATIENT CARE CDS TYPE - BIRTH EPISODE</a>	Changed status to Retired, Name
<a href="#">ADMITTED PATIENT CARE CDS TYPE - DELIVERY EPISODE (RETIRED)</a> renamed from <a href="#">ADMITTED PATIENT CARE CDS TYPE - DELIVERY EPISODE</a>	Changed status to Retired, Name
<a href="#">ADMITTED PATIENT CARE CDS TYPE - DETAINED AND - OR LONG TERM PSYCHIATRIC CENSUS (RETIRED)</a> renamed from <a href="#">ADMITTED PATIENT CARE CDS TYPE - DETAINED AND - OR LONG TERM PSYCHIATRIC CENSUS</a>	Changed status to Retired, Name
<a href="#">ADMITTED PATIENT CARE CDS TYPE - GENERAL EPISODE (RETIRED)</a> renamed from <a href="#">ADMITTED PATIENT CARE CDS TYPE - GENERAL EPISODE</a>	Changed status to Retired, Name
<a href="#">ADMITTED PATIENT CARE CDS TYPE - OTHER BIRTH EVENT (RETIRED)</a> renamed from <a href="#">ADMITTED PATIENT CARE CDS TYPE - OTHER BIRTH EVENT</a>	Changed status to Retired, Name
<a href="#">ADMITTED PATIENT CARE CDS TYPE - OTHER DELIVERY (RETIRED)</a> renamed from <a href="#">ADMITTED PATIENT CARE CDS TYPE - OTHER DELIVERY</a>	Changed status to Retired, Name
<a href="#">CDS INTERCHANGE HEADER (RETIRED)</a> renamed from <a href="#">CDS INTERCHANGE HEADER</a>	Changed status to Retired, Name
<a href="#">CDS INTERCHANGE TRAILER (RETIRED)</a> renamed from <a href="#">CDS INTERCHANGE TRAILER</a>	Changed status to Retired, Name
<a href="#">CDS MESSAGE HEADER (RETIRED)</a> renamed from <a href="#">CDS MESSAGE HEADER</a>	Changed status to Retired, Name
<a href="#">CDS MESSAGE TRAILER (RETIRED)</a> renamed from <a href="#">CDS MESSAGE TRAILER</a>	Changed status to Retired, Name
<a href="#">CDS TRANSACTION HEADER GROUP BULK UPDATE (RETIRED)</a> renamed from <a href="#">CDS TRANSACTION HEADER GROUP BULK UPDATE</a>	Changed status to Retired, Name
<a href="#">CDS TRANSACTION HEADER GROUP NET CHANGE (RETIRED)</a> renamed from <a href="#">CDS TRANSACTION HEADER GROUP NET CHANGE</a>	Changed status to Retired, Name
<a href="#">CDS V6 TYPE 010</a>	Changed Description
<a href="#">CDS V6 TYPE 020</a>	Changed Description
<a href="#">CDS V6 TYPE 021</a>	Changed Description
<a href="#">CDS V6 TYPE 030</a>	Changed Description
<a href="#">CDS V6 TYPE 050</a>	Changed Description
<a href="#">CDS V6 TYPE 060</a>	Changed Description
<a href="#">CDS V6 TYPE 110</a>	Changed Description
<a href="#">CDS V6 TYPE 120</a>	Changed Description
<a href="#">CDS V6 TYPE 130</a>	Changed Description
<a href="#">CDS V6 TYPE 140</a>	Changed Description
<a href="#">CDS V6 TYPE 150</a>	Changed Description
<a href="#">CDS V6 TYPE 160</a>	Changed Description
<a href="#">CDS V6 TYPE 170</a>	Changed Description
<a href="#">CDS V6 TYPE 180</a>	Changed Description
<a href="#">CDS V6 TYPE 190</a>	Changed Description
<a href="#">CDS V6 TYPE 200</a>	Changed Description
<a href="#">ELECTIVE ADMISSION LIST CDS TYPE 030 - END OF PERIOD CENSUS (STANDARD) (RETIRED)</a> renamed from <a href="#">ELECTIVE ADMISSION LIST CDS TYPE 030 - END OF PERIOD CENSUS (STANDARD)</a>	Changed status to Retired, Name
<a href="#">ELECTIVE ADMISSION LIST CDS TYPE 040 - END OF PERIOD CENSUS (OLD) (RETIRED)</a> renamed from <a href="#">ELECTIVE ADMISSION LIST CDS TYPE 040 - END OF PERIOD CENSUS (OLD)</a>	Changed status to Retired, Name
<a href="#">ELECTIVE ADMISSION LIST CDS TYPE 050 - END OF PERIOD CENSUS (NEW) (RETIRED)</a> renamed from <a href="#">ELECTIVE ADMISSION LIST CDS TYPE 050 - END OF PERIOD CENSUS (NEW)</a>	Changed status to Retired, Name
<a href="#">ELECTIVE ADMISSION LIST CDS TYPE 060 - EVENT DURING PERIOD (ADD) (RETIRED)</a> renamed from <a href="#">ELECTIVE ADMISSION LIST CDS TYPE 060 - EVENT DURING PERIOD (ADD)</a>	Changed status to Retired, Name
<a href="#">ELECTIVE ADMISSION LIST CDS TYPE 070 - EVENT DURING PERIOD (REMOVE) (RETIRED)</a> renamed from <a href="#">ELECTIVE ADMISSION LIST CDS TYPE 070 - EVENT DURING PERIOD (REMOVE)</a>	Changed status to Retired, Name
<a href="#">ELECTIVE ADMISSION LIST CDS TYPE 080 - EVENT DURING PERIOD (OFFER) (RETIRED)</a> renamed from <a href="#">ELECTIVE ADMISSION LIST CDS TYPE 080 - EVENT DURING PERIOD (OFFER)</a>	Changed status to Retired, Name
<a href="#">ELECTIVE ADMISSION LIST CDS TYPE 090 - EVENT DURING PERIOD (AVAILABLE/UNAVAILABLE) (RETIRED)</a> renamed from <a href="#">ELECTIVE ADMISSION LIST CDS TYPE 090 - EVENT DURING PERIOD</a>	Changed status to Retired, Name

[\(AVAILABLE/UNAVAILABLE\)](#)

[ELECTIVE ADMISSION LIST CDS TYPE 100 - EVENT DURING PERIOD \(OLD SERVICE AGREEMENT\) \(RETIRED\)](#) renamed from [ELECTIVE ADMISSION LIST CDS TYPE 100 - EVENT DURING PERIOD \(OLD SERVICE AGREEMENT\)](#) Changed status to Retired, Name

[ELECTIVE ADMISSION LIST CDS TYPE 110 - EVENT DURING PERIOD \(NEW SERVICE AGREEMENT\) \(RETIRED\)](#) renamed from [ELECTIVE ADMISSION LIST CDS TYPE 110 - EVENT DURING PERIOD \(NEW SERVICE AGREEMENT\)](#) Changed status to Retired, Name

[OLD VERSION 3 ADMITTED PATIENT CARE CDS TYPE - BIRTH EPISODE \(RETIRED\)](#) renamed from [OLD VERSION 3 ADMITTED PATIENT CARE CDS TYPE - BIRTH EPISODE](#) Changed status to Retired, Name

[OLD VERSION 3 ADMITTED PATIENT CARE CDS TYPE - DELIVERY EPISODE \(RETIRED\)](#) renamed from [OLD VERSION 3 ADMITTED PATIENT CARE CDS TYPE - DELIVERY EPISODE](#) Changed status to Retired, Name

[OLD VERSION 3 ADMITTED PATIENT CARE CDS TYPE - GENERAL EPISODE \(RETIRED\)](#) renamed from [OLD VERSION 3 ADMITTED PATIENT CARE CDS TYPE - GENERAL EPISODE](#) Changed status to Retired, Name

[OUT-PATIENT ATTENDANCE CDS TYPE \(RETIRED\)](#) renamed from [OUT-PATIENT ATTENDANCE CDS TYPE](#) Changed status to Retired, Name

[WARD ATTENDANCE CDS TYPE \(RETIRED\)](#) renamed from [WARD ATTENDANCE CDS TYPE](#) Changed status to Retired, Name

### **Supporting Information**

[CDS VERSION CDS006 TYPE LIST](#) Changed Description

[CDS VERSION NHS003 AND 4 TYPE LIST \(RETIRED\)](#) renamed from [CDS VERSION NHS003 AND 4 TYPE LIST](#) Changed status to Retired, Name

[CDS VERSION NHS005 TYPE LIST \(RETIRED\)](#) renamed from [CDS VERSION NHS005 TYPE LIST](#) Changed status to Retired, Name

[COMMISSIONING DATA SET VERSIONS](#) Changed Description

[DEFINITIONS MENU](#) Changed Description

[META MODEL](#) Changed Description

[SECURITY ISSUES AND PATIENT CONFIDENTIALITY](#) Changed Description

### **Attribute Definitions**

[ETHNIC CATEGORY CODE](#) Changed Description

### **Data Elements**

[ETHNIC CATEGORY](#) Changed Description

### **Packages**

[ATTRIBUTES](#) Changed Description

[CDS AND HES INDICES](#) New Package

[CLASSES](#) Changed Description

[COMMISSIONING DATA SET \(RETIRED\)](#) renamed from [COMMISSIONING DATA SET](#) Changed status to Retired, Name

[DIAGRAMS](#) Changed Description

[META MODEL](#) Changed Description

**Date:** 5 November 2008

**Sponsor:** Information Centre

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

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## **ACCIDENT AND EMERGENCY ATTENDANCE CDS TYPE (RETIRED)\_ renamed from ACCIDENT AND EMERGENCY ATTENDANCE CDS TYPE**

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Change to Data Set: Changed status to Retired, Name

- Retired ACCIDENT AND EMERGENCY ATTENDANCE CDS TYPE
- Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.ACCIDENT\_AND\_EMERGENCY\_ATTENDANCE\_CDS\_TYPE to Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.ACCIDENT\_AND\_EMERGENCY\_ATTENDANCE\_CDS\_TYPE

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## **ADMITTED PATIENT CARE CDS TYPE - BIRTH EPISODE (RETIRED)\_ renamed from ADMITTED PATIENT CARE CDS TYPE - BIRTH EPISODE**

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Change to Data Set: Changed status to Retired, Name

- Retired ADMITTED PATIENT CARE CDS TYPE - BIRTH EPISODE

- Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.ADMITTED\_PATIENT\_CARE\_CDS\_TYPE\_-\_BIRTH\_EPISODE to Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.ADMITTED\_PATIENT\_CARE\_CDS\_TYPE\_-\_BIRTH\_EPISODE

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### **ADMITTED PATIENT CARE CDS TYPE - DELIVERY EPISODE (RETIRED)\_ renamed from ADMITTED PATIENT CARE CDS TYPE - DELIVERY EPISODE**

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Change to Data Set: Changed status to Retired, Name

- Retired ADMITTED PATIENT CARE CDS TYPE - DELIVERY EPISODE
- Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.ADMITTED\_PATIENT\_CARE\_CDS\_TYPE\_-\_DELIVERY\_EPISODE to Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.ADMITTED\_PATIENT\_CARE\_CDS\_TYPE\_-\_DELIVERY\_EPISODE

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### **ADMITTED PATIENT CARE CDS TYPE - DETAINED AND - OR LONG TERM PSYCHIATRIC CENSUS (RETIRED) renamed from ADMITTED PATIENT CARE CDS TYPE - DETAINED AND - OR LONG TERM PSYCHIATRIC CENSUS**

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Change to Data Set: Changed status to Retired, Name

- Retired ADMITTED PATIENT CARE CDS TYPE - DETAINED AND - OR LONG TERM PSYCHIATRIC CENSUS
- Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.ADMITTED\_PATIENT\_CARE\_CDS\_TYPE\_-\_DETAINED\_AND\_-\_OR\_LONG\_TERM\_PSYCHIATRIC\_CENSUS to Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.ADMITTED\_PATIENT\_CARE\_CDS\_TYPE\_-\_DETAINED\_AND\_-\_OR\_LONG\_TERM\_PSYCHIATRIC\_CENSUS

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### **ADMITTED PATIENT CARE CDS TYPE - GENERAL EPISODE (RETIRED)\_ renamed from ADMITTED PATIENT CARE CDS TYPE - GENERAL EPISODE**

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Change to Data Set: Changed status to Retired, Name

- Retired ADMITTED PATIENT CARE CDS TYPE - GENERAL EPISODE
- Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.ADMITTED\_PATIENT\_CARE\_CDS\_TYPE\_-\_GENERAL\_EPISODE to Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.ADMITTED\_PATIENT\_CARE\_CDS\_TYPE\_-\_GENERAL\_EPISODE

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### **ADMITTED PATIENT CARE CDS TYPE - OTHER BIRTH EVENT (RETIRED)\_ renamed from ADMITTED PATIENT CARE CDS TYPE - OTHER BIRTH EVENT**

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Change to Data Set: Changed status to Retired, Name

- Retired ADMITTED PATIENT CARE CDS TYPE - OTHER BIRTH EVENT
- Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.ADMITTED\_PATIENT\_CARE\_CDS\_TYPE\_-\_OTHER\_BIRTH\_EVENT to Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.ADMITTED\_PATIENT\_CARE\_CDS\_TYPE\_-\_OTHER\_BIRTH\_EVENT

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### **ADMITTED PATIENT CARE CDS TYPE - OTHER DELIVERY (RETIRED)\_ renamed from ADMITTED PATIENT CARE CDS TYPE - OTHER DELIVERY**

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Change to Data Set: Changed status to Retired, Name

- Retired ADMITTED PATIENT CARE CDS TYPE - OTHER DELIVERY
- Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.ADMITTED\_PATIENT\_CARE\_CDS\_TYPE\_-\_OTHER\_DELIVERY to Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.ADMITTED\_PATIENT\_CARE\_CDS\_TYPE\_-\_OTHER\_DELIVERY

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### **CDS INTERCHANGE HEADER (RETIRED)\_ renamed from CDS INTERCHANGE HEADER**

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Change to Data Set: Changed status to Retired, Name

- Retired CDS INTERCHANGE HEADER
- Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.CDS\_INTERCHANGE\_HEADER to Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.CDS\_INTERCHANGE\_HEADER

## CDS INTERCHANGE TRAILER (RETIRED)\_ renamed from CDS INTERCHANGE TRAILER

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Change to Data Set: Changed status to Retired, Name

- Retired CDS INTERCHANGE TRAILER
  - Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.CDS\_INTERCHANGE\_TRAILER to Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.CDS\_INTERCHANGE\_TRAILER
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## CDS MESSAGE HEADER (RETIRED)\_ renamed from CDS MESSAGE HEADER

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Change to Data Set: Changed status to Retired, Name

- Retired CDS MESSAGE HEADER
  - Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.CDS\_MESSAGE\_HEADER to Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.CDS\_MESSAGE\_HEADER
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## CDS MESSAGE TRAILER (RETIRED)\_ renamed from CDS MESSAGE TRAILER

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Change to Data Set: Changed status to Retired, Name

- Retired CDS MESSAGE TRAILER
  - Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.CDS\_MESSAGE\_TRAILER to Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.CDS\_MESSAGE\_TRAILER
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## CDS TRANSACTION HEADER GROUP BULK UPDATE (RETIRED)\_ renamed from CDS TRANSACTION HEADER GROUP BULK UPDATE

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Change to Data Set: Changed status to Retired, Name

- Retired CDS TRANSACTION HEADER GROUP BULK UPDATE
  - Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.CDS\_TRANSACTION\_HEADER\_GROUP\_BULK\_UPDATE to Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.CDS\_TRANSACTION\_HEADER\_GROUP\_BULK\_UPDATE
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## CDS TRANSACTION HEADER GROUP NET CHANGE (RETIRED)\_ renamed from CDS TRANSACTION HEADER GROUP NET CHANGE

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Change to Data Set: Changed status to Retired, Name

- Retired CDS TRANSACTION HEADER GROUP NET CHANGE
  - Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.CDS\_TRANSACTION\_HEADER\_GROUP\_NET\_CHANGE to Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.CDS\_TRANSACTION\_HEADER\_GROUP\_NET\_CHANGE
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## CDS V6 TYPE 010

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Change to Data Set: Changed Description

### [CDS V6 TYPE 010 - ACCIDENT AND EMERGENCY CDS](#)

**This Commissioning Data Set carries the data for an Accident and Emergency Attendance Episode and consists of the following Commissioning Data Set Data Groups:**

INTERCHANGE, MESSAGE and COMMISSIONING DATA SET TRANSACTION HEADERS and TRAILERS (defined independently)  
PATIENT PATHWAY  
PATIENT IDENTITY  
PATIENT CHARACTERISTICS  
GENERAL PRACTITIONER REGISTRATION  
ATTENDANCE OCCURRENCE - Activity Characteristics  
ATTENDANCE OCCURRENCE - Service Agreement Details  
ATTENDANCE OCCURRENCE - Person Group (A And E Consultant)  
ATTENDANCE OCCURRENCE - Clinical Information (Diagnosis)  
ATTENDANCE OCCURRENCE - Clinical Information (Investigation)  
ATTENDANCE OCCURRENCE - Clinical Information (Treatment)  
HEALTHCARE RESOURCE GROUP

The markers in the columns "OPT, U/A and HES" indicate the NHS recommendations for the inclusion of data:

M = Mandatory - data must be included **where** available

O = Optional - data need not be included

= Must **Not** Be Used

**CDS V6 TYPE 010 - ACCIDENT AND EMERGENCY CDS**

**COMMISSIONING DATA SET DATA GROUP: PATIENT PATHWAY:**

To carry the details of the Patient Pathway.

One optional occurrence of this Group is permitted.

Opt	CDS Data Element	
O	<a href="#">UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)</a>	
O	<a href="#">PATIENT PATHWAY IDENTIFIER</a>	
O	<a href="#">ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)</a>	
O	<a href="#">REFERRAL TO TREATMENT STATUS</a>	
O	<a href="#">REFERRAL TO TREATMENT PERIOD START DATE</a>	
O	<a href="#">REFERRAL TO TREATMENT PERIOD END DATE</a>	
*	LEAD CARE ACTIVITY INDICATOR (not defined or approved by the Information Standards Board)	

**COMMISSIONING DATA SET DATA GROUP: PATIENT IDENTITY:**

To carry the identity of the Patient.

One occurrence of this Group is permitted.

Opt	Commissioning Data Set Data Element	
M	<a href="#">LOCAL PATIENT IDENTIFIER</a>	
M	<a href="#">ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)</a>	
O	<a href="#">NHS NUMBER</a>	
M	<a href="#">NHS NUMBER STATUS INDICATOR</a>	
O	<a href="#">PATIENT NAME</a>	
O	<a href="#">PATIENT USUAL ADDRESS</a>	
M	<a href="#">POSTCODE OF USUAL ADDRESS</a>	
M	<a href="#">ORGANISATION CODE (PCT OF RESIDENCE)</a>	
M	<a href="#">PERSON BIRTH DATE</a> (From commissioning data set 6-1)	

**Note:**

For reasons of confidentiality, the [PATIENT](#)'s preferred name and address (not including [POSTCODE OF USUAL ADDRESS](#)) must **not** be carried where a valid NHS Number is present. For patients with sensitive conditions (as defined in DSCN 41/98/P26), all [PATIENT](#) identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), [ORGANISATION CODE \(PCT OF RESIDENCE\)](#) and [PERSON BIRTH DATE](#) (in [PATIENT](#) Characteristics data group below).

**Note:**

For Security Issues and Patient Confidentiality, the [PATIENT NAME](#) and [PATIENT USUAL ADDRESS](#) (not including [POSTCODE OF USUAL ADDRESS](#)) must not be carried where a valid NHS NUMBER is present, even if the NHS NUMBER is not verified.

For patients with sensitive conditions (as defined in Security Issues and Patient Confidentiality), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), and [PERSON BIRTH DATE](#).

**COMMISSIONING DATA SET DATA GROUP: PATIENT CHARACTERISTICS:**

To carry the characteristics of the Patient.

One occurrence of this Group is permitted.

Opt	Commissioning Data Set Data Element	
M	<a href="#">PERSON BIRTH DATE</a>	
M	<a href="#">PERSON BIRTH DATE</a> (Commissioning data set 6-0 only)	
M	<a href="#">PERSON GENDER CURRENT</a>	
⊖	<a href="#">CARER SUPPORT INDICATOR</a>	
O	<a href="#">CARER SUPPORT INDICATOR</a>	
M		

ETHNIC CATEGORY  
(from Commissioning Data Set Version 6-1)

**COMMISSIONING DATA SET DATA GROUP: GP REGISTRATION:**  
To carry the Patient's General Medical Practitioner and General Practice details.  
One occurrence of this Group is permitted.

O	<a href="#">GENERAL MEDICAL PRACTITIONER (SPECIFIED)</a>
M	<a href="#">GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)</a>

**COMMISSIONING DATA SET DATA GROUP: ATTENDANCE OCCURRENCE - Activity Characteristics:**  
To carry the details of the Accident and Emergency attendance.

M	<a href="#">A and E ATTENDANCE NUMBER</a>
M	<a href="#">A and E ARRIVAL MODE</a>
M	<a href="#">A and E ATTENDANCE CATEGORY</a>
M	<a href="#">A and E ATTENDANCE DISPOSAL</a>
M	<a href="#">A and E INCIDENT LOCATION TYPE</a>
M	<a href="#">A and E PATIENT GROUP</a>
M	<a href="#">SOURCE OF REFERRAL FOR A and E</a>
M	<a href="#">A and E DEPARTMENT TYPE</a>
M	<a href="#">ARRIVAL DATE</a> This is the <b>mandatory</b> date used to derive the <b>mandatory</b> <a href="#">CDS ACTIVITY DATE</a>
M	<a href="#">ARRIVAL TIME</a>
M	<a href="#">AGE AT CDS ACTIVITY DATE</a>
M	<a href="#">A and E INITIAL ASSESSMENT TIME</a> (first and unplanned follow-up attendances only)
M	<a href="#">A and E TIME SEEN FOR TREATMENT</a>
M	<a href="#">A and E ATTENDANCE CONCLUSION TIME</a>
M	<a href="#">A and E DEPARTURE TIME</a>

**COMMISSIONING DATA SET DATA GROUP: ATTENDANCE OCCURRENCE - Service Agreement Details:**  
To carry the details of the Service Agreement for the Accident and Emergency Attendance.  
One occurrence of this Data Group is permitted.

M	<a href="#">COMMISSIONING SERIAL NUMBER</a>
O	<a href="#">NHS SERVICE AGREEMENT LINE NUMBER</a>
O	<a href="#">PROVIDER REFERENCE NUMBER</a>
O	<a href="#">COMMISSIONER REFERENCE NUMBER</a>
M	<a href="#">ORGANISATION CODE (CODE OF PROVIDER)</a>
M	<a href="#">ORGANISATION CODE (CODE OF COMMISSIONER)</a>

**COMMISSIONING DATA SET DATA GROUP: ATTENDANCE OCCURRENCE - Person Group (A + E Consultant):**  
To carry the details of the responsible Clinician.  
One occurrence of this Group is permitted.

M	<a href="#">A and E STAFF MEMBER CODE</a>
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**COMMISSIONING DATA SET DATA GROUP: ATTENDANCE OCCURRENCE -Clinical Diagnosis Details - ICD:**  
To carry the details of the Diagnosis Code Scheme and the Diagnoses.  
One occurrence of this Group is permitted.

O	<a href="#">DIAGNOSIS SCHEME IN USE</a>
O	<a href="#">PRIMARY DIAGNOSIS (ICD)</a>
O	<a href="#">SECONDARY DIAGNOSIS (ICD)</a> Multiple Secondary Diagnoses may be recorded.

**COMMISSIONING DATA SET DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Diagnosis Details - READ:**  
To carry the details of the Diagnosis Code Scheme and the Diagnoses.  
One occurrence of this Group is permitted.

O	<a href="#">DIAGNOSIS SCHEME IN USE</a>
O	<a href="#">PRIMARY DIAGNOSIS (READ)</a>
O	<a href="#">SECONDARY DIAGNOSIS (READ)</a> Multiple Secondary Diagnoses may be recorded.

**COMMISSIONING DATA SET DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Diagnosis Details - A + E Coded:**  
To carry the details of the Diagnosis Code Scheme and the Diagnoses.  
One occurrence of this Group is permitted.



M	<a href="#">DIAGNOSIS SCHEME IN USE</a>	
M	<a href="#">ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST</a>	
M	<a href="#">ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND</a> Multiple Secondary Diagnoses may be recorded.	
<b>COMMISSIONING DATA SET DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Investigation Details - A + E:</b> To carry the details of the Investigation Code Scheme and the Investigations undertaken. Multiple occurrences of this Group are permitted.		
M	<a href="#">INVESTIGATION SCHEME IN USE</a>	
M	<a href="#">ACCIDENT AND EMERGENCY INVESTIGATION - FIRST</a>	
M	<a href="#">ACCIDENT AND EMERGENCY INVESTIGATION - SECOND</a> Multiple Secondary Investigations may be recorded.	
<b>COMMISSIONING DATA SET DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Activity / Treatment Group (OPCS):</b> To carry the details of the OPCS coded Clinical Activities and Treatments undertaken. One occurrence of this Group is permitted.		
O	<a href="#">PROCEDURE SCHEME IN USE</a>	
O	<a href="#">PRIMARY PROCEDURE (OPCS)</a>	
O	<a href="#">PROCEDURE DATE</a> (of Primary Procedure)	
	(Multiple occurrences of this sub-group may be recorded)	
O	<a href="#">PROCEDURE (OPCS)</a>	
O	<a href="#">PROCEDURE DATE</a> (of Secondary Procedure)	
<b>COMMISSIONING DATA SET DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Activity / Treatment Group (READ):</b> To carry the details of the READ coded Clinical Activities and Treatments undertaken. One occurrence of this Group is permitted.		
O	<a href="#">PROCEDURE SCHEME IN USE</a>	
O	<a href="#">PRIMARY PROCEDURE (READ)</a>	
O	<a href="#">PROCEDURE DATE</a> (of Primary Procedure)	
	(Multiple occurrences of this sub-group may be recorded)	
O	<a href="#">PROCEDURE (READ)</a>	
O	<a href="#">PROCEDURE DATE</a> (of Secondary Procedure)	
<b>COMMISSIONING DATA SET DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Activity / Treatment Group (A + E):</b> To carry the details of the A + E coded Clinical Activities and Treatments undertaken. One occurrence of this Group is permitted.		
M	<a href="#">PROCEDURE SCHEME IN USE</a>	
M	<a href="#">ACCIDENT AND EMERGENCY TREATMENT - FIRST</a>	
M	<a href="#">PROCEDURE DATE</a> (of First Treatment)	
	(Multiple occurrences of this sub-group may be recorded)	
M	<a href="#">ACCIDENT AND EMERGENCY TREATMENT - SECOND</a>	
M	<a href="#">PROCEDURE DATE</a> (of Subsequent Treatments)	
<b>COMMISSIONING DATA SET DATA GROUP: HEALTHCARE RESOURCE GROUP - Activity Characteristics:</b> To carry the details of the Healthcare Resource Group.		
M	<a href="#">HEALTHCARE RESOURCE GROUP CODE</a>	
M	<a href="#">HEALTHCARE RESOURCE GROUP CODE-VERSION NUMBER</a>	
<b>COMMISSIONING DATA SET DATA GROUP: Healthcare Resource Group Activity - Clinical Activity Group:</b> To carry the details of the Healthcare Resource Group Dominant Grouping Variable - Procedure. Note that this will not apply when no operation was carried out. In this case, the segment referring to Healthcare Resource Group Dominant Grouping Variable - Procedure should be omitted.		
O	<a href="#">PROCEDURE SCHEME IN USE</a>	
O	<a href="#">HRG DOMINANT GROUPING VARIABLE-PROCEDURE</a>	

**Note:**

In addition, Accident and Emergency reference costs are mandated and collected via a direct data flow between Providers and the [Department of Health](#).

**CDS V6 TYPE 020**

Change to Data Set: Changed Description

**[CDS V6 TYPE 020 - OUTPATIENT CDS](#)**

The Outpatient CDS carries the data for a Care Activity or a cancelled / missed Care Appointment. The data set applies for Consultant, Nurse, Midwife, and other [CARE PROFESSIONALS](#) attendances and appointments, including Ward Attendances for nursing care.

This CDS Type must not be used for "Future Outpatients" - for this CDS TYPE 021 must be used.

The CDS consists of the following CDS Data Groups:

- INTERCHANGE, MESSAGE and CDS TRANSACTION HEADERS and TRAILERS (defined independently)
- PATIENT PATHWAY
- PATIENT IDENTITY
- PATIENT CHARACTERISTICS
- CARE EPISODE
- ATTENDANCE OCCURRENCE
- GP REGISTRATION
- REFERRAL
- MISSED APPOINTMENT OCCURRENCE
- HEALTHCARE RESOURCE GROUP

The markers in the columns "OPT, U/A and HES" indicate the NHS recommendations for the inclusion of data:

M = Mandatory - data must be included **where** available

O = Optional - data need not be included

= Must **Not** Be Used

CDS V6 TYPE 020 - THE OUTPATIENT CDS (Known in the Schema as the Care Activity CDS)		
CDS DATA GROUP: PATIENT PATHWAY: To carry the details of the Patient Pathway. One optional occurrence of this Group is permitted.		
Opt	CDS Data Element	
O	<a href="#">UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)</a>	
O	<a href="#">PATIENT PATHWAY IDENTIFIER</a>	
O	<a href="#">ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)</a>	
O	<a href="#">REFERRAL TO TREATMENT STATUS</a>	
O	<a href="#">REFERRAL TO TREATMENT PERIOD START DATE</a>	
O	<a href="#">REFERRAL TO TREATMENT PERIOD END DATE</a>	
*	LEAD CARE ACTIVITY INDICATOR (Not defined or approved by the Information Standards Board)	
CDS DATA GROUP: PATIENT IDENTITY: To carry the identity of the Patient. One occurrence of this Group is permitted.		
Opt	CDS Data Element	
M	<a href="#">LOCAL PATIENT IDENTIFIER</a>	
M	<a href="#">ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)</a>	
M	<a href="#">NHS NUMBER</a>	
M	<a href="#">NHS NUMBER STATUS INDICATOR</a>	
O	<a href="#">PATIENT NAME</a>	
O	<a href="#">PATIENT USUAL ADDRESS</a>	
M	<a href="#">POSTCODE OF USUAL ADDRESS</a>	
M	<a href="#">ORGANISATION CODE (PCT OF RESIDENCE)</a>	
M	<a href="#">PERSON BIRTH DATE</a> (From commissioning data set 6-1)	

**Note:-**

For reasons of confidentiality, the patient's preferred name and address (not including [POSTCODE OF USUAL ADDRESS](#)) must **not** be carried where a valid NHS Number is present. For patients with sensitive conditions (as defined in DSCN 41/98/P26), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), [ORGANISATION CODE \(PCT OF RESIDENCE\)](#), and [PERSON BIRTH DATE](#) (in Patient Characteristics data group below):

**Note:**

For Security Issues and Patient Confidentiality, the [PATIENT NAME](#) and [PATIENT USUAL ADDRESS](#) (not including [POSTCODE OF USUAL ADDRESS](#)) must not be carried where a valid NHS NUMBER is present, even if the NHS

NUMBER is not verified.

For patients with sensitive conditions (as defined in Security Issues and Patient Confidentiality), all patient identifiable information must be removed from Commissioning Data Set records. This includes LOCAL PATIENT IDENTIFIER, NHS NUMBER, PATIENT NAME, PATIENT USUAL ADDRESS, POSTCODE OF USUAL ADDRESS, and PERSON BIRTH DATE.

**CDS DATA GROUP: PATIENT CHARACTERISTICS:**  
To carry the characteristics of the Patient.  
One occurrence of this Group is permitted.

Opt	CDS Data Element	
<del>M</del>	<del>PERSON BIRTH DATE</del>	
M	PERSON BIRTH DATE (Commissioning data set 6-0 only)	
M	PERSON GENDER CURRENT	
<del>⊖</del>	<del>CARER SUPPORT INDICATOR</del>	
O	CARER SUPPORT INDICATOR	
M	ETHNIC CATEGORY (from Commissioning Data Set Version 6-1)	

**CDS DATA GROUP: CARE EPISODE - Person Group (Consultant):**  
To carry the details of the responsible Consultant.  
One occurrence of this Group is permitted.

M	CONSULTANT CODE	
M	MAIN SPECIALTY CODE	
M	TREATMENT FUNCTION CODE	

**CDS DATA GROUP: CARE EPISODE - CLINICAL DIAGNOSIS (ICD):**  
To carry the details of the ICD Diagnosis Scheme and the Diagnoses.

O	DIAGNOSIS SCHEME IN USE	
O	PRIMARY DIAGNOSIS (ICD)	
O	SECONDARY DIAGNOSIS (ICD) Multiple Secondary Diagnoses may be recorded.	

**CDS DATA GROUP: CARE EPISODE - CLINICAL DIAGNOSIS (READ):**  
To carry the details of the READ Diagnosis Scheme and the Diagnoses.

O	DIAGNOSIS SCHEME IN USE	
O	PRIMARY DIAGNOSIS (READ)	
O	SECONDARY DIAGNOSIS (READ) Multiple Secondary Diagnoses may be recorded.	

**CDS DATA GROUP: ATTENDANCE OCCURRENCE - Activity Characteristics:**  
To carry the details of the Care Attendance or cancelled appointment.

M	ATTENDANCE IDENTIFIER	
M	ADMINISTRATIVE CATEGORY	
M	ATTENDED OR DID NOT ATTEND	
M	FIRST ATTENDANCE	
M	MEDICAL STAFF TYPE SEEING PATIENT	
M	OPERATION STATUS (per attendance)	
M	OUTCOME OF ATTENDANCE	
M	APPOINTMENT DATE This is the <b>mandatory</b> date used to derive the <b>mandatory</b> CDS ACTIVITY DATE.	
M	AGE AT CDS ACTIVITY DATE	
O	EARLIEST REASONABLE OFFER DATE	

**CDS DATA GROUP: ATTENDANCE OCCURRENCE - Service Agreement Details:**  
To carry the details of the Service Agreement for the Care Attendance.

M	COMMISSIONING SERIAL NUMBER	
O	NHS SERVICE AGREEMENT LINE NUMBER	
O	PROVIDER REFERENCE NUMBER	
M	COMMISSIONER REFERENCE NUMBER	
M	ORGANISATION CODE (CODE OF PROVIDER)	
M	ORGANISATION CODE (CODE OF COMMISSIONER)	

CDS DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Activity Group (OPCS): To carry the details of the OPCS coded Clinical Activities undertaken.		
O	<a href="#">PROCEDURE SCHEME IN USE</a>	
O	<a href="#">PRIMARY PROCEDURE (OPCS)</a>	
O	<a href="#">PROCEDURE DATE</a> (of Primary Procedure)	
(Multiple Procedures may be recorded)		
O	<a href="#">PROCEDURE (OPCS)</a>	
O	<a href="#">PROCEDURE DATE</a> (of Secondary Procedure)	
CDS DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Activity Group (READ): To carry the details of the READ coded Clinical Activities undertaken.		
O	<a href="#">PROCEDURE SCHEME IN USE</a>	
O	<a href="#">PRIMARY PROCEDURE (READ)</a>	
O	<a href="#">PROCEDURE DATE</a> (of Primary Procedure)	
(Multiple Procedures may be recorded)		
O	<a href="#">PROCEDURE (READ)</a>	
O	<a href="#">PROCEDURE DATE</a> (of Secondary Procedure)	
CDS DATA GROUP: ATTENDANCE OCCURRENCE - Location Group of Care Attendance: To carry the details of the location and Site Code of Treatment. One occurrence of this Group is permitted.		
M	<a href="#">LOCATION CLASS</a>	
M	<a href="#">SITE CODE (OF TREATMENT)</a>	
*	<a href="#">LOCATION TYPE</a> Definition and value list currently under review	
CDS DATA GROUP: GP REGISTRATION: To carry the Patient's General Medical Practitioner and General Practice details. One occurrence of this Group is permitted.		
O	<a href="#">GENERAL MEDICAL PRACTITIONER (SPECIFIED)</a>	
M	<a href="#">GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)</a>	
CDS DATA GROUP: REFERRAL - Activity Characteristics: To carry the details of the referral. One occurrence of this Group is permitted.		
M	<a href="#">PRIORITY TYPE</a>	
M	<a href="#">SERVICE TYPE REQUESTED</a>	
M	<a href="#">SOURCE OF REFERRAL FOR OUT-PATIENTS</a>	
M	<a href="#">REFERRAL REQUEST RECEIVED DATE</a>	
CDS DATA GROUP: REFERRAL - Person Group (Referrer): To carry the details of the referrer. One occurrence of this Group is permitted.		
M	<a href="#">REFERRER CODE</a>	
M	<a href="#">REFERRING ORGANISATION CODE</a>	
CDS DATA GROUP: MISSED APPOINTMENT - Occurrence: To carry the details of a missed appointment. One occurrence of this Group is permitted.		
M	<a href="#">LAST DNA OR PATIENT CANCELLED DATE</a>	
CDS DATA GROUP: HEALTHCARE RESOURCE GROUP - Activity Characteristics: To carry the details of the Healthcare Resource Group. One occurrence of this Group is permitted.		
O	<a href="#">HEALTHCARE RESOURCE GROUP CODE</a>	
O	<a href="#">HEALTHCARE RESOURCE GROUP CODE-VERSION NUMBER</a>	
CDS DATA GROUP: HEALTHCARE RESOURCE GROUP - Clinical Activity Group: To carry the details of the HRG Dominant Grouping Variable - Procedure.		
O	<a href="#">PROCEDURE SCHEME IN USE</a>	
O	<a href="#">HRG DOMINANT GROUPING VARIABLE-PROCEDURE</a>	

**Note:**

HRG Dominant Grouping Variable does not apply to Care Attendances but the data structure is retained for documentation purposes.

**CDS V6 TYPE 021 - FUTURE OUTPATIENT CDS**

The Future Outpatient CDS carries the data for a forthcoming Care Activity, future or planned Care Appointment. The data set applies for Consultant, Nurse and Midwife attendances and appointments including Ward Attendances for nursing care.

The CDS TYPE 021 consists of the following CDS Data Groups:

INTERCHANGE, MESSAGE and CDS TRANSACTION HEADERS and TRAILERS (defined independently)

PATIENT PATHWAY

PATIENT IDENTITY

PATIENT CHARACTERISTICS

CARE EPISODE

ATTENDANCE OCCURRENCE

GP REGISTRATION

REFERRAL

HEALTHCARE RESOURCE GROUP

**Note:** Each CDS must contain a valid [CDS ACTIVITY DATE](#) and when using the CDS BULK REPLACEMENT UPDATE MECHANISM this date must also be compatible with the [CDS REPORT PERIOD START DATE](#) and the [CDS REPORT PERIOD END DATE](#) specified as part of the CDS EXCHANGE PROTOCOL.

The CDS ACTIVITY DATE has an "originating date" held within the CDS data and for the Future Outpatient CDS Type this is the APPOINTMENT DATE held in the Attendance Occurrence-Activity Characteristics data structure.

Where the source application system cannot provide a valid date, the default value may be applied, see [APPOINTMENT DATE](#).

The markers in the columns "OPT, U/A and HES" indicate the NHS recommendations for the inclusion of data:

M = Mandatory - data must be included **where** available

O = Optional - data need not be included

= Must **Not** Be Used

CDS V6 TYPE 021 - THE FUTURE OUTPATIENT CDS (Known in the Schema as Future Care Activity CDS)		
<b>CDS DATA GROUP: PATIENT PATHWAY:</b> To carry the details of the Patient Pathway. One optional occurrence of this Group is permitted.		
Opt	CDS Data Element	
O	<a href="#">UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)</a>	
O	<a href="#">PATIENT PATHWAY IDENTIFIER</a>	
O	<a href="#">ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)</a>	
O	<a href="#">REFERRAL TO TREATMENT STATUS</a> (intended status of the anticipated appointment)	
O	<a href="#">REFERRAL TO TREATMENT PERIOD START DATE</a>	
O	<a href="#">REFERRAL TO TREATMENT PERIOD END DATE</a>	
*	LEAD CARE ACTIVITY INDICATOR (Not defined or approved by the Information Standards Board)	
<b>CDS DATA GROUP: PATIENT IDENTITY:</b> To carry the identity of the Patient. One occurrence of this Group is permitted.		
Opt	CDS Data Element	
M	<a href="#">LOCAL PATIENT IDENTIFIER</a>	
M	<a href="#">ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)</a>	
M	<a href="#">NHS NUMBER</a>	
M	<a href="#">NHS NUMBER STATUS INDICATOR</a>	
O	<a href="#">PATIENT NAME</a>	
O	<a href="#">PATIENT USUAL ADDRESS</a>	
M	<a href="#">POSTCODE OF USUAL ADDRESS</a>	
M	<a href="#">ORGANISATION CODE (PCT OF RESIDENCE)</a>	
M	<a href="#">PERSON BIRTH DATE</a> (From commissioning data set 6-1 only)	

**Note:**

For reasons of confidentiality, the patient's preferred name and address (not including [POSTCODE OF USUAL ADDRESS](#)) must **not** be carried where a valid NHS Number is present. For patients with sensitive conditions (as defined in DSCN 41/98/P26), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), [ORGANISATION CODE \(PCT OF RESIDENCE\)](#) and [PERSON BIRTH DATE](#) (in Patient Characteristics data group below):

**Note:**

For Security Issues and Patient Confidentiality, the [PATIENT NAME](#) and [PATIENT USUAL ADDRESS](#) (not including [POSTCODE OF USUAL ADDRESS](#)) must not be carried where a valid [NHS NUMBER](#) is present, even if the [NHS NUMBER](#) is not verified.

For patients with sensitive conditions (as defined in Security Issues and Patient Confidentiality), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), and [PERSON BIRTH DATE](#).

**CDS DATA GROUP: PATIENT CHARACTERISTICS:**  
To carry the characteristics of the Patient.  
One occurrence of this Group is permitted.

Opt	CDS Data Element	
<del>M</del>	<del><a href="#">PERSON BIRTH DATE</a></del>	
M	<a href="#">PERSON BIRTH DATE</a> (Commissioning data set 6-0 only)	
M	<a href="#">PERSON GENDER CURRENT</a>	
<del>⊖</del>	<del><a href="#">CARER SUPPORT INDICATOR</a></del>	
O	<a href="#">CARER SUPPORT INDICATOR</a>	
*	<a href="#">ETHNIC CATEGORY</a> (from Commissioning Data Set Version 6-1. Note this CDS type has not been approved by ISB and this item is included as a placeholder for future development.)	

**CDS DATA GROUP: CARE EPISODE - Person Group (Consultant):**  
To carry the details of the responsible Consultant.  
One occurrence of this Group is permitted.

M	<a href="#">CONSULTANT CODE</a>	
M	<a href="#">MAIN SPECIALTY CODE</a>	
M	<a href="#">TREATMENT FUNCTION CODE</a>	

**CDS DATA GROUP: CARE EPISODE - CLINICAL DIAGNOSIS (ICD):**  
To carry the details of the ICD Diagnosis Scheme and the provisional Diagnoses.

O	<a href="#">DIAGNOSIS SCHEME IN USE</a>	
O	<a href="#">PRIMARY DIAGNOSIS (ICD)</a>	
O	<a href="#">SECONDARY DIAGNOSIS (ICD)</a> Multiple Secondary Diagnoses may be recorded.	

**CDS DATA GROUP: CARE EPISODE - CLINICAL DIAGNOSIS (READ):**  
To carry the details of the READ Diagnosis Scheme and the provisional Diagnoses.

O	<a href="#">DIAGNOSIS SCHEME IN USE</a>	
O	<a href="#">PRIMARY DIAGNOSIS (READ)</a>	
O	<a href="#">SECONDARY DIAGNOSIS (READ)</a> Multiple Secondary Diagnoses may be recorded.	

**CDS DATA GROUP: ATTENDANCE OCCURRENCE - Activity Characteristics:**  
To carry the details of the Future Care Attendance or cancelled future appointment.

O	<a href="#">ATTENDANCE IDENTIFIER</a>	
M	<a href="#">ADMINISTRATIVE CATEGORY</a>	
O	<a href="#">ATTENDED OR DID NOT ATTEND</a>	
M	<a href="#">FIRST ATTENDANCE</a>	
O	<a href="#">MEDICAL STAFF TYPE SEEING PATIENT</a>	
O	<a href="#">OPERATION STATUS</a> (per attendance)	
O	<a href="#">OUTCOME OF ATTENDANCE</a>	
M	<a href="#">APPOINTMENT DATE</a> This is the <b>mandatory</b> date used to derive the <b>mandatory</b> <a href="#">CDS ACTIVITY DATE</a> .	
M	<a href="#">AGE AT CDS ACTIVITY DATE</a>	
O	<a href="#">EARLIEST REASONABLE OFFER DATE</a>	

CDS DATA GROUP: ATTENDANCE OCCURRENCE - Service Agreement Details: To carry the details of the Service Agreement for the Future Care Attendance.		
M	COMMISSIONING SERIAL NUMBER	
O	NHS SERVICE AGREEMENT LINE NUMBER	
O	PROVIDER REFERENCE NUMBER	
M	COMMISSIONER REFERENCE NUMBER	
M	ORGANISATION CODE (CODE OF PROVIDER)	
M	ORGANISATION CODE (CODE OF COMMISSIONER)	
CDS DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Activity Group (OPCS): To carry the details of the OPCS coded Clinical Activities to be undertaken.		
O	PROCEDURE SCHEME IN USE	
O	PRIMARY PROCEDURE (OPCS)	
O	PROCEDURE DATE (of Primary Procedure)	
	(Multiple Procedures may be recorded)	
O	PROCEDURE (OPCS)	
O	PROCEDURE DATE (of Secondary Procedure)	
CDS DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Activity Group (READ): To carry the details of the READ coded Clinical Activities to be undertaken.		
O	PROCEDURE SCHEME IN USE	
O	PRIMARY PROCEDURE (READ)	
O	PROCEDURE DATE (of Primary Procedure)	
	(Multiple Procedures may be recorded)	
O	PROCEDURE (READ)	
O	PROCEDURE DATE (of Secondary Procedure)	
CDS DATA GROUP: ATTENDANCE OCCURRENCE - Location Group of the Future Care Attendance: To carry the details of the location and Site Code of Treatment. One occurrence of this Group is permitted.		
O	LOCATION CLASS	
O	SITE CODE (OF TREATMENT)	
*	LOCATION TYPE Definition and value list currently under review	
CDS DATA GROUP: GP REGISTRATION: To carry the Patient's General Medical Practitioner and General Practice details. One occurrence of this Group is permitted.		
O	GENERAL MEDICAL PRACTITIONER (SPECIFIED)	
M	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	
CDS DATA GROUP: REFERRAL - Activity Characteristics: To carry the details of the referral. One occurrence of this Group is permitted.		
M	PRIORITY TYPE	
M	SERVICE TYPE REQUESTED	
M	SOURCE OF REFERRAL FOR OUT-PATIENTS	
M	REFERRAL REQUEST RECEIVED DATE	
CDS DATA GROUP: REFERRAL - Person Group (Referrer): To carry the details of the referrer. One occurrence of this Group is permitted.		
M	REFERRER CODE	
M	REFERRING ORGANISATION CODE	
CDS DATA GROUP: MISSED APPOINTMENT - Occurrence: To carry the details of a missed appointment. One occurrence of this Group is permitted.		
O	LAST DNA OR PATIENT CANCELLED DATE	
CDS DATA GROUP: HEALTHCARE RESOURCE GROUP - Activity Characteristics: To carry the details of the anticipated Healthcare Resource Group. One occurrence of this Group is permitted.		
O	HEALTHCARE RESOURCE GROUP CODE	
O	HEALTHCARE RESOURCE GROUP CODE-VERSION NUMBER	
CDS DATA GROUP: (HCA) Healthcare Resource Group Activity - Clinical Activity Group:		

To carry the details of the anticipated HRG Dominant Grouping Variable - Procedure.

O	<a href="#">PROCEDURE SCHEME IN USE</a>	
O	<a href="#">HRG DOMINANT GROUPING VARIABLE-PROCEDURE</a>	

**Note:**

HRG Dominant Grouping Variable does not apply to Care Attendances but the data structure is retained for documentation purposes.

**CDS V6 TYPE 030**

Change to Data Set: Changed Description

**[CDS V6 TYPE 030 - EAL - END OF PERIOD CENSUS STANDARD CDS](#)**

The Elective Admission List CDSs consist of two distinct types of data sets:

- EAL - End Of Period Census CDS Types, and
- EAL - Event During Period CDS Types.

The End Of Period Census CDSs carry details for all booked, planned and waiting list admissions consisting of records of patients waiting for elective admission at a specified date. These should be sent within one month of the end of the period to which they relate unless a shorter time-scale has been agreed with the recipient.

Three derivations are permitted:

- 1) CDS Type 030 - The End Of Period Census (STANDARD)
- 2) CDS Type 040 - The End Of Period Census (OLD)
- 3) CDS Type 050 - The End Of Period Census (NEW)

This derivation, CDS Type = 030 - The End Of Period Census (STANDARD), is the simplest variation and, with one exception detailed below, all Providers must be able to create it as defined and all Commissioners must be able to process it.

The exception as identified above is for an Elective Admission List Removal. Some providers send a final EAL-End Of Period Census CDS after the patient has been removed from the list to identify when and why this took place. Commissioners who do not wish to receive such final EAL-End Of Period Census CDSs should ignore them.

The CDS TYPE 030 consists of the following CDS Data Groups:

- INTERCHANGE, MESSAGE and CDS TRANSACTION HEADERS and TRAILERS (defined independently)
- PATIENT PATHWAY
- PATIENT IDENTITY
- PATIENT CHARACTERISTICS
- COMMISSIONING OCCURRENCE
- EAL ENTRY
- GP REGISTRATION
- OFFER OF ADMISSION
- ORIGINAL EAL ENTRY
- REFERRAL
- EAL ENTRY REMOVAL
- HEALTHCARE RESOURCE GROUP

The markers in the columns "OPT, U/A and HES" indicate the NHS recommendations for the inclusion of data:

- M = Mandatory - data must be included **where** available
- O = Optional - data need not be included
- = Must **Not** Be Used

**CDS V6 TYPE 030 - THE ELECTIVE ADMISSION LIST END OF PERIOD CENSUS - STANDARD CDS**

**CDS DATA GROUP: PATIENT PATHWAY:**  
To carry the details of the Patient's Pathway.  
One optional occurrence of this Group is permitted.

Opt	CDS Data Element	
O	<a href="#">UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)</a>	
O	<a href="#">PATIENT PATHWAY IDENTIFIER</a>	
O	<a href="#">ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)</a>	



O	<a href="#">REFERRAL TO TREATMENT STATUS</a> (intended status of the anticipated admission)	
O	<a href="#">REFERRAL TO TREATMENT PERIOD START DATE</a>	
O	<a href="#">REFERRAL TO TREATMENT PERIOD END DATE</a>	
*	LEAD CARE ACTIVITY INDICATOR (Not defined or approved by the Information Standards Board)	

**CDS DATA GROUP: (PATIENT IDENTITY):**  
To carry the identity of the Patient.  
One occurrence of this Group is permitted.

Opt	CDS Data Element	
M	<a href="#">LOCAL PATIENT IDENTIFIER</a>	
M	<a href="#">ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)</a>	
M	<a href="#">NHS NUMBER</a>	
M	<a href="#">NHS NUMBER STATUS INDICATOR</a>	
O	<a href="#">PATIENT NAME</a>	
O	<a href="#">PATIENT USUAL ADDRESS</a>	
M	<a href="#">POSTCODE OF USUAL ADDRESS</a>	
M	<a href="#">ORGANISATION CODE (PCT OF RESIDENCE)</a>	
M	<a href="#">PERSON BIRTH DATE</a> (from commissioning data set 6-1)	

**Note:**

For reasons of confidentiality, the patient's preferred name and address (not including [POSTCODE OF USUAL ADDRESS](#)) must **not** be carried where a valid NHS Number is present. For patients with sensitive conditions (as defined in DSCN 41/98/P26), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), [ORGANISATION CODE \(PCT OF RESIDENCE\)](#), and [PERSON BIRTH DATE](#) (in Patient Characteristics data group below).

**Note:**

For Security Issues and Patient Confidentiality, the [PATIENT NAME](#) and [PATIENT USUAL ADDRESS](#) (not including [POSTCODE OF USUAL ADDRESS](#)) must not be carried where a valid [NHS NUMBER](#) is present, even if the [NHS NUMBER](#) is not verified.

For patients with sensitive conditions (as defined in Security Issues and Patient Confidentiality), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), and [PERSON BIRTH DATE](#).

**CDS DATA GROUP: PATIENT CHARACTERISTICS:**  
To carry the characteristics of the Patient.  
One occurrence of this Group is permitted.

Opt	CDS Data Element	
<del>M</del>	<del><a href="#">PERSON BIRTH DATE</a></del>	
M	<a href="#">PERSON BIRTH DATE</a> (commissioning data set 6-0 only)	
M	<a href="#">PERSON GENDER CURRENT</a>	
O	<a href="#">CARER SUPPORT INDICATOR</a>	

**CDS DATA GROUP: COMMISSIONING OCCURRENCE - Service Agreement Details:**  
To carry the details of the Service Agreement for the Care Attendance.

M	<a href="#">COMMISSIONING SERIAL NUMBER</a>	
O	<a href="#">NHS SERVICE AGREEMENT LINE NUMBER</a>	
O	<a href="#">PROVIDER REFERENCE NUMBER</a>	
M	<a href="#">COMMISSIONER REFERENCE NUMBER</a>	
M	<a href="#">ORGANISATION CODE (CODE OF PROVIDER)</a>	
M	<a href="#">ORGANISATION CODE (CODE OF COMMISSIONER)</a>	
O	<a href="#">NHS SERVICE AGREEMENT CHANGE DATE</a>	

**CDS DATA GROUP: EAL ENTRY - Activity Characteristics:**  
To carry the details of the EAL ENTRY Occurrence.

M	<a href="#">ELECTIVE ADMISSION LIST ENTRY NUMBER</a>	
M	<a href="#">ADMINISTRATIVE CATEGORY</a>	
M	<a href="#">COUNT OF DAYS SUSPENDED</a>	
M	<a href="#">ELECTIVE ADMISSION LIST STATUS</a>	
M	<a href="#">ELECTIVE ADMISSION TYPE</a>	

M	<a href="#">INTENDED MANAGEMENT</a>	
M	<a href="#">INTENDED PROCEDURE STATUS</a>	
M	<a href="#">PRIORITY TYPE</a>	
M	<a href="#">DECIDED TO ADMIT DATE</a> (for this provider) This is the <b>mandatory</b> date used to derive the <b>mandatory</b> <a href="#">CDS ACTIVITY DATE</a>	
M	<a href="#">AGE AT CDS ACTIVITY DATE</a>	
O	<a href="#">GUARANTEED ADMISSION DATE</a>	
M	<a href="#">LAST DNA OR PATIENT CANCELLED DATE</a>	
O	<a href="#">WAITING LIST ENTRY LAST REVIEWED DATE</a>	
<b>CDS DATA GROUP: EAL ENTRY - Person Group (Consultant):</b> To carry the details of the responsible Clinician. One occurrence of this Group is permitted.		
M	<a href="#">CONSULTANT CODE</a>	
M	<a href="#">MAIN SPECIALTY CODE</a>	
M	<a href="#">TREATMENT FUNCTION CODE</a>	
<b>CDS DATA GROUP: INTENDED PROCEDURES - OPCS:</b> To carry the details of the Intended OPCS Procedures.		
O	<a href="#">PROCEDURE SCHEME IN USE</a>	
O	<a href="#">PRIMARY PROCEDURE (OPCS)</a>	
O	<a href="#">PROCEDURE DATE</a> (of Primary Procedure)	
O	(Multiple Procedures may be recorded) <a href="#">PROCEDURE (OPCS)</a>	
O	<a href="#">PROCEDURE DATE</a> (of Secondary Procedure)	
<b>CDS DATA GROUP: INTENDED PROCEDURES - READ:</b> To carry the details of the Intended READ Procedures.		
O	<a href="#">PROCEDURE SCHEME IN USE</a>	
O	<a href="#">PRIMARY PROCEDURE (READ)</a>	
O	<a href="#">PROCEDURE DATE</a> (of Primary Procedure)	
O	(Multiple Procedures may be recorded) <a href="#">PROCEDURE (READ)</a>	
O	<a href="#">PROCEDURE DATE</a> (of Secondary Procedure)	
<b>CDS DATA GROUP: INTENDED PROCEDURES - Location Group:</b> To carry the details of the Intended Location.		
O	<a href="#">LOCATION CLASS</a>	
O	<a href="#">INTENDED SITE CODE (OF TREATMENT)</a>	
*	<a href="#">LOCATION TYPE</a> Definition and value list under review	
<b>CDS DATA GROUP: GP REGISTRATION:</b> To carry the Patient's General Medical Practitioner and General Practice details. One occurrence of this Group is permitted.		
O	<a href="#">GENERAL MEDICAL PRACTITIONER (SPECIFIED)</a>	
M	<a href="#">GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)</a>	
<b>CDS DATA GROUP: REFERRAL:</b> To carry the details of the Patient's Registered GMP. One occurrence of this Group is permitted.		
M	<a href="#">REFERRER CODE</a>	
M	<a href="#">REFERRING ORGANISATION CODE</a>	
<b>CDS DATA GROUP: OFFER OF ADMISSION:</b> To carry the details of the Offer of Admission and the Outcome.		
O	<a href="#">ADMISSION OFFER OUTCOME</a>	
M	<a href="#">OFFERED FOR ADMISSION DATE</a>	
O	<a href="#">EARLIEST REASONABLE OFFER DATE</a>	
<b>CDS DATA GROUP: - ORIGINAL EAL ENTRY:</b> To carry the date on which the decision to admit was made.		
M	<a href="#">ORIGINAL DECIDED TO ADMIT DATE</a>	
<b>CDS DATA GROUP: EAL ENTRY REMOVAL:</b>		

To carry the details of the removal from the EAL. One occurrence of this Group is permitted.	
O	<a href="#">ELECTIVE ADMISSION LIST REMOVAL REASON</a>
O	<a href="#">ELECTIVE ADMISSION LIST REMOVAL DATE</a>
CDS DATA GROUP: HEALTHCARE RESOURCE GROUP - Activity Characteristics: To carry the details of the Healthcare Resource Group. One occurrence of this Group is permitted.	
O	<a href="#">HEALTHCARE RESOURCE GROUP CODE</a>
O	<a href="#">HEALTHCARE RESOURCE GROUP CODE-VERSION NUMBER</a>
CDS DATA GROUP: (HCA) Healthcare Resource Group Activity - Clinical Activity Group: To carry the details of the HRG Dominant Grouping Variable - Procedure. Note that this will not apply when no operation was carried out.	
O	<a href="#">PROCEDURE SCHEME IN USE</a>
O	<a href="#">HRG DOMINANT GROUPING VARIABLE-PROCEDURE</a>

**CDS V6 TYPE 050**

Change to Data Set: Changed Description

**CDS V6 TYPE 050 - EAL - END OF PERIOD CENSUS NEW CDS**

The Elective Admission List CDSs consist of two distinct types of data sets:  
EAL - End Of Period Census CDS Types, and  
EAL - Event During Period CDS Types.

The End Of Period Census CDSs carry details for all booked, planned and waiting list admissions consisting of records of patients waiting for elective admission at a specified date. These should be sent within one month of the end of the period to which they relate unless a shorter time-scale has been agreed with the recipient.

Three derivations are permitted:

- 1) CDS Type 030 - The End Of Period Census (STANDARD)
- 2) CDS Type 040 - The End Of Period Census (OLD)
- 3) CDS Type 050 - The End Of Period Census (NEW)

This derivation, CDS Type = 050 - The End Of Period Census (NEW), may be used to report to a new Commissioner an EAL Entry that had previously been the responsibility of another Commissioner.

The CDS TYPE 050 consists of the following CDS Data Groups:

- INTERCHANGE, MESSAGE and CDS TRANSACTION HEADERS and TRAILERS (defined independently)
- PATIENT PATHWAY
- PATIENT IDENTITY
- PATIENT CHARACTERISTICS
- COMMISSIONING OCCURRENCE
- EAL ENTRY
- GP REGISTRATION
- OFFER OF ADMISSION
- ORIGINAL EAL ENTRY
- REFERRAL
- EAL ENTRY REMOVAL
- HEALTHCARE RESOURCE GROUP

The markers in the columns "OPT, U/A and HES" indicate the NHS recommendations for the inclusion of data:

- M = Mandatory - data must be included **where** available
- O = Optional - data need not be included
- = Must **Not** Be Used

<b>CDS V6 TYPE 050 - THE ELECTIVE ADMISSION LIST END OF PERIOD CENSUS - NEW CDS</b>
<b>CDS DATA GROUP: PATIENT PATHWAY:</b>

To carry the details of the Patient Pathway.  
One optional occurrence of this Group is permitted.

Opt	CDS Data Element	
O	<a href="#">UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)</a>	
O	<a href="#">PATIENT PATHWAY IDENTIFIER</a>	
O	<a href="#">ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)</a>	
O	<a href="#">REFERRAL TO TREATMENT STATUS</a> (intended status of the anticipated admission)	
O	<a href="#">REFERRAL TO TREATMENT PERIOD START DATE</a>	
O	<a href="#">REFERRAL TO TREATMENT PERIOD END DATE</a>	
*	LEAD CARE ACTIVITY INDICATOR (Not defined or approved by the Information Standards Board)	

CDS DATA GROUP: PATIENT IDENTITY:  
To carry the details of the Patient.  
One occurrence of this Group is permitted.

Opt	CDS Data Element	
M	<a href="#">LOCAL PATIENT IDENTIFIER</a>	
M	<a href="#">ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)</a>	
M	<a href="#">NHS NUMBER</a>	
M	<a href="#">NHS NUMBER STATUS INDICATOR</a>	
O	<a href="#">PATIENT NAME</a>	
O	<a href="#">PATIENT USUAL ADDRESS</a>	
M	<a href="#">POSTCODE OF USUAL ADDRESS</a>	
M	<a href="#">ORGANISATION CODE (PCT OF RESIDENCE)</a>	
M	<a href="#">PERSON BIRTH DATE</a> (from commissioning data set 6-1)	

**Note:**

For reasons of confidentiality, the patient's preferred name and address (not including [POSTCODE OF USUAL ADDRESS](#)) must **not** be carried where a valid NHS Number is present. For patients with sensitive conditions (as defined in DSCN-41/98/P26), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), [ORGANISATION CODE \(PCT OF RESIDENCE\)](#) and [PERSON BIRTH DATE](#) (in Patient Characteristics data group below).

**Note:**

For Security Issues and Patient Confidentiality, the patient's preferred name and address (not including [POSTCODE OF USUAL ADDRESS](#)) must **not** be carried where a valid NHS Number is present. For patients with sensitive conditions (as defined in Security Issues and Patient Confidentiality), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), and [PERSON BIRTH DATE](#).

CDS DATA GROUP: PATIENT CHARACTERISTICS:  
To carry the details of the Patient.  
One occurrence of this Group is permitted.

Opt	CDS Data Element	
M	<a href="#">PERSON BIRTH DATE</a>	
M	<a href="#">PERSON BIRTH DATE</a> (Commissioning data set 6-0 only)	
M	<a href="#">PERSON GENDER CURRENT</a>	
O	<a href="#">CARER SUPPORT INDICATOR</a>	

CDS DATA GROUP: COMMISSIONING OCCURRENCE - Service Agreement Details:  
To carry the details of the Service Agreement for the Care Attendance.

M	<a href="#">COMMISSIONING SERIAL NUMBER</a>	
O	<a href="#">NHS SERVICE AGREEMENT LINE NUMBER</a>	
O	<a href="#">PROVIDER REFERENCE NUMBER</a>	
M	<a href="#">COMMISSIONER REFERENCE NUMBER</a>	
M	<a href="#">ORGANISATION CODE (CODE OF PROVIDER)</a>	
M	<a href="#">ORGANISATION CODE (CODE OF COMMISSIONER)</a>	
M	<a href="#">NHS SERVICE AGREEMENT CHANGE DATE</a> This is the <b>mandatory</b> date used to derive the <b>mandatory</b> <a href="#">CDS ACTIVITY DATE</a> .	

CDS DATA GROUP: EAL ENTRY - Activity Characteristics:

**To carry the details of the Care Attendance or missed appointment.**

M	<a href="#">ELECTIVE ADMISSION LIST ENTRY NUMBER</a>	
M	<a href="#">ADMINISTRATIVE CATEGORY</a>	
M	<a href="#">COUNT OF DAYS SUSPENDED</a>	
M	<a href="#">ELECTIVE ADMISSION LIST STATUS</a>	
M	<a href="#">ELECTIVE ADMISSION TYPE</a>	
M	<a href="#">INTENDED MANAGEMENT</a>	
M	<a href="#">INTENDED PROCEDURE STATUS</a>	
M	<a href="#">PRIORITY TYPE</a>	
M	<a href="#">DECIDED TO ADMIT DATE</a> (for this provider)	
M	<a href="#">AGE AT CDS ACTIVITY DATE</a>	
O	<a href="#">GUARANTEED ADMISSION DATE</a>	
M	<a href="#">LAST DNA OR PATIENT CANCELLED DATE</a>	
O	<a href="#">WAITING LIST ENTRY LAST REVIEWED DATE</a>	

**CDS DATA GROUP: EAL ENTRY - Person Group (Consultant):**  
 To carry the details of the responsible Clinician.  
 One occurrence of this Group is permitted.

M	<a href="#">CONSULTANT CODE</a>	
M	<a href="#">MAIN SPECIALTY CODE</a>	
M	<a href="#">TREATMENT FUNCTION CODE</a>	

**CDS DATA GROUP: INTENDED PROCEDURES - OPCS:**  
 To carry the details of the Intended OPCS Procedures.

O	<a href="#">PROCEDURE SCHEME IN USE</a>	
O	<a href="#">PRIMARY PROCEDURE (OPCS)</a>	
O	<a href="#">PROCEDURE DATE</a> (of Primary Procedure)	
	(Multiple Procedures may be recorded)	
O	<a href="#">PROCEDURE (OPCS)</a>	
O	<a href="#">PROCEDURE DATE</a> (of Secondary Procedure)	

**CDS DATA GROUP: INTENDED PROCEDURES - READ:**  
 To carry the details of the Intended READ Procedures.

O	<a href="#">PROCEDURE SCHEME IN USE</a>	
O	<a href="#">PRIMARY PROCEDURE (READ)</a>	
O	<a href="#">PROCEDURE DATE</a> (of Primary Procedure)	
	(Multiple Procedures may be recorded)	
O	<a href="#">PROCEDURE (READ)</a>	
O	<a href="#">PROCEDURE DATE</a> (of Secondary Procedure)	

**CDS DATA GROUP: INTENDED PROCEDURES - Location Group:**  
 To carry the details of the Intended Location.

O	<a href="#">LOCATION CLASS</a>	
O	<a href="#">INTENDED SITE CODE (OF TREATMENT)</a>	
*	<a href="#">LOCATION TYPE</a> Definition and value list under review	

**CDS DATA GROUP: GP REGISTRATION:**  
 To carry the Patient's General Medical Practitioner and General Practice details.  
 One occurrence of this Group is permitted.

O	<a href="#">GENERAL MEDICAL PRACTITIONER (SPECIFIED)</a>	
M	<a href="#">GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)</a>	

**CDS DATA GROUP: REFERRAL:**  
 To carry the details of the referral.  
 One occurrence of this Group is permitted.

M	<a href="#">REFERRER CODE</a>	
M	<a href="#">REFERRING ORGANISATION CODE</a>	

**CDS DATA GROUP: OFFER OF ADMISSION:**  
 To carry the details of the Offer of Admission and the Outcome.

O	<a href="#">ADMISSION OFFER OUTCOME</a>	
M	<a href="#">OFFERED FOR ADMISSION DATE</a>	

O	<a href="#">EARLIEST REASONABLE OFFER DATE</a>	
<b>CDS DATA GROUP: - ORIGINAL EAL ENTRY:</b> To carry the date on which the decision to admit was made.		
M	<a href="#">ORIGINAL DECIDED TO ADMIT DATE</a>	
<b>CDS DATA GROUP: EAL ENTRY REMOVAL:</b> To carry the details of the removal from the EAL. One occurrence of this Group is permitted.		
O	<a href="#">ELECTIVE ADMISSION LIST REMOVAL REASON</a>	
O	<a href="#">ELECTIVE ADMISSION LIST REMOVAL DATE</a>	
<b>CDS DATA GROUP: HEALTHCARE RESOURCE GROUP - Activity Characteristics:</b> To carry the details of the Healthcare Resource Group. One occurrence of this Group is permitted.		
O	<a href="#">HEALTHCARE RESOURCE GROUP CODE</a>	
O	<a href="#">HEALTHCARE RESOURCE GROUP CODE-VERSION NUMBER</a>	
<b>CDS DATA GROUP: (HCA) Healthcare Resource Group Activity - Clinical Activity Group:</b> To carry the details of the HRG Dominant Grouping Variable - Procedure. Note that this will not apply when no operation was carried out.		
O	<a href="#">PROCEDURE SCHEME IN USE</a>	
O	<a href="#">HRG DOMINANT GROUPING VARIABLE-PROCEDURE</a>	

## CDS V6 TYPE 060

Change to Data Set: Changed Description

### [CDS V6 TYPE 060 - EAL - EVENT DURING PERIOD - ADD CDS](#)

The Elective Admission List CDSs consist of two distinct types of data sets:

**EAL - End Of Period Census CDS Types, and  
EAL - Event During Period CDS Types.**

The Event During Period CDS Types carry details for all events - patients added or removed from the Elective Admission List - that have taken place during the period.

These CDSs are intended for those Providers and Commissioners who have the capability to implement transaction-based processing. They should be supplemented where required by an annual EAL End Of Period Census.

Six EAL Event During Period derivations are permitted:

- 1) CDS Type 060 - The Event During Period (ADD)
- 2) CDS Type 070 - The Event During Period (REMOVE)
- 3) CDS Type 080 - The Event During Period (OFFER)
- 4) CDS Type 090 - The Event During Period (AVAILABLE / UNAVAILABLE)
- 5) CDS Type 100 - The Event During Period (OLD SERVICE AGREEMENT)
- 6) CDS Type 110 - The Event During Period (NEW SERVICE AGREEMENT)

This derivation, CDS TYPE = 060, is the Event During Period (ADD) and is used to make an initial report that the EAL entry has been added to the Provider's Elective Admission List.

Note that for EAL Event During Period CDS Types, the Unique CDS Identifier, as held in the CDS Transaction Header Group, must be completed in order to provide the EAL identity.

The CDS TYPE 060 consists of the following CDS Data Groups:

INTERCHANGE, MESSAGE and CDS TRANSACTION HEADERS and TRAILERS (defined independently)  
 PATIENT PATHWAY  
 PATIENT IDENTITY  
 PATIENT CHARACTERISTICS  
 COMMISSIONING OCCURRENCE  
 EAL ENTRY  
 GP REGISTRATION  
 OFFER OF ADMISSION  
 ORIGINAL EAL ENTRY  
 REFERRAL

The markers in the columns "OPT, U/A and HES" indicate the NHS recommendations for the inclusion of data:

M = Mandatory - data must be included **where** available

O = Optional - data need not be included

= Must **Not** Be Used

### CDS V6 TYPE 060 - THE ELECTIVE ADMISSION LIST EVENT DURING PERIOD - ADD CDS

**CDS DATA GROUP: PATIENT PATHWAY:**  
To carry the details of the Patient Pathway.  
One optional occurrence of this Group is permitted.

Opt	CDS Data Element	
O	<a href="#">UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)</a>	
O	<a href="#">PATIENT PATHWAY IDENTIFIER</a>	
O	<a href="#">ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)</a>	
O	<a href="#">REFERRAL TO TREATMENT STATUS</a> (intended status of the anticipated admission)	
O	<a href="#">REFERRAL TO TREATMENT PERIOD START DATE</a>	
O	<a href="#">REFERRAL TO TREATMENT PERIOD END DATE</a>	
*	LEAD CARE ACTIVITY INDICATOR (Not defined or approved by the Information Standards Board)	

**CDS DATA GROUP: PATIENT IDENTITY:**  
To carry the identity of the Patient.  
One occurrence of this Group is permitted.

Opt	CDS Data Element	
M	<a href="#">LOCAL PATIENT IDENTIFIER</a>	
M	<a href="#">ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)</a>	
M	<a href="#">NHS NUMBER</a>	
M	<a href="#">NHS NUMBER STATUS INDICATOR</a>	
O	<a href="#">PATIENT NAME</a>	
O	<a href="#">PATIENT USUAL ADDRESS</a>	
M	<a href="#">POSTCODE OF USUAL ADDRESS</a>	
M	<a href="#">ORGANISATION CODE (PCT OF RESIDENCE)</a>	
M	<a href="#">PERSON BIRTH DATE</a> (from commissioning data set 6-1)	

**Note:**

For reasons of confidentiality, the patient's preferred name and address (not including [POSTCODE OF USUAL ADDRESS](#)) must **not** be carried where a valid NHS Number is present. For patients with sensitive conditions (as defined in DSCN 41/98/P26), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), [ORGANISATION CODE \(PCT OF RESIDENCE\)](#) and [PERSON BIRTH DATE](#) (in Patient Characteristics data group below).

**Note:**

For Security Issues and Patient Confidentiality, the [PATIENT NAME](#) and [PATIENT USUAL ADDRESS](#) (not including [POSTCODE OF USUAL ADDRESS](#)) must not be carried where a valid [NHS NUMBER](#) is present, even if the [NHS NUMBER](#) is not verified.

For patients with sensitive conditions (as defined in [Security Issues and Patient Confidentiality](#)), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), and [PERSON BIRTH DATE](#).

**CDS DATA GROUP: PATIENT CHARACTERISTICS:**  
To carry the characteristics of the Patient.  
One occurrence of this Group is permitted.

Opt	CDS Data Element	
M	<a href="#">PERSON BIRTH DATE</a>	
M	<a href="#">PERSON BIRTH DATE</a> (Commissioning data set 6-0 only)	
M	<a href="#">PERSON GENDER CURRENT</a>	
O	<a href="#">CARER SUPPORT INDICATOR</a>	

**CDS DATA GROUP: COMMISSIONING OCCURRENCE - Service Agreement Details:**  
To carry the details of the Service Agreement for the Care Attendance.

M	<a href="#">COMMISSIONING SERIAL NUMBER</a>	
O	<a href="#">NHS SERVICE AGREEMENT LINE NUMBER</a>	
O	<a href="#">PROVIDER REFERENCE NUMBER</a>	
M	<a href="#">COMMISSIONER REFERENCE NUMBER</a>	
M	<a href="#">ORGANISATION CODE (CODE OF COMMISSIONER)</a>	
M	<a href="#">ORGANISATION CODE (CODE OF PROVIDER)</a>	
O	<a href="#">NHS SERVICE AGREEMENT CHANGE DATE</a>	

**CDS DATA GROUP: EAL ENTRY - Activity Characteristics:**  
To carry the details of the EAL ENTRY Occurrence.

M	<a href="#">ELECTIVE ADMISSION LIST ENTRY NUMBER</a>	
M	<a href="#">ADMINISTRATIVE CATEGORY</a>	
M	<a href="#">COUNT OF DAYS SUSPENDED</a>	
M	<a href="#">ELECTIVE ADMISSION LIST STATUS</a>	
M	<a href="#">ELECTIVE ADMISSION TYPE</a>	
M	<a href="#">INTENDED MANAGEMENT</a>	
M	<a href="#">INTENDED PROCEDURE STATUS</a>	
M	<a href="#">PRIORITY TYPE</a>	
M	<a href="#">DECIDED TO ADMIT DATE</a> This is the <b>mandatory</b> date used to derive the <b>mandatory</b> <a href="#">CDS ACTIVITY DATE</a> . for this provider)	
M	<a href="#">AGE AT CDS ACTIVITY DATE</a>	
O	<a href="#">GUARANTEED ADMISSION DATE</a>	
M	<a href="#">LAST DNA OR PATIENT CANCELLED DATE</a>	
O	<a href="#">WAITING LIST ENTRY LAST REVIEWED DATE</a>	

**CDS DATA GROUP: EAL ENTRY - Person Group (Consultant):**  
To carry the details of the responsible Clinician.  
One occurrence of this Group is permitted.

M	<a href="#">CONSULTANT CODE</a>	
M	<a href="#">MAIN SPECIALTY CODE</a>	
M	<a href="#">TREATMENT FUNCTION CODE</a>	

**CDS DATA GROUP: INTENDED PROCEDURES - OPCS:**  
To carry the details of the Intended OPCS Procedures.

O	<a href="#">PROCEDURE SCHEME IN USE</a>	
O	<a href="#">PRIMARY PROCEDURE (OPCS)</a>	
O	<a href="#">PROCEDURE DATE</a> (of Primary Procedure)	
	(Multiple Procedures may be recorded)	
O	<a href="#">PROCEDURE (OPCS)</a>	
O	<a href="#">PROCEDURE DATE</a> (of Secondary Procedure)	

**CDS DATA GROUP: INTENDED PROCEDURES - READ:**  
To carry the details of the Intended READ Procedures.

O	<a href="#">PROCEDURE SCHEME IN USE</a>	
O	<a href="#">PRIMARY PROCEDURE (READ)</a>	
O	<a href="#">PROCEDURE DATE</a> (of Primary Procedure)	
	(Multiple Procedures may be recorded)	
O	<a href="#">PROCEDURE (READ)</a>	
O	<a href="#">PROCEDURE DATE</a> (of Secondary Procedure)	

**CDS DATA GROUP: INTENDED PROCEDURES - Location Group:**  
To carry the details of the Intended Location.

O	<a href="#">LOCATION CLASS</a>	
O	<a href="#">INTENDED SITE CODE (OF TREATMENT)</a>	
*	<a href="#">LOCATION TYPE</a> Definition and value list under review	

**CDS DATA GROUP: GP REGISTRATION:**  
To carry the Patient's General Medical Practitioner and General Practice details.  
One occurrence of this Group is permitted.

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O	<a href="#">GENERAL MEDICAL PRACTITIONER (SPECIFIED)</a>	
M	<a href="#">GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)</a>	
<b>CDS DATA GROUP: REFERRAL:</b> To carry the details of the referral. One occurrence of this Group is permitted.		
M	<a href="#">REFERRER CODE</a>	
M	<a href="#">REFERRING ORGANISATION CODE</a>	
<b>CDS DATA GROUP: OFFER OF ADMISSION:</b> To carry the details of the Offer of Admission and the Outcome.		
O	<a href="#">ADMISSION OFFER OUTCOME</a>	
M	<a href="#">OFFERED FOR ADMISSION DATE</a>	
O	<a href="#">EARLIEST REASONABLE OFFER DATE</a>	
<b>CDS DATA GROUP: - ORIGINAL EAL ENTRY:</b> To carry the date on which the decision to admit was made.		
M	<a href="#">ORIGINAL DECIDED TO ADMIT DATE</a>	
<b>CDS DATA GROUP: HEALTHCARE RESOURCE GROUP - Activity Characteristics:</b> To carry the details of the Healthcare Resource Group. One occurrence of this Group is permitted.		
O	<a href="#">HEALTHCARE RESOURCE GROUP CODE</a>	
O	<a href="#">HEALTHCARE RESOURCE GROUP CODE-VERSION NUMBER</a>	
<b>CDS DATA GROUP: (HCA) Healthcare Resource Group Activity - Clinical Activity Group:</b> To carry the details of the HRG Dominant Grouping Variable - Procedure. Note that this will not apply when no operation was carried out.		
O	<a href="#">PROCEDURE SCHEME IN USE</a>	
O	<a href="#">HRG DOMINANT GROUPING VARIABLE-PROCEDURE</a>	

## CDS V6 TYPE 110

Change to Data Set: Changed Description

### [CDS V6 TYPE 110 - EAL - NEW SERVICE AGREEMENT CDS](#)

The Elective Admission List CDSs consist of two distinct types of data sets:

- EAL - End Of Period Census CDS Types, and
- EAL - Event During Period CDS Types.

The Event During Period CDS Types carry details for all events - patients added or removed from the Elective Admission List - that have taken place during the period.

These CDSs are intended for those Providers and Commissioners who have the capability to implement transaction-based processing. They should be supplemented where required by an annual EAL End Of Period Census.

Six EAL Event During Period derivations are permitted:

- 1) CDS Type 060 - The Event During Period (ADD)
- 2) CDS Type 070 - The Event During Period (REMOVE)
- 3) CDS Type 080 - The Event During Period (OFFER)
- 4) CDS Type 090 - The Event During Period (AVAILABLE / UNAVAILABLE)
- 5) CDS Type 100 - The Event During Period (OLD SERVICE AGREEMENT)
- 6) CDS Type 110 - The Event During Period (NEW SERVICE AGREEMENT)

This derivation, CDS TYPE = 110, is the Event During Period (NEW SERVICE AGREEMENT) and is used to make an initial report to a new Commissioner of an EAL entry that had previously been the responsibility of another Commissioner.

Note that for EAL Event During Period CDS Types, the Unique CDS Identifier, as held in the CDS Transaction Header Group, must be completed in order to provide the EAL identity.

The CDS TYPE 110 consists of the following CDS Data Groups:

INTERCHANGE, MESSAGE and CDS TRANSACTION HEADERS and TRAILERS (defined independently)  
 PATIENT PATHWAY  
 PATIENT IDENTITY

PATIENT CHARACTERISTICS  
 COMMISSIONING OCCURRENCE  
 EAL ENTRY  
 GP REGISTRATION  
 OFFER OF ADMISSION  
 ORIGINAL EAL ENTRY  
 REFERRAL  
 HEALTHCARE RESOURCE GROUP

The markers in the columns "OPT, U/A and HES" indicate the NHS recommendations for the inclusion of data:

M = Mandatory - data must be included **where** available

O = Optional - data need not be included

= Must **Not** Be Used

**CDS V6 TYPE 110 - THE ELECTIVE ADMISSION LIST EVENT DURING PERIOD - NEW SERVICE AGREEMENT CDS**

**CDS DATA GROUP: PATIENT PATHWAY:**  
 To carry the details of the Patient Pathway.  
 One optional occurrence of this Group is permitted.

Opt	CDS Data Element
O	<a href="#">UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)</a>
O	<a href="#">PATIENT PATHWAY IDENTIFIER</a>
O	<a href="#">ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)</a>
O	<a href="#">REFERRAL TO TREATMENT STATUS</a> (intended status of the anticipated admission)
O	<a href="#">REFERRAL TO TREATMENT PERIOD START DATE</a>
O	<a href="#">REFERRAL TO TREATMENT PERIOD END DATE</a>
*	LEAD CARE ACTIVITY INDICATOR (Not defined or approved by the Information Standards Board)

**CDS DATA GROUP: PATIENT IDENTITY:**  
 To carry the details of the Patient.  
 One occurrence of this Group is permitted.

Opt	CDS Data Element
M	<a href="#">LOCAL PATIENT IDENTIFIER</a>
M	<a href="#">ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)</a>
M	<a href="#">NHS NUMBER</a>
M	<a href="#">NHS NUMBER STATUS INDICATOR</a>
O	<a href="#">PATIENT NAME</a>
O	<a href="#">PATIENT USUAL ADDRESS</a>
M	<a href="#">POSTCODE OF USUAL ADDRESS</a>
M	<a href="#">ORGANISATION CODE (PCT OF RESIDENCE)</a>
M	<a href="#">PERSON BIRTH DATE</a> (from commissioning data set 6-1)

**Note:**

For reasons of confidentiality, the patient's preferred name and address (not including [POSTCODE OF USUAL ADDRESS](#)) must **not** be carried where a valid NHS Number is present. For patients with sensitive conditions (as defined in DSCN 41/98/P26), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), [ORGANISATION CODE \(PCT OF RESIDENCE\)](#) and [PERSON BIRTH DATE](#) (in Patient Characteristics data group below).

**Note:**

For Security Issues and Patient Confidentiality, the patient's preferred name and address (not including [POSTCODE OF USUAL ADDRESS](#)) must **not** be carried where a valid NHS Number is present. For patients with sensitive conditions (as defined in [Security Issues and Patient Confidentiality](#)), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), and [PERSON BIRTH DATE](#).

**CDS DATA GROUP: PATIENT CHARACTERISTICS:**  
 To carry the details of the Patient.  
 One occurrence of this Group is permitted.

Opt	CDS Data Element
M	<a href="#">PERSON BIRTH DATE</a>
M	<a href="#">PERSON BIRTH DATE</a>

	(Commissioning data set 6-0 only)	
M	PERSON GENDER CURRENT	
O	CARER SUPPORT INDICATOR	
<b>CDS DATA GROUP: COMMISSIONING OCCURRENCE - Service Agreement Details:</b> To carry the details of the Service Agreement for the Care Attendance.		
M	COMMISSIONING SERIAL NUMBER	
O	NHS SERVICE AGREEMENT LINE NUMBER	
O	PROVIDER REFERENCE NUMBER	
M	COMMISSIONER REFERENCE NUMBER	
M	ORGANISATION CODE (CODE OF PROVIDER)	
M	ORGANISATION CODE (CODE OF COMMISSIONER)	
M	NHS SERVICE AGREEMENT CHANGE DATE This is the <b>mandatory</b> date used to derive the <b>mandatory</b> CDS ACTIVITY DATE.	
<b>CDS DATA GROUP: EAL ENTRY - Activity Characteristics:</b> To carry the details of the EAL ENTRY Occurrence.		
M	ELECTIVE ADMISSION LIST ENTRY NUMBER	
M	ADMINISTRATIVE CATEGORY	
M	COUNT OF DAYS SUSPENDED	
M	ELECTIVE ADMISSION LIST STATUS	
M	ELECTIVE ADMISSION TYPE	
M	INTENDED MANAGEMENT	
M	INTENDED PROCEDURE STATUS	
M	PRIORITY TYPE	
M	DECIDED TO ADMIT DATE (for this provider)	
M	AGE AT CDS ACTIVITY DATE	
O	GUARANTEED ADMISSION DATE	
M	LAST DNA OR PATIENT CANCELLED DATE	
O	WAITING LIST ENTRY LAST REVIEWED DATE	
<b>CDS DATA GROUP: EAL ENTRY - Person Group (Consultant):</b> To carry the details of the responsible Clinician. One occurrence of this Group is permitted.		
M	CONSULTANT CODE	
M	MAIN SPECIALTY CODE	
M	TREATMENT FUNCTION CODE	
<b>CDS DATA GROUP: INTENDED PROCEDURES - OPCS:</b> To carry the details of the Intended OPCS Procedures.		
O	PROCEDURE SCHEME IN USE	
O	PRIMARY PROCEDURE (OPCS)	
O	PROCEDURE DATE (of Primary Procedure)	
O	(Multiple Procedures may be recorded) PROCEDURE (OPCS)	
O	PROCEDURE DATE (of Secondary Procedure)	
<b>CDS DATA GROUP: INTENDED PROCEDURES - READ:</b> To carry the details of the Intended READ Procedures.		
O	PROCEDURE SCHEME IN USE	
O	PRIMARY PROCEDURE (READ)	
O	PROCEDURE DATE (of Primary Procedure)	
O	(Multiple Procedures may be recorded) PROCEDURE (READ)	
O	PROCEDURE DATE (of Secondary Procedure)	
<b>CDS DATA GROUP: INTENDED PROCEDURES - Location Group:</b> To carry the details of the Intended Location.		
O	LOCATION CLASS	
O	INTENDED SITE CODE (OF TREATMENT)	
*	LOCATION TYPE Definition and value list under review	

<b>CDS DATA GROUP: GP REGISTRATION:</b> To carry the Patient's General Medical Practitioner and General Practice details. One occurrence of this Group is permitted.		
O	GENERAL MEDICAL PRACTITIONER (SPECIFIED)	
M	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	
<b>CDS DATA GROUP: REFERRAL:</b> To carry the details of the referral. One occurrence of this Group is permitted.		
M	REFERRER CODE	
M	REFERRING ORGANISATION CODE	
<b>CDS DATA GROUP: OFFER OF ADMISSION:</b> To carry the details of the Offer of Admission and the Outcome.		
O	ADMISSION OFFER OUTCOME	
M	OFFERED FOR ADMISSION DATE	
O	EARLIEST REASONABLE OFFER DATE	
<b>CDS DATA GROUP: - ORIGINAL EAL ENTRY:</b> To carry the date on which the decision to admit was made.		
M	ORIGINAL DECIDED TO ADMIT DATE	
<b>CDS DATA GROUP: HEALTHCARE RESOURCE GROUP - Activity Characteristics:</b> To carry the details of the Healthcare Resource Group. One occurrence of this Group is permitted.		
O	HEALTHCARE RESOURCE GROUP CODE	
O	HEALTHCARE RESOURCE GROUP CODE-VERSION NUMBER	
<b>CDS DATA GROUP: (HCA) Healthcare Resource Group Activity - Clinical Activity Group:</b> To carry the details of the HRG Dominant Grouping Variable - Procedure. Note that this will not apply when no operation was carried out.		
O	PROCEDURE SCHEME IN USE	
O	HRG DOMINANT GROUPING VARIABLE-PROCEDURE	

## CDS V6 TYPE 120

Change to Data Set: Changed Description

### CDS V6 TYPE 120 - ADMITTED PATIENT CARE - FINISHED BIRTH EPISODE CDS

The Finished Birth Episode Commissioning Data Set Type carries the data for a Finished Birth Episode which is required when a delivery has resulted in a registrable birth. This may take place in either NHS Hospitals or in non-NHS organisations funded by the NHS. The information is taken from the birth notification for each baby born.

In addition to Finished Birth Episodes an Unfinished Birth Episode CDS record is required for all Unfinished Birth Episodes at midnight on 31 March each year.

The CDS TYPE 120 consists of the following CDS Data Groups:

- INTERCHANGE, MESSAGE and CDS TRANSACTION HEADERS and TRAILERS (defined independently)
- PATIENT PATHWAY
- PATIENT IDENTITY
- PATIENT CHARACTERISTICS
- HOSPITAL PROVIDER SPELL
- CONSULTANT EPISODE
- CRITICAL CARE PERIOD
- GP REGISTRATION
- REFERRAL
- PREGNANCY
- ANTENATAL CARE
- HOSPITAL LABOUR / DELIVERY
- BIRTH OCCURRENCE
- HEALTHCARE RESOURCE GROUP

The markers in the columns "OPT, U/A and HES" indicate the NHS recommendations for the inclusion of data:

M = Mandatory - data must be included **where** available

O = Optional - data need not be included

\* = Must **Not** Be Used

R in the column headed **U/A** indicates the data is required in the Unfinished Episode / Annual Census of Unfinished Episode record and on an End of Year Census record.

An entry in the column headed **HES** indicates that the data element is extracted from the SUS database for Hospital Episode Statistics. Data extracted for HES purposes contains some derived items. The CDS/HES Cross Reference Tables show these derivations.

**CDS V6 TYPE 120 - THE FINISHED BIRTH EPISODE CDS**

**CDS DATA GROUP: PATIENT PATHWAY:**  
To carry the details of the Patient Pathway.  
One optional occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
O	<a href="#">UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)</a>		
O	<a href="#">PATIENT PATHWAY IDENTIFIER</a>		
O	<a href="#">ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)</a>		
O	<a href="#">REFERRAL TO TREATMENT STATUS</a>		
O	<a href="#">REFERRAL TO TREATMENT PERIOD START DATE</a>		
O	<a href="#">REFERRAL TO TREATMENT PERIOD END DATE</a>		
*	LEAD CARE ACTIVITY INDICATOR (Not defined or approved by the Information Standards Board)		

**CDS DATA GROUP: PATIENT IDENTITY:**  
To carry the personal details of the Patient (the BABY).  
One occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
M	<a href="#">LOCAL PATIENT IDENTIFIER</a>	R	•
M	<a href="#">ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)</a>	R	
O	<a href="#">NHS NUMBER</a>	R	•
M	<a href="#">NHS NUMBER STATUS INDICATOR</a>	R	•
O	<a href="#">PATIENT NAME</a>	R	
M	<a href="#">PERSON BIRTH DATE</a> (from commissioning data set 6-1)	R	•

**Note:**

For reasons of confidentiality, the patient's name must **not** be carried where a valid NHS Number is present. For patients with sensitive conditions (as defined in DSCN 41/98/P26), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#), [NHS NUMBER](#), [PATIENT NAME](#), and [PERSON BIRTH DATE](#) (in Patient Characteristics data group below).

Birth Episodes do not carry address details for a baby.

By local agreement it may be assumed that the baby's address details are those of its mother whose details may be carried in the Birth Occurrence Group - Person Group (Mother) data structure.

**Note:**

For Security Issues and Patient Confidentiality, the [PATIENT NAME](#) and [PATIENT USUAL ADDRESS](#) (not including [POSTCODE OF USUAL ADDRESS](#)) must not be carried where a valid [NHS NUMBER](#) is present, even if the [NHS NUMBER](#) is not verified.

For patients with sensitive conditions (as defined in Security Issues and Patient Confidentiality), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [NHS NUMBER](#), [PATIENT NAME](#) and [PERSON BIRTH DATE](#).

Birth Episodes do not carry address details for a baby.

By local agreement it may be assumed that the baby's address details are those of its mother whose details may be carried in the Birth Occurrence Group - Person Group (Mother) data structure.

**CDS DATA GROUP: PATIENT CHARACTERISTICS:**  
To carry the characteristics of the Patient (the BABY).  
One occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
<del>M</del>	<del><a href="#">PERSON BIRTH DATE</a></del>	<del>R</del>	<del>•</del>
M	<a href="#">PERSON BIRTH DATE</a> (commissioning data set 6-0 only)	R	•
M	<a href="#">PERSON GENDER CURRENT</a>	R	•

⊖	<a href="#">ETHNIC CATEGORY</a>	R	
M	<a href="#">ETHNIC CATEGORY</a>	R	
M	<a href="#">LIVE OR STILL BIRTH</a>	R	•
M	<a href="#">BIRTH WEIGHT</a>	R	•

**CDS DATA GROUP: HOSPITAL PROVIDER SPELL - Admission Characteristics:**  
To carry the admission details of the Spell containing the Birth Episode.  
One occurrence of this Group is permitted.

M	<a href="#">HOSPITAL PROVIDER SPELL NUMBER</a>	R	•
M	<a href="#">ADMINISTRATIVE CATEGORY (ON ADMISSION)</a>	R	•
M	<a href="#">PATIENT CLASSIFICATION</a>	R	•
M	<a href="#">ADMISSION METHOD (HOSPITAL PROVIDER SPELL)</a>	R	•
M	<a href="#">SOURCE OF ADMISSION (HOSPITAL PROVIDER SPELL)</a>	R	•
M	<a href="#">START DATE (HOSPITAL PROVIDER SPELL)</a>	R	•
M	<a href="#">AGE ON ADMISSION</a>	R	•

**CDS DATA GROUP: HOSPITAL PROVIDER SPELL - Discharge Characteristics:**  
To carry the discharge details of the Spell containing the Birth Episode.  
One occurrence of this Group is permitted.

M	<a href="#">DISCHARGE DESTINATION (HOSPITAL PROVIDER SPELL)</a>		•
M	<a href="#">DISCHARGE METHOD (HOSPITAL PROVIDER SPELL)</a>		•
O	<a href="#">DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL)</a>		•
M	<a href="#">DISCHARGE DATE (HOSPITAL PROVIDER SPELL)</a>		•

**CDS DATA GROUP: CONSULTANT EPISODE - Activity Characteristics:**  
To carry the details of the Birth Episode undergone by the Patient.  
One occurrence of this Group is permitted.

M	<a href="#">EPISODE NUMBER</a>	R	•
M	<a href="#">LAST EPISODE IN SPELL INDICATOR</a>	R	•
*	<a href="#">ADMINISTRATIVE CATEGORY (AT START OF EPISODE)</a> (Not defined or approved by the Information Standards Board)	R	•
M	<a href="#">OPERATION STATUS</a>	R	•
O	<a href="#">NEONATAL LEVEL OF CARE</a>	R	•
M	<a href="#">START DATE (EPISODE)</a>	R	•
M	<a href="#">END DATE (EPISODE)</a> This is the <b>mandatory</b> date used to derive the <b>mandatory</b> <a href="#">CDS ACTIVITY DATE</a> .		•
M	<a href="#">AGE AT CDS ACTIVITY DATE</a>	R	•

**CDS DATA GROUP: CONSULTANT EPISODE - Service Agreement Details:**  
To carry the details of the Service Agreement for the Birth Episode.

M	<a href="#">COMMISSIONING SERIAL NUMBER</a>	R	•
O	<a href="#">NHS SERVICE AGREEMENT LINE NUMBER</a>	R	
O	<a href="#">PROVIDER REFERENCE NUMBER</a>		
M	<a href="#">COMMISSIONER REFERENCE NUMBER</a>	R	
M	<a href="#">ORGANISATION CODE (CODE OF PROVIDER)</a>	R	•
M	<a href="#">ORGANISATION CODE (CODE OF COMMISSIONER)</a>	R	•

**CDS DATA GROUP: CONSULTANT EPISODE - Person Group (Consultant):**  
To carry the details of the responsible Consultant, Midwife or Nurse.  
One occurrence of this Group is permitted.

M	<a href="#">CONSULTANT CODE</a>	R	•
M	<a href="#">MAIN SPECIALTY CODE</a>	R	•
M	<a href="#">TREATMENT FUNCTION CODE</a>	R	•

**CDS DATA GROUP: CONSULTANT EPISODE Clinical Diagnosis Group (ICD):**  
To carry the details of the ICD Diagnoses.

M	<a href="#">DIAGNOSIS SCHEME IN USE</a>		
M	<a href="#">PRIMARY DIAGNOSIS (ICD)</a>		•
M	<a href="#">SECONDARY DIAGNOSIS (ICD)</a> (Multiple occurrences may be recorded)		•

**CDS DATA GROUP: CONSULTANT EPISODE Clinical Diagnosis Group (READ):**  
To carry the details of the READ Diagnoses.

O	<a href="#">DIAGNOSIS SCHEME IN USE</a>		
O	<a href="#">PRIMARY DIAGNOSIS (READ)</a>		
O	<a href="#">SECONDARY DIAGNOSIS (READ)</a> (Multiple occurrences may be recorded)		

**CDS DATA GROUP: CONSULTANT EPISODE - Clinical Activity Group (OPCS):**  
To carry the details of the OPCS coded Clinical Activities.

M	<a href="#">PROCEDURE SCHEME IN USE</a>		
M	<a href="#">PRIMARY PROCEDURE (OPCS)</a>		•
M	<a href="#">PROCEDURE DATE</a>		•
	(Multiple occurrences of this sub-group may be recorded)		
M	<a href="#">PROCEDURE (OPCS)</a>		•
M	<a href="#">PROCEDURE DATE</a>		•

**CDS DATA GROUP: CONSULTANT EPISODE - Clinical Activity Group (READ):**  
To carry the details of the READ coded Clinical Activities.

O	<a href="#">PROCEDURE SCHEME IN USE</a>		
O	<a href="#">PRIMARY PROCEDURE (READ)</a>		
O	<a href="#">PROCEDURE DATE</a>		
	(Multiple occurrences of this sub-group may be recorded)		
O	<a href="#">PROCEDURE (READ)</a>		
O	<a href="#">PROCEDURE DATE</a>		

**CDS DATA GROUP: CONSULTANT EPISODE - Location Group At Start Of Episode:**  
To carry the details of the location at the start of the Birth Episode.  
One occurrence of this Group is permitted.

M	<a href="#">LOCATION CLASS</a>	R	
M	<a href="#">SITE CODE (OF TREATMENT)</a>	R	•
*	<a href="#">LOCATION TYPE</a> Definition and value list under review	R	
O	<a href="#">INTENDED CLINICAL CARE INTENSITY</a>	R	•
O	<a href="#">AGE GROUP INTENDED</a>	R	•
O	<a href="#">SEX OF PATIENTS</a>	R	•
O	<a href="#">WARD DAY PERIOD AVAILABILITY</a>	R	•
O	<a href="#">WARD NIGHT PERIOD AVAILABILITY</a>	R	•

**CDS DATA GROUP: CONSULTANT EPISODE - Location Group Of Ward Stay:**  
To carry the details of one or more Ward Stays.  
Up to 97 occurrences of this Group are permitted.

M	<a href="#">LOCATION CLASS</a>		
M	<a href="#">SITE CODE (OF TREATMENT)</a>		
*	<a href="#">LOCATION TYPE</a> Definition and value list under review		
O	<a href="#">INTENDED CLINICAL CARE INTENSITY</a>		
O	<a href="#">AGE GROUP INTENDED</a>		
O	<a href="#">SEX OF PATIENTS</a>		
O	<a href="#">WARD DAY PERIOD AVAILABILITY</a>		
O	<a href="#">WARD NIGHT PERIOD AVAILABILITY</a>		
O	<a href="#">START DATE</a>		
O	<a href="#">END DATE</a>		

**CDS DATA GROUP: CONSULTANT EPISODE - Location Group At End Of Episode:**  
To carry the details of the location at the end of the Birth Episode.  
One occurrence of this Group is permitted.

M	<a href="#">LOCATION CLASS</a>		
M	<a href="#">SITE CODE (OF TREATMENT)</a>		
*	<a href="#">LOCATION TYPE</a> Definition and value list under review		
O	<a href="#">INTENDED CLINICAL CARE INTENSITY</a>		
O	<a href="#">AGE GROUP INTENDED</a>		

O	<a href="#">SEX OF PATIENTS</a>		
O	<a href="#">WARD DAY PERIOD AVAILABILITY</a>		
O	<a href="#">WARD NIGHT PERIOD AVAILABILITY</a>		

**CDS DATA GROUP: NEONATAL CRITICAL CARE PERIOD:**  
To carry the details of the first 9 Critical Care Periods for Neonatal Critical Care.

See [CRITICAL CARE PERIOD](#)

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 be always 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 for the Hospital Provider Spell.

**CDS DATA GROUP: CRITICAL CARE PERIOD - NEONATAL CARE - Admission Characteristics**

To carry the details of the Neonatal Critical Care Admission.

One occurrence is permitted for each Critical Care Period recorded.

M	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>	R	•
M	<a href="#">CRITICAL CARE START DATE</a>	R	•
M	<a href="#">CRITICAL CARE START TIME</a>	R	•
M	<a href="#">CRITICAL CARE UNIT FUNCTION</a>	R	•
M	<a href="#">GESTATION LENGTH (AT DELIVERY)</a>	R	•

**CDS DATA GROUP: CRITICAL CARE PERIOD - NEONATAL DAILY CARE - Activity Characteristics**

To carry the details of the Neonatal Critical Care Activity.

Up to 999 daily occurrences per Critical Care Period are supported.

M	<a href="#">ACTIVITY DATE (CRITICAL CARE)</a>	R	•
M	<a href="#">PERSON WEIGHT</a>	R	•
M	<a href="#">CRITICAL CARE ACTIVITY CODE</a> (up to 20 codes per daily activity occurrence may be recorded)	R	•
M	<a href="#">HIGH COST DRUGS (OPCS)</a> (up to 20 codes per daily activity occurrence may be recorded)	R	•

**CDS DATA GROUP: CRITICAL CARE PERIOD - NEONATAL CARE - Discharge Characteristics**

To carry the details of the Discharge from Neonatal Critical Care.

One occurrence of this Group is permitted.

M	<a href="#">CRITICAL CARE DISCHARGE DATE</a>	R	•
M	<a href="#">CRITICAL CARE DISCHARGE TIME</a>	R	•

**CDS DATA GROUP: PAEDIATRIC CRITICAL CARE PERIOD:**

To carry the details of the first 9 Critical Care Periods for Paediatric Critical Care.

See [CRITICAL CARE PERIOD](#)

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 be always 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 for the Hospital Provider Spell.

**CDS DATA GROUP: CRITICAL CARE PERIOD - PAEDIATRIC CARE - Admission Characteristics**

To carry the details of the Paediatric Critical Care Admission.

One occurrence is permitted for each Critical Care Period recorded.

M	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>	R	•
M	<a href="#">CRITICAL CARE START DATE</a>	R	•
M	<a href="#">CRITICAL CARE START TIME</a>	R	•
M	<a href="#">CRITICAL CARE UNIT FUNCTION</a>	R	•

**CDS DATA GROUP: CRITICAL CARE PERIOD - PAEDIATRIC DAILY CARE - Activity Characteristics**

To carry the details of the Paediatric Critical Care Activity.

Up to 999 daily occurrences per Critical Care Period are supported.

M	<a href="#">ACTIVITY DATE (CRITICAL CARE)</a>	R	•
M	<a href="#">CRITICAL CARE ACTIVITY CODE</a> (up to 20 codes per daily activity occurrence may be recorded)	R	•
M	<a href="#">HIGH COST DRUGS (OPCS)</a> (up to 20 codes per daily activity occurrence may be recorded)	R	•



**CDS DATA GROUP: CRITICAL CARE PERIOD - PAEDIATRIC CARE - Discharge Characteristics**  
 To carry the details of the Discharge from Paediatric Critical Care.  
 One occurrence of this Group is permitted.

M	<a href="#">CRITICAL CARE DISCHARGE DATE</a>	R	•
M	<a href="#">CRITICAL CARE DISCHARGE TIME</a>	R	•

**CDS DATA GROUP: ADULT CRITICAL CARE PERIOD:**  
 To carry the details of the first 9 Critical Care Periods for Adult Critical Care.  
 See [CRITICAL CARE PERIOD](#)  
 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 be always 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 for the Hospital Provider Spell.

**CDS DATA GROUP: CRITICAL CARE PERIOD - ADULT CARE - Admission Characteristics**  
 To carry the details of the Admission to Adult Critical Care.  
 One occurrence is permitted for each Critical Care Period recorded.

M	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>	R	•
M	<a href="#">CRITICAL CARE START DATE</a>	R	•
O	<a href="#">CRITICAL CARE START TIME</a>	R	•
M	<a href="#">CRITICAL CARE UNIT FUNCTION</a>	R	•
O	<a href="#">CRITICAL CARE UNIT BED CONFIGURATION</a>		•
O	<a href="#">CRITICAL CARE ADMISSION SOURCE</a>		•
O	<a href="#">CRITICAL CARE SOURCE LOCATION</a>		•
O	<a href="#">CRITICAL CARE ADMISSION TYPE</a>		•

**CDS DATA GROUP: CRITICAL CARE PERIOD - ADULT CARE - Activity Characteristics**  
 To carry the details of the Adult Critical Care Activity.  
 One occurrence of this Group is permitted for each Critical Care Period.

M	<a href="#">ADVANCED RESPIRATORY SUPPORT DAYS</a>		•
M	<a href="#">BASIC RESPIRATORY SUPPORT DAYS</a>		•
M	<a href="#">ADVANCED CARDIOVASCULAR SUPPORT DAYS</a>		•
M	<a href="#">BASIC CARDIOVASCULAR SUPPORT DAYS</a>		•
M	<a href="#">RENAL SUPPORT DAYS</a>		•
M	<a href="#">NEUROLOGICAL SUPPORT DAYS</a>		•
O	<a href="#">GASTRO-INTESTINAL SUPPORT DAYS</a>		•
M	<a href="#">DERMATOLOGICAL SUPPORT DAYS</a>		•
M	<a href="#">LIVER SUPPORT DAYS</a>		•
M	<a href="#">ORGAN SUPPORT MAXIMUM</a>		•
M	<a href="#">CRITICAL CARE LEVEL 2 DAYS</a>		•
M	<a href="#">CRITICAL CARE LEVEL 3 DAYS</a>		•

**CDS DATA GROUP: CRITICAL CARE PERIOD - ADULT CARE - Discharge Characteristics**  
 To carry the details of the Discharge from Adult Critical Care.  
 One occurrence of this Group is permitted.

M	<a href="#">CRITICAL CARE DISCHARGE DATE</a>	R	•
M	<a href="#">CRITICAL CARE DISCHARGE TIME</a>	R	•
O	<a href="#">CRITICAL CARE DISCHARGE READY DATE</a>	R	•
O	<a href="#">CRITICAL CARE DISCHARGE READY TIME</a>	R	•
O	<a href="#">CRITICAL CARE DISCHARGE STATUS</a>	R	•
O	<a href="#">CRITICAL CARE DISCHARGE DESTINATION</a>	R	•
O	<a href="#">CRITICAL CARE DISCHARGE LOCATION</a>	R	•

**CDS DATA GROUP: GP REGISTRATION:**  
 To carry the Patient's General Medical Practitioner and General Practice details.  
 One occurrence of this Group is permitted.

O	<a href="#">GENERAL MEDICAL PRACTITIONER (SPECIFIED)</a>	R	•
M	<a href="#">GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)</a>	R	•

**CDS DATA GROUP: REFERRAL:**

<b>To carry the details of the referrer. One occurrence of this Group is permitted.</b>			
M	<a href="#">REFERRER CODE</a>	R	•
M	<a href="#">REFERRING ORGANISATION CODE</a>	R	•
<b>CDS DATA GROUP: PREGNANCY - Activity Characteristics: To carry the details of the Pregnancy. One occurrence of this Group is permitted.</b>			
M	<a href="#">NUMBER OF BABIES</a>	R	•
<b>CDS DATA GROUP: ANTENATAL CARE - Activity Characteristics: To carry the details of the Antenatal Care. One occurrence of this Group is permitted.</b>			
M	<a href="#">FIRST ANTENATAL ASSESSMENT DATE</a>	R	•
<b>CDS DATA GROUP: ANTENATAL CARE - PERSON GROUP - Responsible Clinician: To carry the details of the Clinician responsible for the Antenatal Care. One occurrence of this Group is permitted.</b>			
M	<a href="#">GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE)</a>	R	
O	<a href="#">GENERAL MEDICAL PRACTITIONER PRACTICE (ANTENATAL CARE)</a>	R	
<b>CDS DATA GROUP: ANTENATAL CARE - LOCATION GROUP - Delivery Place Intended: To carry the details of the intended delivery place. One occurrence of this Group is permitted.</b>			
M	<a href="#">LOCATION CLASS</a>	R	
*	<a href="#">LOCATION TYPE</a> Definition and value list under review	R	
M	<a href="#">DELIVERY PLACE CHANGE REASON</a>	R	•
M	<a href="#">DELIVERY PLACE TYPE (INTENDED)</a>	R	•
<b>CDS DATA GROUP: HOSPITAL LABOUR / DELIVERY - Activity Characteristics: To carry the details of the Labour / Delivery. One occurrence of this Group is permitted.</b>			
M	<a href="#">ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY</a>	R	•
M	<a href="#">ANAESTHETIC GIVEN POST LABOUR OR DELIVERY</a>	R	•
O	<a href="#">GESTATION LENGTH (LABOUR ONSET)</a>	R	•
M	<a href="#">LABOUR OR DELIVERY ONSET METHOD</a>	R	•
M	<a href="#">DELIVERY DATE</a>	R	•
<b>CDS DATA GROUP: BIRTH OCCURRENCE - Activity Characteristics: To carry the details of the birth occurrence. One occurrence of this Group is permitted.</b>			
M	<a href="#">BIRTH ORDER</a>	R	•
M	<a href="#">DELIVERY METHOD</a>	R	•
M	<a href="#">GESTATION LENGTH (ASSESSMENT)</a>	R	•
M	<a href="#">RESUSCITATION METHOD</a>	R	•
M	<a href="#">STATUS OF PERSON CONDUCTING DELIVERY</a>	R	•
<b>CDS DATA GROUP: BIRTH OCCURRENCE PERSON IDENTITY - (MOTHER): To carry the identity details of the baby's mother. One occurrence of this Group is permitted.</b>			
O	<a href="#">LOCAL PATIENT IDENTIFIER (MOTHER)</a>	R	
O	<a href="#">ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (MOTHER))</a>	R	
O	<a href="#">NHS NUMBER (MOTHER)</a>	R	
M	<a href="#">NHS NUMBER STATUS INDICATOR (MOTHER)</a>	R	
O	<a href="#">PATIENT USUAL ADDRESS (MOTHER)</a>		
M	<a href="#">POSTCODE OF USUAL ADDRESS (MOTHER)</a>	R	•
M	<a href="#">ORGANISATION CODE (PCT OF RESIDENCE (MOTHER))</a>	R	•
M	<a href="#">PERSON BIRTH DATE (MOTHER) (from commissioning data set 6-1)</a>	R	•

**Note:**

Birth Episodes do not carry address details for a baby.

By local agreement it may be assumed that the baby's address details are those of its mother.

**Note:**

For Security Issues and Patient Confidentiality, the mother's name must **not** be carried where a valid NHS Number is present.

For patients with sensitive conditions (as defined in Security Issues and Patient Confidentiality), all the mother's identifiable information must be removed from Commissioning Data Set records. This includes LOCAL PATIENT IDENTIFIER (MOTHER), NHS NUMBER (MOTHER), PATIENT USUAL ADDRESS (MOTHER), POSTCODE OF USUAL ADDRESS (MOTHER) and PERSON BIRTH DATE (MOTHER).

**CDS DATA GROUP: BIRTH OCCURRENCE PERSON CHARACTERISTICS - (MOTHER):**

To carry the characteristics of the baby's mother.

One occurrence of this Group is permitted.

**CDS DATA GROUP: BIRTH OCCURRENCE PERSON CHARACTERISTICS - (MOTHER):**

To carry the characteristics of the baby's mother.

One occurrence of this Group is permitted.

(commissioning data set 6-0 only)

M	<a href="#">PERSON BIRTH DATE (MOTHER)</a>	R	•
M	<a href="#">PERSON BIRTH DATE (MOTHER)</a> (commissioning data set 6-0 only)	R	•

**CDS DATA GROUP: BIRTH OCCURRENCE - LOCATION GROUP - Delivery Place Actual:**

To carry the details of the actual delivery place.

One occurrence of this Group is permitted.

M	<a href="#">LOCATION CLASS</a>		
*	<a href="#">LOCATION TYPE</a> Definition and value list under review		
M	<a href="#">DELIVERY PLACE TYPE (ACTUAL)</a>	R	•

**CDS DATA GROUP: HEALTHCARE RESOURCE GROUP: - Activity Characteristics:**

To carry the details of the Healthcare Resource Group.

One occurrence of this Group is permitted.

M	<a href="#">HEALTHCARE RESOURCE GROUP CODE</a>		•
M	<a href="#">HEALTHCARE RESOURCE GROUP CODE-VERSION NUMBER</a>		•

**CDS DATA GROUP: HEALTHCARE RESOURCE GROUP - Clinical Activity Group:**

To carry the details of the HRG Dominant Grouping Variable - Procedure. Note that this will not apply when no operation was carried out. In this case, the segment referring to HRG Dominant Grouping Variable - Procedure should be omitted.

One Procedure, either OPCS or READ, may be specified.

O	<a href="#">PROCEDURE SCHEME IN USE</a>		
O	<a href="#">HRG DOMINANT GROUPING VARIABLE-PROCEDURE</a>		•

**CDS V6 TYPE 130**

Change to Data Set: Changed Description

**[CDS V6 TYPE 130 - ADMITTED PATIENT CARE - FINISHED GENERAL EPISODE CDS](#)**

The Admitted Patient Care Finished General Episode Commissioning Data Set Type carries the data for a Finished General Episode.

It covers all NHS and private Admitted Patient Care (day case and inpatient) activity taking place in any acute, community, psychiatric NHS Trust or Primary Care Trust or other NHS hospital under the care of a consultant, midwife or nurse. Additionally, NHS funded Admitted Patient Care taking place in non-NHS hospitals and institutions is required.

In addition to Finished General Episodes an Unfinished General Episode CDS record is required for all Unfinished General Episodes at midnight on 31 March each year. Unfinished General Episode CDS records are also required for short-stay informal psychiatric patients who are resident in hospital or on leave of absence (home leave) on 31 March and who have been in hospital for less than 12 months.

The CDS TYPE 130 consists of the following CDS Data Groups:

INTERCHANGE, MESSAGE and CDS TRANSACTION HEADERS and TRAILERS (shown independently)

PATIENT PATHWAY

PATIENT IDENTITY

PATIENT CHARACTERISTICS

HOSPITAL PROVIDER SPELL

CONSULTANT EPISODE

CRITICAL CARE PERIOD  
 GP REGISTRATION  
 REFERRAL  
 EAL ENTRY  
 HEALTHCARE RESOURCE GROUP

The markers in the columns "OPT, U/A and HES" indicate the NHS recommendations for the inclusion of data:

**M** = Mandatory - data must be included **where** available

**O** = Optional - data need not be included

**\*** = Must **Not** Be Used

**R** in the column headed **U/A** indicates the data is required in the Unfinished Episode / Annual Census of Unfinished Episode record and on an End of Year Census record.

An entry in the column headed **HES** indicates that the data element is extracted from the SUS database for Hospital Episode Statistics. Data extracted for HES purposes contains some derived items. The CDS/HES Cross Reference Tables show these derivations.

**CDS V6 TYPE 130 - THE FINISHED GENERAL EPISODE CDS**

**CDS DATA GROUP: PATIENT PATHWAY:**  
 To carry the details of the Patient Pathway.  
 One optional occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
O	<a href="#">UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)</a>		
O	<a href="#">PATIENT PATHWAY IDENTIFIER</a>		
O	<a href="#">ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)</a>		
O	<a href="#">REFERRAL TO TREATMENT STATUS</a>		
O	<a href="#">REFERRAL TO TREATMENT PERIOD START DATE</a>		
O	<a href="#">REFERRAL TO TREATMENT PERIOD END DATE</a>		
*	LEAD CARE ACTIVITY INDICATOR (Not defined or approved by the Information Standards Board)		

**CDS DATA GROUP: PATIENT IDENTITY:**  
 To carry the identity of the Patient.  
 One occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
M	<a href="#">LOCAL PATIENT IDENTIFIER</a>	R	•
M	<a href="#">ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)</a>	R	
M	<a href="#">NHS NUMBER</a>	R	•
M	<a href="#">NHS NUMBER STATUS INDICATOR</a>	R	•
O	<a href="#">PATIENT NAME</a>	R	
O	<a href="#">PATIENT USUAL ADDRESS</a>	R	
M	<a href="#">POSTCODE OF USUAL ADDRESS</a>	R	•
M	<a href="#">ORGANISATION CODE (PCT OF RESIDENCE)</a>	R	•
M	<a href="#">PERSON BIRTH DATE</a> (from commissioning data set 6-1)	R	•

**Note:**

For reasons of confidentiality, the patient's preferred name and address (not including [POSTCODE OF USUAL ADDRESS](#)) must **not** be carried where a valid NHS Number is present. For patients with sensitive conditions (as defined in DSCN 41/98/P26), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), [ORGANISATION CODE \(PCT OF RESIDENCE\)](#) and [PERSON BIRTH DATE](#) (in Patient Characteristics data group below).

**Note:**

For Security Issues and Patient Confidentiality, the [PATIENT NAME](#) and [PATIENT USUAL ADDRESS](#) (not including [POSTCODE OF USUAL ADDRESS](#)) must **not** be carried where a valid [NHS NUMBER](#) is present, even if the [NHS NUMBER](#) is not verified.

For patients with sensitive conditions (as defined in Security Issues and Patient Confidentiality), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), and [PERSON BIRTH DATE](#).

CDS DATA GROUP: PATIENT CHARACTERISTICS: To carry the characteristics of the Patient. One occurrence of this Group is permitted.			
Opt	CDS data element	U/A	HES
<del>M</del>	<del>PERSON BIRTH DATE</del>	R	•
M	PERSON BIRTH DATE (commissioning data set 6-0 only)	R	•
M	PERSON GENDER CURRENT	R	•
O	CARER SUPPORT INDICATOR	R	•
M	ETHNIC CATEGORY	R	•
M	PERSON MARITAL STATUS (psychiatric patients only)	R	•
M	LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION) (psychiatric patients only)	R	•
CDS DATA GROUP: HOSPITAL PROVIDER SPELL - Admission Characteristics: To carry the discharge details of the Spell containing the Episode. One occurrence of this Group is permitted.			
M	HOSPITAL PROVIDER SPELL NUMBER	R	•
M	ADMINISTRATIVE CATEGORY (ON ADMISSION)	R	•
M	PATIENT CLASSIFICATION	R	•
M	ADMISSION METHOD (HOSPITAL PROVIDER SPELL)	R	•
M	SOURCE OF ADMISSION (HOSPITAL PROVIDER SPELL)	R	•
M	START DATE (HOSPITAL PROVIDER SPELL)	R	•
M	AGE ON ADMISSION	R	•
CDS DATA GROUP: HOSPITAL PROVIDER SPELL - Discharge Characteristics: To carry the discharge details of the Spell containing the Episode. One occurrence of this Group is permitted.			
M	DISCHARGE DESTINATION (HOSPITAL PROVIDER SPELL)		•
M	DISCHARGE METHOD (HOSPITAL PROVIDER SPELL)		•
O	DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL)		•
M	DISCHARGE DATE (HOSPITAL PROVIDER SPELL)		•
CDS DATA GROUP: CONSULTANT EPISODE - Activity Characteristics: To carry the details of the Episode undergone by the Patient. One occurrence of this Group is permitted.			
M	EPISODE NUMBER	R	•
M	LAST EPISODE IN SPELL INDICATOR	R	•
*	ADMINISTRATIVE CATEGORY (AT START OF EPISODE) (Not defined or approved by the Information Standards Board)	R	•
M	OPERATION STATUS	R	•
O	NEONATAL LEVEL OF CARE	R	•
O	FIRST REGULAR DAY OR NIGHT ADMISSION	R	•
M	PSYCHIATRIC PATIENT STATUS	R	•
*	LEGAL STATUS CLASSIFICATION CODE (AT START OF EPISODE) (Not defined or approved by the Information Standards Board) (psychiatric patients only)	R	•
M	START DATE (EPISODE)	R	•
M	END DATE (EPISODE) This is the <b>mandatory</b> date used to derive the <b>mandatory</b> CDS ACTIVITY DATE.		•
M	AGE AT CDS ACTIVITY DATE	R	•
CDS DATA GROUP: CONSULTANT EPISODE - Service Agreement Details: To carry the details of the Service Agreement for the Episode.			
M	COMMISSIONING SERIAL NUMBER	R	•
O	NHS SERVICE AGREEMENT LINE NUMBER	R	
O	PROVIDER REFERENCE NUMBER		
M	COMMISSIONER REFERENCE NUMBER	R	
M	ORGANISATION CODE (CODE OF PROVIDER)	R	•

M	<a href="#">ORGANISATION CODE (CODE OF COMMISSIONER)</a>	R	•
<b>CDS DATA GROUP: CONSULTANT EPISODE - Person Group (Consultant):</b> To carry the details of the responsible Consultant, Midwife or Nurse. One occurrence of this Group is permitted.			
M	<a href="#">CONSULTANT CODE</a>	R	•
M	<a href="#">MAIN SPECIALTY CODE</a>	R	•
M	<a href="#">TREATMENT FUNCTION CODE</a>	R	•
<b>CDS DATA GROUP: CONSULTANT EPISODE Clinical Diagnosis Group (ICD):</b> To carry the details of the ICD Diagnoses.			
M	<a href="#">DIAGNOSIS SCHEME IN USE</a>		
M	<a href="#">PRIMARY DIAGNOSIS (ICD)</a>		•
M	<a href="#">SECONDARY DIAGNOSIS (ICD)</a> (Multiple occurrences may be recorded)		•
<b>CDS DATA GROUP: CONSULTANT EPISODE Clinical Diagnosis Group (READ):</b> To carry the details of the READ Diagnoses.			
O	<a href="#">DIAGNOSIS SCHEME IN USE</a>		
O	<a href="#">PRIMARY DIAGNOSIS (READ)</a>		
O	<a href="#">SECONDARY DIAGNOSIS (READ)</a> (Multiple occurrences may be recorded)		
<b>CDS DATA GROUP: CONSULTANT EPISODE - Clinical Activity Group (OPCS):</b> To carry the details of the OPCS coded Clinical Activities.			
M	<a href="#">PROCEDURE SCHEME IN USE</a>		
M	<a href="#">PRIMARY PROCEDURE (OPCS)</a>		•
M	<a href="#">PROCEDURE DATE</a>		•
(Multiple occurrences of this sub-group may be recorded)			
M	<a href="#">PROCEDURE (OPCS)</a>		•
M	<a href="#">PROCEDURE DATE</a>		•
<b>CDS DATA GROUP: CONSULTANT EPISODE - Clinical Activity Group (READ):</b> To carry the details of the READ coded Clinical Activities.			
O	<a href="#">PROCEDURE SCHEME IN USE</a>		
O	<a href="#">PRIMARY PROCEDURE (READ)</a>		
O	<a href="#">PROCEDURE DATE</a>		
(Multiple occurrences of this sub-group may be recorded)			
O	<a href="#">PROCEDURE (READ)</a>		
O	<a href="#">PROCEDURE DATE</a>		
<b>CDS DATA GROUP: CONSULTANT EPISODE - Location Group At Start Of Episode:</b> To carry the details of the location at the start of the Episode. One occurrence of this Group is permitted.			
M	<a href="#">LOCATION CLASS</a>	R	
M	<a href="#">SITE CODE (OF TREATMENT)</a>	R	•
*	<a href="#">LOCATION TYPE</a> Definition and value list under review	R	
O	<a href="#">INTENDED CLINICAL CARE INTENSITY</a>	R	•
O	<a href="#">AGE GROUP INTENDED</a>	R	•
O	<a href="#">SEX OF PATIENTS</a>	R	•
O	<a href="#">WARD DAY PERIOD AVAILABILITY</a>	R	•
O	<a href="#">WARD NIGHT PERIOD AVAILABILITY</a>	R	•
<b>CDS DATA GROUP: CONSULTANT EPISODE - Location Group Of Ward Stay:</b> To carry the details of one or more Ward Stays. Up to 97 occurrences of this Group are permitted.			
M	<a href="#">LOCATION CLASS</a>		
M	<a href="#">SITE CODE (OF TREATMENT)</a>		
*	<a href="#">LOCATION TYPE</a> Definition and value list under review		
O	<a href="#">INTENDED CLINICAL CARE INTENSITY</a>		
O	<a href="#">AGE GROUP INTENDED</a>		
O	<a href="#">SEX OF PATIENTS</a>		

O	<a href="#">WARD DAY PERIOD AVAILABILITY</a>		
O	<a href="#">WARD NIGHT PERIOD AVAILABILITY</a>		
O	<a href="#">START DATE</a>		
O	<a href="#">END DATE</a>		

**CDS DATA GROUP: CONSULTANT EPISODE - Location Group At End Of Episode:**  
 To carry the details of the location at the end of the Episode.  
 One occurrence of this Group is permitted.

M	<a href="#">LOCATION CLASS</a>		
M	<a href="#">SITE CODE (OF TREATMENT)</a>		
*	<a href="#">LOCATION TYPE</a> Definition and value list under review		
O	<a href="#">INTENDED CLINICAL CARE INTENSITY</a>		
O	<a href="#">AGE GROUP INTENDED</a>		
O	<a href="#">SEX OF PATIENTS</a>		
O	<a href="#">WARD DAY PERIOD AVAILABILITY</a>		
O	<a href="#">WARD NIGHT PERIOD AVAILABILITY</a>		

**CDS DATA GROUP: NEONATAL CRITICAL CARE PERIOD:**  
 To carry the details of the first 9 Critical Care Periods for Neonatal Critical Care.  
 See [CRITICAL CARE PERIOD](#)  
 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 be always 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 for the Hospital Provider Spell.

**CDS DATA GROUP: CRITICAL CARE PERIOD - NEONATAL CARE - Admission Characteristics**  
 To carry the details of the Neonatal Critical Care Admission.  
 One occurrence is permitted for each Critical Care Period recorded.

M	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>	R	•
M	<a href="#">CRITICAL CARE START DATE</a>	R	•
M	<a href="#">CRITICAL CARE START TIME</a>	R	•
M	<a href="#">CRITICAL CARE UNIT FUNCTION</a>	R	•
M	<a href="#">GESTATION LENGTH (AT DELIVERY)</a>	R	•

**CDS DATA GROUP: CRITICAL CARE PERIOD - NEONATAL DAILY CARE - Activity Characteristics**  
 To carry the details of the Neonatal Critical Care Activity.  
 Up to 999 daily occurrences per Critical Care Period are supported.

M	<a href="#">ACTIVITY DATE (CRITICAL CARE)</a>	R	•
M	<a href="#">PERSON WEIGHT</a>	R	•
M	<a href="#">CRITICAL CARE ACTIVITY CODE</a> (up to 20 codes per daily activity occurrence may be recorded)	R	•
M	<a href="#">HIGH COST DRUGS (OPCS)</a> (up to 20 codes per daily activity occurrence may be recorded)	R	•

**CDS DATA GROUP: CRITICAL CARE PERIOD - NEONATAL CARE - Discharge Characteristics**  
 To carry the details of the Discharge from Neonatal Critical Care.  
 One occurrence of this Group is permitted.

M	<a href="#">CRITICAL CARE DISCHARGE DATE</a>	R	•
M	<a href="#">CRITICAL CARE DISCHARGE TIME</a>	R	•

**CDS DATA GROUP: PAEDIATRIC CRITICAL CARE PERIOD:**  
 To carry the details of the first 9 Critical Care Periods for Paediatric Critical Care.  
 See [CRITICAL CARE PERIOD](#)  
 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 be always 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 for the Hospital Provider Spell.

**CDS DATA GROUP: CRITICAL CARE PERIOD - PAEDIATRIC CARE - Admission Characteristics**  
 To carry the details of the Paediatric Critical Care Admission.  
 One occurrence is permitted for each Critical Care Period recorded.

M	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>	R	•
M	<a href="#">CRITICAL CARE START DATE</a>	R	•
M	<a href="#">CRITICAL CARE START TIME</a>	R	•
M	<a href="#">CRITICAL CARE UNIT FUNCTION</a>	R	•

**CDS DATA GROUP: CRITICAL CARE PERIOD - PAEDIATRIC DAILY CARE - Activity Characteristics**  
 To carry the details of the Paediatric Critical Care Activity.  
 Up to 999 daily occurrences per Critical Care Period are supported.

M	<a href="#">ACTIVITY DATE (CRITICAL CARE)</a>	R	•
M	<a href="#">CRITICAL CARE ACTIVITY CODE</a> (up to 20 codes per daily activity occurrence may be recorded)	R	•
M	<a href="#">HIGH COST DRUGS (OPCS)</a> (up to 20 codes per daily activity occurrence may be recorded)	R	•

**CDS DATA GROUP: CRITICAL CARE PERIOD - PAEDIATRIC CARE - Discharge Characteristics**  
 To carry the details of the Discharge from Paediatric Critical Care.  
 One occurrence of this Group is permitted.

M	<a href="#">CRITICAL CARE DISCHARGE DATE</a>	R	•
M	<a href="#">CRITICAL CARE DISCHARGE TIME</a>	R	•

**CDS DATA GROUP: ADULT CRITICAL CARE PERIOD:**  
 To carry the details of the first 9 Critical Care Periods for Adult Critical Care.  
 See [CRITICAL CARE PERIOD](#)  
 The data elements [CRITICAL CARE START DATE](#), [CRITICAL CARE LOCAL IDENTIFIER](#) and [CRITICAL CARE UNIT FUNCTION](#) must be always 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 for the Hospital Provider Spell.

**CDS DATA GROUP: CRITICAL CARE PERIOD - ADULT CARE - Admission Characteristics**  
 To carry the details of the Admission to Adult Critical Care.  
 One occurrence is permitted for each Critical Care Period recorded.

M	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>	R	•
M	<a href="#">CRITICAL CARE START DATE</a>	R	•
O	<a href="#">CRITICAL CARE START TIME</a>	R	•
M	<a href="#">CRITICAL CARE UNIT FUNCTION</a>	R	•
O	<a href="#">CRITICAL CARE UNIT BED CONFIGURATION</a>		•
O	<a href="#">CRITICAL CARE ADMISSION SOURCE</a>		•
O	<a href="#">CRITICAL CARE SOURCE LOCATION</a>		•
O	<a href="#">CRITICAL CARE ADMISSION TYPE</a>		•

**CDS DATA GROUP: CRITICAL CARE PERIOD - ADULT CARE - Activity Characteristics**  
 To carry the details of the Adult Critical Care Activity.  
 One occurrence of this data group is supported.

M	<a href="#">ADVANCED RESPIRATORY SUPPORT DAYS</a>		•
M	<a href="#">BASIC RESPIRATORY SUPPORT DAYS</a>		•
M	<a href="#">ADVANCED CARDIOVASCULAR SUPPORT DAYS</a>		•
M	<a href="#">BASIC CARDIOVASCULAR SUPPORT DAYS</a>		•
M	<a href="#">RENAL SUPPORT DAYS</a>		•
M	<a href="#">NEUROLOGICAL SUPPORT DAYS</a>		•
O	<a href="#">GASTRO-INTESTINAL SUPPORT DAYS</a>		•
M	<a href="#">DERMATOLOGICAL SUPPORT DAYS</a>		•
M	<a href="#">LIVER SUPPORT DAYS</a>		•
M	<a href="#">ORGAN SUPPORT MAXIMUM</a>		•
M	<a href="#">CRITICAL CARE LEVEL 2 DAYS</a>		•
M	<a href="#">CRITICAL CARE LEVEL 3 DAYS</a>		•

**CDS DATA GROUP: CRITICAL CARE PERIOD - ADULT CARE - Discharge Characteristics**  
 To carry the details of the Discharge from Adult Critical Care.  
 One occurrence of this Group is permitted.

M	<a href="#">CRITICAL CARE DISCHARGE DATE</a>	R	•
M	<a href="#">CRITICAL CARE DISCHARGE TIME</a>	R	•
O	<a href="#">CRITICAL CARE DISCHARGE READY DATE</a>	R	•



O	<a href="#">CRITICAL CARE DISCHARGE READY TIME</a>	R	•
O	<a href="#">CRITICAL CARE DISCHARGE STATUS</a>	R	•
O	<a href="#">CRITICAL CARE DISCHARGE DESTINATION</a>	R	•
O	<a href="#">CRITICAL CARE DISCHARGE LOCATION</a>	R	•
<b>CDS DATA GROUP: GP REGISTRATION:</b> To carry the Patient's General Medical Practitioner and General Practice details. One occurrence of this Group is permitted.			
O	<a href="#">GENERAL MEDICAL PRACTITIONER (SPECIFIED)</a>	R	•
M	<a href="#">GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)</a>	R	•
<b>CDS DATA GROUP: REFERRAL:</b> To carry the details of the referrer. One occurrence of this Group is permitted.			
M	<a href="#">REFERRER CODE</a>	R	•
M	<a href="#">REFERRING ORGANISATION CODE</a>	R	•
<b>CDS DATA GROUP: ELECTIVE ADMISSION LIST ENTRY:</b> To carry the details of the Elective Admission List Entry. One occurrence of this Group is permitted.			
M	<a href="#">DURATION OF ELECTIVE WAIT</a>	R	•
M	<a href="#">INTENDED MANAGEMENT</a>	R	•
M	<a href="#">DECIDED TO ADMIT DATE</a>	R	•
O	<a href="#">EARLIEST REASONABLE OFFER DATE</a>	R	•
<b>CDS DATA GROUP: HEALTHCARE RESOURCE GROUP - Activity Characteristics:</b> To carry the details of the Healthcare Resource Group. One occurrence of this Group is permitted.			
M	<a href="#">HEALTHCARE RESOURCE GROUP CODE</a>		•
M	<a href="#">HEALTHCARE RESOURCE GROUP CODE-VERSION NUMBER</a>		•
<b>CDS DATA GROUP: HEALTHCARE RESOURCE GROUP - Clinical Activity Group:</b> To carry the details of the HRG Dominant Grouping Variable - Procedure. Note that this will not apply when no operation was carried out. In this case, the segment referring to HRG Dominant Grouping Variable - Procedure should be omitted. One Procedure, either OPCS or READ, may be specified.			
O	<a href="#">PROCEDURE SCHEME IN USE</a>		
O	<a href="#">HRG DOMINANT GROUPING VARIABLE-PROCEDURE</a>		•

## CDS V6 TYPE 140

Change to Data Set: Changed Description

### [CDS V6 TYPE 140 - ADMITTED PATIENT CARE - FINISHED DELIVERY EPISODE CDS](#)

The Admitted Patient Care Finished Delivery Episode Commissioning Data Set Type carries the data for a Finished Delivery Episode which is required when a delivery has resulted in a registrable birth. This may take place in either NHS Hospitals or in non-NHS organisations funded by the NHS. The information is taken from the birth notification for each baby born.

In addition to Finished Delivery Episodes an Unfinished Delivery Episode CDS record is required for all Unfinished Birth Episodes at midnight on 31 March each year.

The CDS TYPE 140 consists of the following CDS Data Groups:

INTERCHANGE, MESSAGE and CDS TRANSACTION HEADERS and TRAILERS (defined independently)

PATIENT PATHWAY

PATIENT IDENTITY

PATIENT CHARACTERISTICS

HOSPITAL PROVIDER SPELL

CONSULTANT EPISODE

CRITICAL CARE PERIOD

GP REGISTRATION

REFERRAL

PREGNANCY

ANTENATAL CARE

HOSPITAL LABOUR / DELIVERY

BIRTH OCCURRENCE

**HEALTHCARE RESOURCE GROUP**

The markers in the columns "OPT, U/A and HES" indicate the NHS recommendations for the inclusion of data:

**M** = Mandatory - data must be included **where** available

**O** = Optional - data need not be included

**\*** = Must **Not** Be Used

**R** in the column headed **U/A** indicates the data is required in the Unfinished Episode / Annual Census of Unfinished Episode record and on an End of Year Census record.

An entry in the column headed **HES** indicates that the data element is extracted from the SUS database for Hospital Episode Statistics.

Data extracted for HES purposes contains some derived items. The CDS/HES Cross Reference Tables show these derivations.

**CDS V6 TYPE 140 - THE FINISHED DELIVERY EPISODE CDS**

**CDS DATA GROUP: PATIENT PATHWAY:**  
To carry the details of the Patient Pathway.  
One optional occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
O	<a href="#">UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)</a>		
O	<a href="#">PATIENT PATHWAY IDENTIFIER</a>		
O	<a href="#">ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)</a>		
O	<a href="#">REFERRAL TO TREATMENT STATUS</a>		
O	<a href="#">REFERRAL TO TREATMENT PERIOD START DATE</a>		
O	<a href="#">REFERRAL TO TREATMENT PERIOD END DATE</a>		
*	LEAD CARE ACTIVITY INDICATOR (Not defined or approved by the Information Standards Board)		

**CDS DATA GROUP: PATIENT IDENTITY:**  
To carry the identity details of the Patient (the MOTHER).  
One occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
M	<a href="#">LOCAL PATIENT IDENTIFIER</a>	R	•
M	<a href="#">ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)</a>	R	
M	<a href="#">NHS NUMBER</a>	R	•
M	<a href="#">NHS NUMBER STATUS INDICATOR</a>	R	•
O	<a href="#">PATIENT NAME</a>	R	
O	<a href="#">PATIENT USUAL ADDRESS</a>	R	
M	<a href="#">POSTCODE OF USUAL ADDRESS</a>	R	•
M	<a href="#">ORGANISATION CODE (PCT OF RESIDENCE)</a>	R	•
M	<a href="#">PERSON BIRTH DATE</a> (from commissioning data set 6-1)	R	•

**Note:**

For reasons of confidentiality, the patient's preferred name and address (not including [POSTCODE OF USUAL ADDRESS](#)) must **not** be carried where a valid NHS Number is present. For patients with sensitive conditions (as defined in DSCN 41/98/P26), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), [ORGANISATION CODE \(PCT OF RESIDENCE\)](#) and [PERSON BIRTH DATE](#) (in Patient Characteristics data group below):

**Note:**

For Security Issues and Patient Confidentiality, the [PATIENT NAME](#) and [PATIENT USUAL ADDRESS](#) (not including [POSTCODE OF USUAL ADDRESS](#)) must not be carried where a valid [NHS NUMBER](#) is present, even if the [NHS NUMBER](#) is not verified.

For patients with sensitive conditions (as defined in [Security Issues and Patient Confidentiality](#)), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), and [PERSON BIRTH DATE](#).

**CDS DATA GROUP: PATIENT CHARACTERISTICS:**  
To carry the characteristics of the Patient (the MOTHER).  
One occurrence of this Group is permitted.

M	<a href="#">PERSON BIRTH DATE</a>	R	•
M	<a href="#">PERSON BIRTH DATE</a>	R	•

	(commissioning data set 6-0 only)		
M	<a href="#">PERSON GENDER CURRENT</a>	R	•
O	<a href="#">CARER SUPPORT INDICATOR</a>	R	•
M	<a href="#">ETHNIC CATEGORY</a>	R	•
M	<a href="#">PERSON MARITAL STATUS</a> (psychiatric patients only)	R	•
M	<a href="#">LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)</a> (psychiatric patients only)	R	•

**CDS DATA GROUP: DELIVERY CHARACTERISTICS:**  
To carry the delivery characteristics of the Patient (the MOTHER).  
One occurrence of this Group is permitted.

M	<a href="#">PREGNANCY TOTAL PREVIOUS PREGNANCIES</a>		•
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**CDS DATA GROUP: HOSPITAL PROVIDER SPELL - Admission Characteristics:**  
To carry the admission details of the Spell containing the Delivery Episode.  
One occurrence of this Group is permitted.

M	<a href="#">HOSPITAL PROVIDER SPELL NUMBER</a>	R	•
M	<a href="#">ADMINISTRATIVE CATEGORY (ON ADMISSION)</a>	R	•
M	<a href="#">PATIENT CLASSIFICATION</a>	R	•
M	<a href="#">ADMISSION METHOD (HOSPITAL PROVIDER SPELL)</a>	R	•
M	<a href="#">SOURCE OF ADMISSION (HOSPITAL PROVIDER SPELL)</a>	R	•
M	<a href="#">START DATE (HOSPITAL PROVIDER SPELL)</a>	R	•
M	<a href="#">AGE ON ADMISSION</a>	R	•

**CDS DATA GROUP: HOSPITAL PROVIDER SPELL - Discharge Characteristics:**  
To carry the discharge details of the Spell containing the Delivery Episode.  
One occurrence of this Group is permitted.

M	<a href="#">DISCHARGE DESTINATION (HOSPITAL PROVIDER SPELL)</a>		•
M	<a href="#">DISCHARGE METHOD (HOSPITAL PROVIDER SPELL)</a>		•
O	<a href="#">DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL)</a>		•
M	<a href="#">DISCHARGE DATE (HOSPITAL PROVIDER SPELL)</a>		•

**CDS DATA GROUP: CONSULTANT EPISODE - Activity Characteristics:**  
To carry the details of the Delivery Episode undergone by the Patient.  
One occurrence of this Group is permitted.

M	<a href="#">EPISODE NUMBER</a>	R	•
M	<a href="#">LAST EPISODE IN SPELL INDICATOR</a>	R	•
*	<a href="#">ADMINISTRATIVE CATEGORY (AT START OF EPISODE)</a> (Not defined or approved by the Information Standards Board)	R	•
M	<a href="#">OPERATION STATUS</a>	R	•
M	<a href="#">PSYCHIATRIC PATIENT STATUS</a>	R	•
*	<a href="#">LEGAL STATUS CLASSIFICATION CODE (AT START OF EPISODE)</a> (Not defined or approved by the Information Standards Board) (psychiatric patients only)	R	•
M	<a href="#">START DATE (EPISODE)</a>	R	•
M	<a href="#">END DATE (EPISODE)</a> This is the <b>mandatory</b> date used to derive the <b>mandatory</b> <a href="#">CDS ACTIVITY DATE</a> .		•
M	<a href="#">AGE AT CDS ACTIVITY DATE</a>	R	•

**CDS DATA GROUP: CONSULTANT EPISODE - Service Agreement Details:**  
To carry the details of the Service Agreement for the Birth Episode.

M	<a href="#">COMMISSIONING SERIAL NUMBER</a>	R	•
O	<a href="#">NHS SERVICE AGREEMENT LINE NUMBER</a>	R	
O	<a href="#">PROVIDER REFERENCE NUMBER</a>		
M	<a href="#">COMMISSIONER REFERENCE NUMBER</a>	R	
M	<a href="#">ORGANISATION CODE (CODE OF PROVIDER)</a>	R	•
M	<a href="#">ORGANISATION CODE (CODE OF COMMISSIONER)</a>	R	•

**CDS DATA GROUP: CONSULTANT EPISODE - Person Group (Consultant):**  
To carry the details of the responsible Consultant, Midwife or Nurse.  
One occurrence of this Group is permitted.

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M	<a href="#">CONSULTANT CODE</a>		R	•
M	<a href="#">MAIN SPECIALTY CODE</a>		R	•
M	<a href="#">TREATMENT FUNCTION CODE</a>		R	•
<b>CDS DATA GROUP: CONSULTANT EPISODE Clinical Diagnosis Group (ICD):</b> To carry the details of the ICD Diagnoses.				
M	<a href="#">DIAGNOSIS SCHEME IN USE</a>			
M	<a href="#">PRIMARY DIAGNOSIS (ICD)</a>			•
M	<a href="#">SECONDARY DIAGNOSIS (ICD)</a> (Multiple occurrences may be recorded)			•
<b>CDS DATA GROUP: CONSULTANT EPISODE Clinical Diagnosis Group (READ):</b> To carry the details of the READ Diagnoses.				
O	<a href="#">DIAGNOSIS SCHEME IN USE</a>			
O	<a href="#">PRIMARY DIAGNOSIS (READ)</a>			
O	<a href="#">SECONDARY DIAGNOSIS (READ)</a> (Multiple occurrences may be recorded)			
<b>CDS DATA GROUP: CONSULTANT EPISODE - Clinical Activity Group (OPCS):</b> To carry the details of the OPCS coded Clinical Activities.				
M	<a href="#">PROCEDURE SCHEME IN USE</a>			
M	<a href="#">PRIMARY PROCEDURE (OPCS)</a>			•
M	<a href="#">PROCEDURE DATE</a>			•
M	(Multiple occurrences of this sub-group may be recorded)			•
M	<a href="#">PROCEDURE (OPCS)</a>			•
M	<a href="#">PROCEDURE DATE</a>			•
<b>CDS DATA GROUP: CONSULTANT EPISODE - Clinical Activity Group (READ):</b> To carry the details of the READ coded Clinical Activities.				
O	<a href="#">PROCEDURE SCHEME IN USE</a>			
O	<a href="#">PRIMARY PROCEDURE (READ)</a>			
O	<a href="#">PROCEDURE DATE</a>			
O	(Multiple occurrences of this sub-group may be recorded)			
O	<a href="#">PROCEDURE (READ)</a>			
O	<a href="#">PROCEDURE DATE</a>			
<b>CDS DATA GROUP: CONSULTANT EPISODE - Location Group At Start Of Episode:</b> To carry the details of the location at the start of the Delivery Episode. One occurrence of this Group is permitted.				
M	<a href="#">LOCATION CLASS</a>		R	
M	<a href="#">SITE CODE (OF TREATMENT)</a>		R	•
*	<a href="#">LOCATION TYPE</a> Definition and value list under review		R	
O	<a href="#">INTENDED CLINICAL CARE INTENSITY</a>		R	•
O	<a href="#">AGE GROUP INTENDED</a>		R	•
O	<a href="#">SEX OF PATIENTS</a>		R	•
O	<a href="#">WARD DAY PERIOD AVAILABILITY</a>		R	•
O	<a href="#">WARD NIGHT PERIOD AVAILABILITY</a>		R	•
<b>CDS DATA GROUP: CONSULTANT EPISODE - Location Group Of Ward Stay:</b> To carry the details of one or more Ward Stays. Up to 97 occurrences of this Group are permitted.				
O	<a href="#">LOCATION CLASS</a>			
O	<a href="#">SITE CODE (OF TREATMENT)</a>			
*	<a href="#">LOCATION TYPE</a> Definition and value list under review			
O	<a href="#">INTENDED CLINICAL CARE INTENSITY</a>			
O	<a href="#">AGE GROUP INTENDED</a>			
O	<a href="#">SEX OF PATIENTS</a>			
O	<a href="#">WARD DAY PERIOD AVAILABILITY</a>			
O	<a href="#">WARD NIGHT PERIOD AVAILABILITY</a>			
O	<a href="#">START DATE</a>			
O	<a href="#">END DATE</a>			

**CDS DATA GROUP: CONSULTANT EPISODE - Location Group At End Of Episode:**  
 To carry the details of the location at the end of the Delivery Episode.  
 One occurrence of this Group is permitted.

O	<a href="#">LOCATION CLASS</a>		
O	<a href="#">SITE CODE (OF TREATMENT)</a>		
*	<a href="#">LOCATION TYPE</a> Definition and value list under review		
O	<a href="#">INTENDED CLINICAL CARE INTENSITY</a>		
O	<a href="#">AGE GROUP INTENDED</a>		
O	<a href="#">SEX OF PATIENTS</a>		
O	<a href="#">WARD DAY PERIOD AVAILABILITY</a>		
O	<a href="#">WARD NIGHT PERIOD AVAILABILITY</a>		

**CDS DATA GROUP: PAEDIATRIC CRITICAL CARE PERIOD:**  
 To carry the details of the first 9 Critical Care Periods for Paediatric Critical Care.  
 See [CRITICAL CARE ACTIVITY](#)  
 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 be always 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 for the Hospital Provider Spell.

**CDS DATA GROUP: CRITICAL CARE PERIOD - PAEDIATRIC CARE - Admission Characteristics**  
 To carry the details of the Paediatric Critical Care Admission.  
 One occurrence is permitted for each Critical Care Period recorded.

M	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>	R	•
M	<a href="#">CRITICAL CARE START DATE</a>	R	•
M	<a href="#">CRITICAL CARE START TIME</a>	R	•
M	<a href="#">CRITICAL CARE UNIT FUNCTION</a>	R	•

**CDS DATA GROUP: CRITICAL CARE PERIOD - PAEDIATRIC DAILY CARE - Activity Characteristics**  
 To carry the details of the Paediatric Critical Care Activity.  
 Up to 999 daily occurrences per Critical Care Period are supported.

M	<a href="#">ACTIVITY DATE (CRITICAL CARE)</a>	R	•
M	<a href="#">CRITICAL CARE ACTIVITY CODE</a> (up to 20 codes per daily activity occurrence may be recorded)	R	•
M	<a href="#">HIGH COST DRUGS (OPCS)</a> (up to 20 codes per daily activity occurrence may be recorded)	R	•

**CDS DATA GROUP: CRITICAL CARE PERIOD - PAEDIATRIC CARE - Discharge Characteristics**  
 To carry the details of the Discharge from Paediatric Critical Care.  
 One occurrence of this Group is permitted for each Critical Care Period.

M	<a href="#">CRITICAL CARE DISCHARGE DATE</a>	R	•
M	<a href="#">CRITICAL CARE DISCHARGE TIME</a>	R	•

**CDS DATA GROUP: ADULT CRITICAL CARE PERIOD:**  
 To carry the details of the first 9 Critical Care Periods for Adult Critical Care.  
 See [CRITICAL CARE PERIOD](#)  
 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 be always 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 for the Hospital Provider Spell.

**CDS DATA GROUP: CRITICAL CARE PERIOD - ADULT CARE - Admission Characteristics**  
 To carry the details of the Admission to Adult Critical Care.  
 One occurrence of this Group per Critical Care Period is permitted.

M	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>	R	•
M	<a href="#">CRITICAL CARE START DATE</a>	R	•
O	<a href="#">CRITICAL CARE START TIME</a>	R	•
M	<a href="#">CRITICAL CARE UNIT FUNCTION</a>	R	•
O	<a href="#">CRITICAL CARE UNIT BED CONFIGURATION</a>		•
O	<a href="#">CRITICAL CARE ADMISSION SOURCE</a>		•

O	<a href="#">CRITICAL CARE SOURCE LOCATION</a>		•
O	<a href="#">CRITICAL CARE ADMISSION TYPE</a>		•
<b>CDS DATA GROUP: CRITICAL CARE PERIOD - ADULT CARE - Activity Characteristics</b> To carry the details of the Adult Critical Care Activity. One occurrence of this Group per Critical Care Period is permitted.			
M	<a href="#">ADVANCED RESPIRATORY SUPPORT DAYS</a>		•
M	<a href="#">BASIC RESPIRATORY SUPPORT DAYS</a>		•
M	<a href="#">ADVANCED CARDIOVASCULAR SUPPORT DAYS</a>		•
M	<a href="#">BASIC CARDIOVASCULAR SUPPORT DAYS</a>		•
M	<a href="#">RENAL SUPPORT DAYS</a>		•
M	<a href="#">NEUROLOGICAL SUPPORT DAYS</a>		•
O	<a href="#">GASTRO-INTESTINAL SUPPORT DAYS</a>		•
M	<a href="#">DERMATOLOGICAL SUPPORT DAYS</a>		•
M	<a href="#">LIVER SUPPORT DAYS</a>		•
M	<a href="#">ORGAN SUPPORT MAXIMUM</a>		•
M	<a href="#">CRITICAL CARE LEVEL 2 DAYS</a>		•
M	<a href="#">CRITICAL CARE LEVEL 3 DAYS</a>		•
<b>CDS DATA GROUP: CRITICAL CARE PERIOD - ADULT CARE - Discharge Characteristics</b> To carry the details of the Discharge from Adult Critical Care. One occurrence of this Group per Critical Care Period is permitted.			
M	<a href="#">CRITICAL CARE DISCHARGE DATE</a>	R	•
M	<a href="#">CRITICAL CARE DISCHARGE TIME</a>	R	•
O	<a href="#">CRITICAL CARE DISCHARGE READY DATE</a>	R	•
O	<a href="#">CRITICAL CARE DISCHARGE READY TIME</a>	R	•
O	<a href="#">CRITICAL CARE DISCHARGE STATUS</a>	R	•
O	<a href="#">CRITICAL CARE DISCHARGE DESTINATION</a>	R	•
O	<a href="#">CRITICAL CARE DISCHARGE LOCATION</a>	R	•
<b>CDS DATA GROUP: GP REGISTRATION:</b> To carry the Patient's General Medical Practitioner and General Practice details. One occurrence of this Group is permitted.			
O	<a href="#">GENERAL MEDICAL PRACTITIONER (SPECIFIED)</a>	R	•
M	<a href="#">GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)</a>	R	•
<b>CDS DATA GROUP: REFERRAL:</b> To carry the details of the referrer. One occurrence of this Group is permitted.			
M	<a href="#">REFERRER CODE</a>	R	•
M	<a href="#">REFERRING ORGANISATION CODE</a>	R	•
<b>CDS DATA GROUP: PREGNANCY - Activity Characteristics:</b> To carry the details of the Pregnancy. One occurrence of this Group is permitted.			
M	<a href="#">NUMBER OF BABIES</a>	R	•
<b>CDS DATA GROUP: ANTENATAL CARE - Activity Characteristics:</b> To carry the details of the Antenatal Care. One occurrence of this Group is permitted.			
M	<a href="#">FIRST ANTENATAL ASSESSMENT DATE</a>	R	•
<b>CDS DATA GROUP: ANTENATAL CARE - PERSON GROUP - Responsible Clinician:</b> To carry the details of the Clinician responsible for the Antenatal Care. One occurrence of this Group is permitted.			
M	<a href="#">GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE)</a>	R	
O	<a href="#">GENERAL MEDICAL PRACTITIONER PRACTICE (ANTENATAL CARE)</a>	R	
<b>CDS DATA GROUP: ANTENATAL CARE - LOCATION GROUP - Delivery Place Intended:</b> To carry the details of the intended delivery place. One occurrence of this Group is permitted.			
M	<a href="#">LOCATION CLASS</a>	R	
*	<a href="#">LOCATION TYPE</a> Definition and value list under review	R	

M	<a href="#">DELIVERY PLACE CHANGE REASON</a>	R	•
M	<a href="#">DELIVERY PLACE TYPE (INTENDED)</a>	R	•
<b>CDS DATA GROUP: HOSPITAL LABOUR / DELIVERY - Activity Characteristics:</b> To carry the details of the Labour / Delivery. One occurrence of this Group is permitted.			
M	<a href="#">ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY</a>	R	•
M	<a href="#">ANAESTHETIC GIVEN POST LABOUR OR DELIVERY</a>	R	•
O	<a href="#">GESTATION LENGTH (LABOUR ONSET)</a>	R	
M	<a href="#">LABOUR OR DELIVERY ONSET METHOD</a>	R	•
M	<a href="#">DELIVERY DATE</a>	R	
<b>CDS DATA GROUP: BIRTH OCCURRENCE GROUP</b> To carry the details up to 9 Birth Occurrences. Each Data Group consists of the following Sub-Groups: ACTIVITY CHARACTERISTICS (max 1 per Baby) PERSON GROUP (BABY) (max 1 per Baby) LOCATION GROUP (max 1 per Baby)			
<b>CDS DATA GROUP: BIRTH OCCURRENCE - Activity Characteristics:</b> To carry the details of the birth occurrence(s). One occurrence of this Group is permitted for each Birth Occurrence Group, one per baby.			
M	<a href="#">BIRTH ORDER</a>	R	•
M	<a href="#">DELIVERY METHOD</a>	R	•
M	<a href="#">GESTATION LENGTH (ASSESSMENT)</a>	R	•
M	<a href="#">RESUSCITATION METHOD</a>	R	•
M	<a href="#">STATUS OF PERSON CONDUCTING DELIVERY</a>	R	•
<b>CDS DATA GROUP: BIRTH OCCURRENCE - PERSON PATIENT IDENTITY (BABY):</b> To carry the personal details of the baby. One occurrence of this Group is permitted for each Birth Occurrence Group, one per Baby.			
O	<a href="#">LOCAL PATIENT IDENTIFIER (BABY)</a>	R	
O	<a href="#">ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (BABY))</a>	R	
O	<a href="#">NHS NUMBER (BABY)</a>	R	
M	<a href="#">NHS NUMBER STATUS INDICATOR (BABY)</a>	R	
M	<a href="#">PERSON BIRTH DATE (BABY)</a> (From Commissioning Data Set 6-1)	R	•
	<b>Note:</b> For Security Issues and Patient Confidentiality, the baby's name must <b>not</b> be carried where a valid NHS Number is present.  For patients with sensitive conditions (as defined in Security Issues and Patient Confidentiality), all the baby's identifiable information must be removed from Commissioning Data Set records. This includes <a href="#">LOCAL PATIENT IDENTIFIER (BABY)</a> , <a href="#">NHS NUMBER (BABY)</a> and <a href="#">PERSON BIRTH DATE (BABY)</a>		
<b>CDS DATA GROUP: BIRTH OCCURRENCE - PERSON CHARACTERISTICS - (BABY):</b> To carry the characteristics of the baby. One occurrence of this Group is permitted for each Birth Occurrence Group, one per Baby.			
<del>M</del>	<del><a href="#">PERSON BIRTH DATE (BABY)</a></del>	<del>R</del>	<del>•</del>
M	<a href="#">PERSON BIRTH DATE (BABY)</a> (Commissioning Data Set 6-0 only)	R	•
M	<a href="#">PERSON GENDER CURRENT (BABY)</a>	R	•
M	<a href="#">LIVE OR STILL BIRTH</a>	R	•
M	<a href="#">BIRTH WEIGHT</a>	R	•
<b>CDS DATA GROUP: BIRTH OCCURRENCE - LOCATION GROUP:</b> To carry the details of the Actual delivery Place. One occurrence of this Group is permitted for each Baby.			
M	<a href="#">LOCATION CLASS</a>	R	
*	<a href="#">LOCATION TYPE</a> Definition and value list under review	R	
M	<a href="#">DELIVERY PLACE TYPE (ACTUAL)</a>	R	•
<b>CDS DATA GROUP: HEALTHCARE RESOURCE GROUP: - Activity Characteristics:</b>			

To carry the details of the Healthcare Resource Group. One occurrence of this Group is permitted.			
M	HEALTHCARE RESOURCE GROUP CODE		•
M	HEALTHCARE RESOURCE GROUP CODE-VERSION NUMBER		•
CDS DATA GROUP: HEALTHCARE RESOURCE GROUP - Clinical Activity Group: To carry the details of the HRG Dominant Grouping Variable - Procedure. Note that this will not apply when no operation was carried out. In this case, the segment referring to HRG Dominant Grouping Variable - Procedure should be omitted. One Procedure, either OPCS or READ, may be specified.			
O	PROCEDURE SCHEME IN USE		
O	HRG DOMINANT GROUPING VARIABLE-PROCEDURE		•

## CDS V6 TYPE 150

Change to Data Set: Changed Description

### CDS V6 TYPE 150 - ADMITTED PATIENT CARE - OTHER BIRTH EVENT CDS

The Admitted Patient Care Other Birth CDS Type carries the data for an Other Birth.

This CDS Type applies to:

- (i) NHS funded home births, and
- (ii) all other birth events which are not NHS-funded, either directly or under an NHS service agreement.

Maternity events, taking place in either NHS hospitals or in non-NHS hospitals funded by the NHS, will be recorded as ordinary Delivery and Birth episodes. The data in these records come from birth notification records and require only a limited data set to be completed.

The CDS TYPE 150 consists of the following CDS Data Groups:

INTERCHANGE, MESSAGE and CDS TRANSACTION HEADERS and TRAILERS (defined independently)  
 PATIENT PATHWAY  
 PATIENT IDENTITY  
 PATIENT CHARACTERISTICS  
 GP REGISTRATION  
 PREGNANCY  
 ANTENATAL CARE  
 OTHER LABOUR / DELIVERY  
 BIRTH OCCURRENCE

The markers in the columns "OPT, U/A and HES" indicate the NHS recommendations for the inclusion of data:

**M** = Mandatory - data must be included **where** available

**O** = Optional - data need not be included

**\*** = Must **Not** Be Used

**R** in the column headed **U/A** indicates the data is required in the Unfinished Episode / Annual Census of Unfinished Episode record and on an End of Year Census record.

An entry in the column headed **HES** indicates that the data element is extracted from the SUS database for Hospital Episode Statistics. Data extracted for HES purposes contains some derived items. The CDS/HES Cross reference Tables show these derivations.

CDS V6 TYPE 150 - THE OTHER BIRTH EVENT CDS			
CDS DATA GROUP: PATIENT PATHWAY: To carry the details of the Patient Pathway. One optional occurrence of this Group is permitted.			
Opt	CDS data element	U/A	HES
O	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)		
O	PATIENT PATHWAY IDENTIFIER		
O	ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)		
O	REFERRAL TO TREATMENT STATUS		
O	REFERRAL TO TREATMENT PERIOD START DATE		
O	REFERRAL TO TREATMENT PERIOD END DATE		
*	LEAD CARE ACTIVITY INDICATOR (Not defined or approved by the Information Standards Board)		



**CDS DATA GROUP: PATIENT IDENTITY:**

To carry the identity details of the Patient (the BABY).  
One occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
M	<a href="#">LOCAL PATIENT IDENTIFIER</a>		•
M	<a href="#">ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)</a>		
O	<a href="#">NHS NUMBER</a>		•
M	<a href="#">NHS NUMBER STATUS INDICATOR</a>		•
O	<a href="#">PATIENT NAME</a>		
M	<a href="#">PERSON BIRTH DATE</a> (from commissioning data set 6-1)		•

**Note:**

For reasons of confidentiality, the patient's name must **not** be carried where a valid NHS Number is present. For patients with sensitive conditions (as defined in DSCN 41/98/P26), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#), [NHS NUMBER](#), [PATIENT NAME](#), and [PERSON BIRTH DATE](#) (in Patient Characteristics data group below).

Birth Episodes do not carry address details for a baby.

By local agreement it may be assumed that the baby's address details are those of its mother whose details may be carried in the Birth Occurrence Group - Person Group (Mother) data structure.

**Note:**

For Security Issues and Patient Confidentiality, the [PATIENT NAME](#) and [PATIENT USUAL ADDRESS](#) (not including [POSTCODE OF USUAL ADDRESS](#)) must **not** be carried where a valid [NHS NUMBER](#) is present, even if the [NHS NUMBER](#) is not verified.

For patients with sensitive conditions (as defined in Security Issues and Patient Confidentiality), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), and [PERSON BIRTH DATE](#).

Birth Episodes do not carry address details for a baby.

By local agreement it may be assumed that the baby's address details are those of its mother whose details may be carried in the Birth Occurrence Group - Person Group (Mother) data structure.

**CDS DATA GROUP: PATIENT CHARACTERISTICS:**

To carry the characteristics of the Patient (the BABY).  
One occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
<del>M</del>	<del><a href="#">PERSON BIRTH DATE</a></del>		<del>•</del>
M	<a href="#">PERSON BIRTH DATE</a> (commissioning data set 6-0 only)		•
M	<a href="#">PERSON GENDER CURRENT</a>		•
<del>⊖</del>	<del><a href="#">ETHNIC CATEGORY</a></del>		
M	<a href="#">ETHNIC CATEGORY</a>		
M	<a href="#">LIVE OR STILL BIRTH</a>		•
M	<a href="#">BIRTH WEIGHT</a>		•

**CDS DATA GROUP: GP REGISTRATION:**

To carry the Patient's General Medical Practitioner and General Practice details.  
One occurrence of this Group is permitted.

O	<a href="#">GENERAL MEDICAL PRACTITIONER (SPECIFIED)</a>		•
M	<a href="#">GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)</a>		•

**CDS DATA GROUP: PREGNANCY - Activity Characteristics:**

To carry the details of the Pregnancy.  
One occurrence of this Group is permitted.

M	<a href="#">NUMBER OF BABIES</a>		•
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**CDS DATA GROUP: ANTENATAL CARE - Activity Characteristics:**

To carry the details of the Antenatal Care.  
One occurrence of this Group is permitted.

M	<a href="#">FIRST ANTENATAL ASSESSMENT DATE</a>		•
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**CDS DATA GROUP: ANTENATAL CARE - PERSON GROUP - Responsible Clinician:**

To carry the details of the Clinician responsible for the Antenatal Care.  
One occurrence of this Group is permitted.

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M	<a href="#">GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE)</a>		
O	<a href="#">GENERAL MEDICAL PRACTITIONER PRACTICE (ANTENATAL CARE)</a>		
<b>CDS DATA GROUP: ANTENATAL CARE - LOCATION GROUP - Delivery Place Intended:</b> To carry the details of the intended delivery place. One occurrence of this Group is permitted.			
M	<a href="#">LOCATION CLASS</a>		
*	<a href="#">LOCATION TYPE</a> Definition and value list under review		
M	<a href="#">DELIVERY PLACE CHANGE REASON</a>		•
M	<a href="#">DELIVERY PLACE TYPE (INTENDED)</a>		•
<b>CDS DATA GROUP: OTHER LABOUR / DELIVERY - Activity Characteristics:</b> To carry the details of the Labour / Delivery. One occurrence of this Group is permitted.			
M	<a href="#">ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY</a>		•
M	<a href="#">ANAESTHETIC GIVEN POST LABOUR OR DELIVERY</a>		•
O	<a href="#">GESTATION LENGTH (LABOUR ONSET)</a>		
M	<a href="#">LABOUR OR DELIVERY ONSET METHOD</a>		•
M	<a href="#">DELIVERY DATE</a> This is the <b>mandatory</b> date used to derive the <b>mandatory</b> <a href="#">CDS ACTIVITY DATE</a> .		
M	<a href="#">AGE AT CDS ACTIVITY DATE</a>		•
<b>CDS DATA GROUP: OTHER LABOUR / DELIVERY - Service Agreement Details:</b> To carry the details of the Service Agreement for the Birth Episode.			
M	<a href="#">COMMISSIONING SERIAL NUMBER</a>		•
O	<a href="#">NHS SERVICE AGREEMENT LINE NUMBER</a>		
O	<a href="#">PROVIDER REFERENCE NUMBER</a>		
M	<a href="#">COMMISSIONER REFERENCE NUMBER</a>		
M	<a href="#">ORGANISATION CODE (CODE OF PROVIDER)</a>		•
M	<a href="#">ORGANISATION CODE (CODE OF COMMISSIONER)</a>		•
<b>CDS DATA GROUP: BIRTH OCCURRENCE - Activity Characteristics:</b> To carry the details of the birth occurrence. One occurrence of this Group is permitted.			
M	<a href="#">BIRTH ORDER</a>		•
M	<a href="#">DELIVERY METHOD</a>		•
M	<a href="#">GESTATION LENGTH (ASSESSMENT)</a>		•
M	<a href="#">RESUSCITATION METHOD</a>		•
M	<a href="#">STATUS OF PERSON CONDUCTING DELIVERY</a>		•
<b>CDS DATA GROUP: BIRTH OCCURRENCE PERSON IDENTITY (MOTHER):</b> To carry the identity of the baby's mother. One occurrence of this Group is permitted.			
O	<a href="#">LOCAL PATIENT IDENTIFIER (MOTHER)</a>		
O	<a href="#">ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (MOTHER))</a>		
O	<a href="#">NHS NUMBER (MOTHER)</a>		
M	<a href="#">NHS NUMBER STATUS INDICATOR (MOTHER)</a>		
O	<a href="#">PATIENT USUAL ADDRESS (MOTHER)</a>		
M	<a href="#">POSTCODE OF USUAL ADDRESS (MOTHER)</a>		•
M	<a href="#">ORGANISATION CODE (PCT OF RESIDENCE (MOTHER))</a>		•
M	<a href="#">PERSON BIRTH DATE (MOTHER)</a> (from commissioning data set 6-1)		•

**Note:**

Birth Episodes do not carry address details for a baby.

By local agreement it may be assumed that the baby's address details are those of its mother.

**Note:**

For Security Issues and Patient Confidentiality, the mother's name must **not** be carried where a valid NHS Number is present. For patients with sensitive conditions (as defined in Security Issues and Patient Confidentiality), all the mother's identifiable information must be removed from Commissioning Data Set records. This includes LOCAL PATIENT IDENTIFIER (MOTHER), NHS NUMBER (MOTHER), PATIENT USUAL ADDRESS (MOTHER), POSTCODE OF USUAL ADDRESS (MOTHER) and PERSON BIRTH DATE (MOTHER).

**CDS DATA GROUP: BIRTH OCCURRENCE PERSON CHARACTERISTICS (MOTHER):**

To carry the characteristics of the baby's mother.  
One occurrence of this Group is permitted.

**CDS DATA GROUP: BIRTH OCCURRENCE PERSON CHARACTERISTICS (MOTHER):**

To carry the characteristics of the baby's mother.

One occurrence of this Group is permitted.

(commissioning data set 6-0 only)

M	<a href="#">PERSON BIRTH DATE (MOTHER)</a>		
M	<a href="#">PERSON BIRTH DATE (MOTHER)</a> (commissioning data set 6-0 only)		

**CDS DATA GROUP: BIRTH OCCURRENCE - LOCATION GROUP:**

To carry the details of the Actual delivery Place.

One occurrence of this Group is permitted for each Baby.

M	<a href="#">LOCATION CLASS</a>		
*	<a href="#">LOCATION TYPE</a> Definition and value list under review		
M	<a href="#">DELIVERY PLACE TYPE (ACTUAL)</a>		

**CDS V6 TYPE 160**

Change to Data Set: Changed Description

**[CDS V6 TYPE 160 - ADMITTED PATIENT CARE - OTHER DELIVERY EVENT CDS](#)**

The Admitted Patient Care Other Delivery CDS Type carries the data for an Other Delivery.

This CDS Type applies to:

- (i) NHS funded home deliveries, and
- (ii) all other delivery events which are not NHS-funded, either directly or under an NHS service agreement.

Maternity events, taking place in either NHS hospitals or in non-NHS hospitals funded by the NHS, will be recorded as ordinary Delivery and Birth episodes. The data in these records come from birth notification records and require only a limited data set to be completed.

The CDS TYPE 160 consists of the following CDS Data Groups:

INTERCHANGE, MESSAGE and CDS TRANSACTION HEADERS and TRAILERS (defined independently)

PATIENT PATHWAY

PATIENT IDENTITY

PATIENT CHARACTERISTICS

GP REGISTRATION

PREGNANCY

ANTENATAL CARE

OTHER LABOUR / DELIVERY

BIRTH OCCURRENCE (max of 9 Babies)

The markers in the columns "OPT, U/A and HES" indicate the NHS recommendations for the inclusion of data:

**M** = Mandatory - data must be included **where** available

**O** = Optional - data need not be included

**\*** = Must **Not** Be Used

**R** in the column headed **U/A** indicates the data is required in the Unfinished Episode / Annual Census of Unfinished Episode record and on an End of Year Census record.

An entry in the column headed **HES** indicates that the data element is extracted from the SUS database for Hospital Episode Statistics.

Data extracted for HES purposes contains some derived items. The CDS/HES Cross Reference Tables show these derivations.

**CDS V6 TYPE 160 - THE OTHER DELIVERY EVENT CDS****CDS DATA GROUP: PATIENT PATHWAY:**

To carry the details of the Patient Pathway.

One optional occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
O	<a href="#">UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)</a>		
O	<a href="#">PATIENT PATHWAY IDENTIFIER</a>		

O	<a href="#">ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)</a>		
O	<a href="#">REFERRAL TO TREATMENT STATUS</a>		
O	<a href="#">REFERRAL TO TREATMENT PERIOD START DATE</a>		
O	<a href="#">REFERRAL TO TREATMENT PERIOD END DATE</a>		
*	LEAD CARE ACTIVITY INDICATOR (Not defined or approved by the Information Standards Board)		

**CDS DATA GROUP: PATIENT IDENTITY:**  
To carry the identity of the Patient (the MOTHER).  
One occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
M	<a href="#">LOCAL PATIENT IDENTIFIER</a>		•
M	<a href="#">ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)</a>		
M	<a href="#">NHS NUMBER</a>		•
M	<a href="#">NHS NUMBER STATUS INDICATOR</a>		•
O	<a href="#">PATIENT NAME</a>		
O	<a href="#">PATIENT USUAL ADDRESS</a>		
M	<a href="#">POSTCODE OF USUAL ADDRESS</a>		•
M	<a href="#">ORGANISATION CODE (PCT OF RESIDENCE)</a>		•
M	<a href="#">PERSON BIRTH DATE</a> (from commissioning data set 6-1)		•

**Note:-**

For reasons of confidentiality, the patient's preferred name and address (not including the [POSTCODE OF USUAL ADDRESS](#)) must **not** be carried where a valid NHS Number is present. For patients with sensitive conditions (as defined in DSCN 41/98/P26), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), [ORGANISATION CODE \(PCT OF RESIDENCE\)](#) and [PERSON BIRTH DATE](#) (in Patient Characteristics data group below).

**Note:**

For Security Issues and Patient Confidentiality, the mother's name must **not** be carried where a valid NHS Number is present.

For patients with sensitive conditions (as defined in Security Issues and Patient Confidentiality), all the mother's identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER \(MOTHER\)](#), [NHS NUMBER \(MOTHER\)](#), [PATIENT USUAL ADDRESS \(MOTHER\)](#), [POSTCODE OF USUAL ADDRESS \(MOTHER\)](#) and [PERSON BIRTH DATE \(MOTHER\)](#).

**CDS DATA GROUP: PATIENT CHARACTERISTICS:**  
To carry the characteristics of the Patient (the MOTHER).  
One occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
M	<a href="#">PERSON BIRTH DATE</a>		•
M	<a href="#">PERSON BIRTH DATE</a> (commissioning data set 6-0 only)		•
M	<a href="#">PERSON GENDER CURRENT</a>		•
O	<a href="#">CARER SUPPORT INDICATOR</a>		•
M	<a href="#">ETHNIC CATEGORY</a>		•
M	<a href="#">PERSON MARITAL STATUS</a> (psychiatric patients only)		•

**CDS DATA GROUP: DELIVERY CHARACTERISTICS:**  
To carry the delivery characteristics of the Patient (the MOTHER).  
One occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
M	<a href="#">PREGNANCY TOTAL PREVIOUS PREGNANCIES</a>		•

**CDS DATA GROUP: GP REGISTRATION:**  
To carry the Patient's General Medical Practitioner and General Practice details.  
One occurrence of this Group is permitted.

O	<a href="#">GENERAL MEDICAL PRACTITIONER (SPECIFIED)</a>		•
M	<a href="#">GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)</a>		•

**CDS DATA GROUP: PREGNANCY - Activity Characteristics:**  
To carry the details of the Pregnancy.  
One occurrence of this Group is permitted.

M	<a href="#">NUMBER OF BABIES</a>			•
<b>CDS DATA GROUP: ANTENATAL CARE - Activity Characteristics:</b> To carry the details of the Antenatal Care. One occurrence of this Group is permitted.				
M	<a href="#">FIRST ANTENATAL ASSESSMENT DATE</a>			•
<b>CDS DATA GROUP: ANTENATAL CARE - PERSON GROUP - Responsible Clinician:</b> To carry the details of the Clinician responsible for the Antenatal Care. One occurrence of this Group is permitted.				
M	<a href="#">GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE)</a>			
O	<a href="#">GENERAL MEDICAL PRACTITIONER PRACTICE (ANTENATAL CARE)</a>			
<b>CDS DATA GROUP: ANTENATAL CARE - LOCATION GROUP - Delivery Place Intended:</b> To carry the details of the intended delivery place. One occurrence of this Group is permitted.				
M	<a href="#">LOCATION CLASS</a>			
*	<a href="#">LOCATION TYPE</a> Definition and value list under review			
M	<a href="#">DELIVERY PLACE CHANGE REASON</a>			•
M	<a href="#">DELIVERY PLACE TYPE (INTENDED)</a>			•
<b>CDS DATA GROUP: OTHER LABOUR / DELIVERY - Activity Characteristics:</b> To carry the details of the Labour / Delivery. One occurrence of this Group is permitted.				
M	<a href="#">ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY</a>			•
M	<a href="#">ANAESTHETIC GIVEN POST LABOUR OR DELIVERY</a>			•
O	<a href="#">GESTATION LENGTH (LABOUR ONSET)</a>			
M	<a href="#">LABOUR OR DELIVERY ONSET METHOD</a>			•
M	<a href="#">DELIVERY DATE</a> This is the <b>mandatory</b> date used to derive the <b>mandatory</b> <a href="#">CDS ACTIVITY DATE</a> .			
M	<a href="#">AGE AT CDS ACTIVITY DATE</a>			•
<b>CDS DATA GROUP: OTHER LABOUR / DELIVERY - Service Agreement Details:</b> To carry the details of the Service Agreement for the Delivery Episode.				
M	<a href="#">COMMISSIONING SERIAL NUMBER</a>			•
O	<a href="#">NHS SERVICE AGREEMENT LINE NUMBER</a>			
O	<a href="#">PROVIDER REFERENCE NUMBER</a>			
M	<a href="#">COMMISSIONER REFERENCE NUMBER</a>			
M	<a href="#">ORGANISATION CODE (CODE OF PROVIDER)</a>			•
M	<a href="#">ORGANISATION CODE (CODE OF COMMISSIONER)</a>			•
<b>CDS DATA GROUP: BIRTH OCCURRENCE GROUP</b> To carry the details of the birth occurrence(s). Up to 9 Birth Occurrence Data Groups are permitted. Each Data Group consists of the following Sub-Groups: ACTIVITY CHARACTERISTICS (max 1) PERSON GROUP (BABY) (max 1) LOCATION GROUP (max 1)				
<b>CDS DATA GROUP: BIRTH OCCURRENCE - Activity Characteristics:</b> To carry the details of the birth occurrence. One occurrence of this Group is permitted for each baby.				
M	<a href="#">BIRTH ORDER</a>			•
M	<a href="#">DELIVERY METHOD</a>			•
M	<a href="#">GESTATION LENGTH (ASSESSMENT)</a>			•
M	<a href="#">RESUSCITATION METHOD</a>			•
M	<a href="#">STATUS OF PERSON CONDUCTING DELIVERY</a>			•
<b>CDS DATA GROUP: BIRTH OCCURRENCE PERSON IDENTITY - BABY:</b> To carry the identity details of each baby. One occurrence of this Group is permitted for each baby.				
O	<a href="#">LOCAL PATIENT IDENTIFIER (BABY)</a>			
O	<a href="#">ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (BABY))</a>			
O	<a href="#">NHS NUMBER (BABY)</a>			
M	<a href="#">NHS NUMBER STATUS INDICATOR (BABY)</a>			

M	PERSON BIRTH DATE (BABY) (From Commissioning Data Set 6-1)		•
	<b>Note:</b> For <u>Security Issues and Patient Confidentiality</u> , the baby's name must <b>not</b> be carried where a valid NHS Number is present.  For patients with sensitive conditions (as defined in <u>Security Issues and Patient Confidentiality</u> ), all the baby's identifiable information must be removed from Commissioning Data Set records. This includes <u>LOCAL PATIENT IDENTIFIER (BABY)</u> , <u>NHS NUMBER (BABY)</u> and <u>PERSON BIRTH DATE (BABY)</u>		
<b>CDS DATA GROUP: BIRTH OCCURRENCE PERSON CHARACTERISTICS - BABY:</b> To carry the birth characteristics details of each baby. One occurrence of this Group is permitted for each baby.			
<del>M</del>	<del>PERSON BIRTH DATE (BABY)</del>		←
M	PERSON BIRTH DATE (BABY) (Commissioning Data Set 6-0 only)		•
M	PERSON GENDER CURRENT (BABY)		•
M	LIVE OR STILL BIRTH		•
M	BIRTH WEIGHT		•
<b>CDS DATA GROUP: BIRTH OCCURRENCE - LOCATION GROUP:</b> To carry the details of the Actual delivery Place. One occurrence of this Group is permitted for each Baby.			
M	LOCATION CLASS		
*	LOCATION TYPE Definition and value list under review		
M	DELIVERY PLACE TYPE (ACTUAL)		•

## CDS V6 TYPE 170

Change to Data Set: Changed Description

## CDS V6 TYPE 170 - ADMITTED PATIENT CARE - DETAINED AND/OR LONG TERM PSYCHIATRIC CENSUS CDS

The Detained and/or Long Term Psychiatric CDS Type carries the data for the Psychiatric Census.

This is a snapshot of a General Episode unfinished as at 31 March each year for which the patient is detained or the Episode is part of a Hospital Provider Spell which has lasted longer than one year and for which the majority of time has been spent under the care of a Consultant in one of the psychiatric specialties.

In the case of Trust mergers and demergers occurring, where the Hospital provider Spell would have lasted longer than one year except for the merger / demerger, patients should be included. The Organisation Code (Code of Provider) will be that of the organisation in existence as at the 31 March Census date.

The CDS TYPE 170 consists of the following CDS Data Groups:

INTERCHANGE, MESSAGE and CDS TRANSACTION HEADERS and TRAILERS (shown independently)

PATIENT PATHWAY

PATIENT IDENTITY

PATIENT CHARACTERISTICS

PATIENT PSYCHIATRIC CHARACTERISTICS

HOSPITAL PROVIDER SPELL

CONSULTANT EPISODE

GP REGISTRATION

REFERRAL

EAL ENTRY

HEALTHCARE RESOURCE GROUP

The markers in the columns "OPT, U/A and HES" indicate the NHS recommendations for the inclusion of data:

**M** = Mandatory - data must be included **where** available

**O** = Optional - data need not be included

**\*** = Must **Not** Be Used

**R** in the column headed **U/A** indicates the data is required in the Unfinished Episode / Annual Census of Unfinished Episode record and on an End of Year Census record.

An entry in the column headed **HES** indicates that the data element is extracted from the SUS database for Hospital Episode Statistics.

Data extracted for HES purposes contains some derived items. The CDS/HES Cross reference Tables show these derivations.

**CDS V6 TYPE 170 - THE DETAINED and/or LONG TERM PSYCHIATRIC CDS**

**CDS DATA GROUP: PATIENT PATHWAY:**  
To carry the details of the Patient Pathway.  
One optional occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
O	<a href="#">UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)</a>		
O	<a href="#">PATIENT PATHWAY IDENTIFIER</a>		
O	<a href="#">ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)</a>		
O	<a href="#">REFERRAL TO TREATMENT STATUS</a>		
O	<a href="#">REFERRAL TO TREATMENT PERIOD START DATE</a>		
O	<a href="#">REFERRAL TO TREATMENT PERIOD END DATE</a>		
*	LEAD CARE ACTIVITY INDICATOR (Not defined or approved by the Information Standards Board)		

**CDS DATA GROUP: PATIENT IDENTITY:**  
To carry the Identity details of the Patient.  
One occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
M	<a href="#">LOCAL PATIENT IDENTIFIER</a>		•
M	<a href="#">ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)</a>		
M	<a href="#">NHS NUMBER</a>		•
M	<a href="#">NHS NUMBER STATUS INDICATOR</a>		•
O	<a href="#">PATIENT NAME</a>		
O	<a href="#">PATIENT USUAL ADDRESS</a>		
M	<a href="#">POSTCODE OF USUAL ADDRESS</a>		•
M	<a href="#">ORGANISATION CODE (PCT OF RESIDENCE)</a>		•
M	<a href="#">PERSON BIRTH DATE</a> (from commissioning data set 6-1)		•

**Note:**

For reasons of confidentiality, the patient's preferred name and address (not including [POSTCODE OF USUAL ADDRESS](#)) must **not** be carried where a valid NHS Number is present. For patients with sensitive conditions (as defined in DSCN 41/98/P26), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), [ORGANISATION CODE \(PCT OF RESIDENCE\)](#) and [PERSON BIRTH DATE](#) (in Patient Characteristics data group below).

**Note:**

For Security Issues and Patient Confidentiality, the [PATIENT NAME](#) and [PATIENT USUAL ADDRESS](#) (not including [POSTCODE OF USUAL ADDRESS](#)) must not be carried where a valid [NHS NUMBER](#) is present, even if the [NHS NUMBER](#) is not verified.

For patients with sensitive conditions (as defined in Security Issues and Patient Confidentiality), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), and [PERSON BIRTH DATE](#).

**CDS DATA GROUP: PATIENT CHARACTERISTICS:**  
To carry the Characteristics of the Patient.  
One occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
<del>M</del>	<del><a href="#">PERSON BIRTH DATE</a></del>		<del>•</del>
M	<a href="#">PERSON BIRTH DATE</a> (commissioning data set 6-0 only)		•
M	<a href="#">PERSON GENDER CURRENT</a>		•
O	<a href="#">CARER SUPPORT INDICATOR</a>		•
M	<a href="#">ETHNIC CATEGORY</a>		•
M	<a href="#">PERSON MARITAL STATUS</a>		•
M	<a href="#">LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)</a>		•

**CDS DATA GROUP: PSYCHIATRIC PATIENT CHARACTERISTICS:**

**To carry the Psychiatric Characteristics of the Patient.  
One occurrence of this Group is permitted.**

Opt	CDS data element	U/A	HES
M	<a href="#">LEGAL STATUS CLASSIFICATION CODE (AT CENSUS DATE)</a>		•
M	<a href="#">DATE DETENTION COMMENCED</a>		•
M	<a href="#">AGE AT CENSUS</a>		•
M	<a href="#">DURATION OF CARE TO PSYCHIATRIC CENSUS DATE</a>		•
M	<a href="#">DURATION OF DETENTION</a>		•
M	<a href="#">MENTAL CATEGORY</a>		•
M	<a href="#">MENTAL CATEGORY</a> (For PATIENTS detained under the Mental Health Act prior to Mental Health Act 2007)		•
M	<a href="#">MENTAL HEALTH ACT 2007 MENTAL CATEGORY</a> (For PATIENTS detained under the Mental Health Act 2007)		•
M	<a href="#">STATUS OF PATIENT INCLUDED IN THE PSYCHIATRIC CENSUS</a>		•

**CDS DATA GROUP: HOSPITAL PROVIDER SPELL - Activity Characteristics:  
To carry the details of the Spell containing the Consultant Episode.  
One occurrence of this Group is permitted.**

M	<a href="#">HOSPITAL PROVIDER SPELL NUMBER</a>	R	•
M	<a href="#">ADMINISTRATIVE CATEGORY (ON ADMISSION)</a>	R	•
M	<a href="#">PATIENT CLASSIFICATION</a>	R	•
M	<a href="#">ADMISSION METHOD (HOSPITAL PROVIDER SPELL)</a>	R	•
M	<a href="#">SOURCE OF ADMISSION (HOSPITAL PROVIDER SPELL)</a>	R	•
M	<a href="#">START DATE (HOSPITAL PROVIDER SPELL)</a>	R	•
M	<a href="#">AGE ON ADMISSION</a>	R	•

**CDS DATA GROUP: CONSULTANT EPISODE - Activity Characteristics:  
To carry the details of the Consultant Episode on the Census Date.  
One occurrence of this Group is permitted.**

M	<a href="#">EPISODE NUMBER</a>	R	•
*	<a href="#">ADMINISTRATIVE CATEGORY (AT START OF EPISODE)</a> (Not defined or approved by the Information Standards Board)	R	•
M	<a href="#">PSYCHIATRIC PATIENT STATUS</a>	R	•
M	<a href="#">START DATE (EPISODE)</a>	R	•
M	<a href="#">DETAINED AND (OR) LONG TERM PSYCHIATRIC CENSUS DATE</a> From CDS Version 6 onwards this is the <b>mandatory</b> date used to derive the <b>mandatory</b> <a href="#">CDS ACTIVITY DATE</a> .	R	•

**CDS DATA GROUP: CONSULTANT EPISODE - Service Agreement Details:  
To carry the details of the Service Agreement for the Consultant Episode on the Census Date.**

M	<a href="#">COMMISSIONING SERIAL NUMBER</a>	R	•
O	<a href="#">NHS SERVICE AGREEMENT LINE NUMBER</a>	R	
O	<a href="#">PROVIDER REFERENCE NUMBER</a>		
M	<a href="#">COMMISSIONER REFERENCE NUMBER</a>		
M	<a href="#">ORGANISATION CODE (CODE OF PROVIDER)</a>	R	•
M	<a href="#">ORGANISATION CODE (CODE OF COMMISSIONER)</a>	R	•

**CDS DATA GROUP: CONSULTANT EPISODE - Person Group (Consultant):  
To carry the details of the responsible Consultant on the Census Date.  
One occurrence of this Group is permitted.**

M	<a href="#">CONSULTANT CODE</a>	R	•
M	<a href="#">MAIN SPECIALTY CODE</a>	R	•
M	<a href="#">TREATMENT FUNCTION CODE</a>	R	•

**CDS DATA GROUP: CONSULTANT EPISODE Clinical Diagnosis Group (ICD):  
To carry the details of the ICD Diagnoses.**

M	<a href="#">DIAGNOSIS SCHEME IN USE</a>		
M	<a href="#">PRIMARY DIAGNOSIS (ICD)</a>		•
M	<a href="#">SECONDARY DIAGNOSIS (ICD)</a> (Multiple occurrences may be recorded)		•



CDS DATA GROUP: CONSULTANT EPISODE Clinical Diagnosis Group (READ): To carry the details of the READ Diagnoses.			
O	<a href="#">DIAGNOSIS SCHEME IN USE</a>		
O	<a href="#">PRIMARY DIAGNOSIS (READ)</a>		
O	<a href="#">SECONDARY DIAGNOSIS (READ)</a> (Multiple occurrences may be recorded)		
CDS DATA GROUP: CONSULTANT EPISODE - Location Group At Start Of Episode: To carry the details of the location at the start of the Consultant Episode. One occurrence of this Group is permitted.			
M	<a href="#">LOCATION CLASS</a>		
M	<a href="#">SITE CODE (OF TREATMENT)</a> (at Start of Episode)		•
*	<a href="#">LOCATION TYPE</a> Definition and value list under review		
O	<a href="#">INTENDED CLINICAL CARE INTENSITY</a>		•
O	<a href="#">AGE GROUP INTENDED</a>		•
O	<a href="#">SEX OF PATIENTS</a>		•
O	<a href="#">WARD DAY PERIOD AVAILABILITY</a>		•
O	<a href="#">WARD NIGHT PERIOD AVAILABILITY</a>		•
CDS DATA GROUP: CONSULTANT EPISODE - Location Group - Ward Stay At Census Date: To carry the details of the location of the Consultant Episode at the Census Date. One occurrence of this Group is permitted.			
M	<a href="#">LOCATION CLASS</a>		
M	<a href="#">SITE CODE (OF TREATMENT)</a> (at Census Date)		•
*	<a href="#">LOCATION TYPE</a> Definition and value list under review		
M	<a href="#">INTENDED CLINICAL CARE INTENSITY</a>		•
M	<a href="#">AGE GROUP INTENDED</a>		•
M	<a href="#">SEX OF PATIENTS</a>		•
M	<a href="#">WARD DAY PERIOD AVAILABILITY</a>		•
M	<a href="#">WARD NIGHT PERIOD AVAILABILITY</a>		•
O	<a href="#">DETAINED AND (OR) LONG TERM PSYCHIATRIC CENSUS DATE</a> (From CDS version 6 onwards, use of this date in this position is <b>optional</b> as the DETAINED AND (OR) LONG TERM PSYCHIATRIC CENSUS DATE <b>must</b> be carried in the Episode Characteristics.)		•
CDS DATA GROUP: GP REGISTRATION: To carry the Patient's General Medical Practitioner and General Practice details. One occurrence of this Group is permitted.			
O	<a href="#">GENERAL MEDICAL PRACTITIONER (SPECIFIED)</a>	R	•
M	<a href="#">GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)</a>	R	•
CDS DATA GROUP: REFERRAL: To carry the details of the referrer. One occurrence of this Group is permitted.			
M	<a href="#">REFERRER CODE</a>	R	•
M	<a href="#">REFERRING ORGANISATION CODE</a>	R	•
CDS DATA GROUP: ELECTIVE ADMISSION LIST ENTRY: To carry the details of the Elective Admission List Entry. One occurrence of this Group is permitted.			
M	<a href="#">DURATION OF ELECTIVE WAIT</a>	R	•
M	<a href="#">INTENDED MANAGEMENT</a>	R	•
M	<a href="#">DECIDED TO ADMIT DATE</a> (for this provider)	R	•
O	<a href="#">EARLIEST REASONABLE OFFER DATE</a>	R	•
CDS DATA GROUP: HEALTHCARE RESOURCE GROUP - Activity Characteristics: To carry the details of the Healthcare Resource Group. One occurrence of this Group is permitted.			
O	<a href="#">HEALTHCARE RESOURCE GROUP CODE</a>		•
O	<a href="#">HEALTHCARE RESOURCE GROUP CODE-VERSION NUMBER</a>		•
CDS DATA GROUP: HEALTHCARE RESOURCE GROUP - Clinical Activity Group: To carry the details of the HRG Dominant Grouping Variable - Procedure. Note that this will not apply when no operation			

was carried out. In this case, the segment referring to HRG Dominant Grouping Variable - Procedure should be omitted. One Procedure, either OPCS or READ, may be specified.

O	<a href="#">PROCEDURE SCHEME IN USE</a>		
O	<a href="#">HRG DOMINANT GROUPING VARIABLE-PROCEDURE</a>		•

## CDS V6 TYPE 180

Change to Data Set: Changed Description

### [CDS V6 TYPE 180 - ADMITTED PATIENT CARE - UNFINISHED BIRTH EPISODE CDS](#)

The Unfinished Birth Episode Commissioning Data Set carries the data for an Unfinished Birth Episode which is required when a delivery has resulted in a registrable birth. This may take place in either NHS Hospitals or in non-NHS organisations funded by the NHS. The information is taken from the birth notification for each baby born.

An Unfinished Birth Episode CDS record is required for all Unfinished Birth Episodes at midnight on 31 March each year.

The CDS TYPE 180 consists of the following CDS Data Groups:

INTERCHANGE, MESSAGE and CDS TRANSACTION HEADERS and TRAILERS (defined independently)

PATIENT PATHWAY

PATIENT IDENTITY

PATIENT CHARACTERISTICS

HOSPITAL PROVIDER SPELL

CONSULTANT EPISODE

CRITICAL CARE PERIOD

GP REGISTRATION

REFERRAL

PREGNANCY

ANTENATAL CARE

HOSPITAL LABOUR / DELIVERY

BIRTH OCCURRENCE

HEALTHCARE RESOURCE GROUP

The markers in the columns "OPT, U/A and HES" indicate the NHS recommendations for the inclusion of data:

**M** = Mandatory - data must be included **where** available

**O** = Optional - data need not be included

**\*** = Must **Not** Be Used

**R** in the column headed **U/A** indicates the data is required in the Unfinished Episode / Annual Census of Unfinished Episode record and on an End of Year Census record.

An entry in the column headed **HES** indicates that the data element is extracted from the SUS database for Hospital Episode Statistics. Data extracted for HES purposes contains some derived items. The CDS/HES Cross Reference Tables show these derivations.

### CDS V6 TYPE 180 - THE UNFINISHED BIRTH EPISODE CDS

**CDS DATA GROUP: PATIENT PATHWAY:**  
To carry the details of the Patient Pathway.  
One optional occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
O	<a href="#">UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)</a>		
O	<a href="#">PATIENT PATHWAY IDENTIFIER</a>		
O	<a href="#">ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)</a>		
O	<a href="#">REFERRAL TO TREATMENT STATUS</a>		
O	<a href="#">REFERRAL TO TREATMENT PERIOD START DATE</a>		
O	<a href="#">REFERRAL TO TREATMENT PERIOD END DATE</a>		
*	LEAD CARE ACTIVITY INDICATOR (Not defined or approved by the Information Standards Board)		

**CDS DATA GROUP: PATIENT IDENTITY:**  
To carry the identity of the Patient (the BABY).  
One occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
M	<a href="#">LOCAL PATIENT IDENTIFIER</a>	R	•

M	<a href="#">ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)</a>	R	
O	<a href="#">NHS NUMBER</a>	R	•
M	<a href="#">NHS NUMBER STATUS INDICATOR</a>	R	•
O	<a href="#">PATIENT NAME</a>	R	
M	<a href="#">PERSON BIRTH DATE</a> (from commissioning data set 6-1)	R	•

**Note:-**

For reasons of confidentiality, the patient's name must **not** be carried where a valid NHS Number is present. For patients with sensitive conditions (as defined in DSCN 41/98/P26), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#), [NHS NUMBER](#), [PATIENT NAME](#), and [PERSON BIRTH DATE](#) (in Patient Characteristics data group below).

Birth Episodes do not carry address details for a baby.

By local agreement it may be assumed that the baby's address details are those of its mother whose details may be carried in the Birth Occurrence Group - Person Group (Mother) data structure.

**Note:**

For Security Issues and Patient Confidentiality, the [PATIENT NAME](#) and [PATIENT USUAL ADDRESS](#) (not including [POSTCODE OF USUAL ADDRESS](#)) must not be carried where a valid [NHS NUMBER](#) is present, even if the [NHS NUMBER](#) is not verified.

For patients with sensitive conditions (as defined in Security Issues and Patient Confidentiality), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), and [PERSON BIRTH DATE](#).

**CDS DATA GROUP: PATIENT CHARACTERISTICS:**  
To carry the characteristics of the Patient (the BABY).  
One occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
<del>M</del>	<del><a href="#">PERSON BIRTH DATE</a></del>	<del>R</del>	<del>•</del>
M	<a href="#">PERSON BIRTH DATE</a> (commissioning data set 6-0 only)	R	•
M	<a href="#">PERSON GENDER CURRENT</a>	R	•
<del>⊖</del>	<del><a href="#">ETHNIC CATEGORY</a></del>	<del>R</del>	
M	<a href="#">ETHNIC CATEGORY</a>	R	
M	<a href="#">LIVE OR STILL BIRTH</a>	R	•
M	<a href="#">BIRTH WEIGHT</a>	R	•

**CDS DATA GROUP: HOSPITAL PROVIDER SPELL - Admission Characteristics:**  
To carry the Admission details of the Spell containing the Birth Episode.  
One occurrence of this Group is permitted.

M	<a href="#">HOSPITAL PROVIDER SPELL NUMBER</a>	R	•
M	<a href="#">ADMINISTRATIVE CATEGORY (ON ADMISSION)</a>	R	•
M	<a href="#">PATIENT CLASSIFICATION</a>	R	•
M	<a href="#">ADMISSION METHOD (HOSPITAL PROVIDER SPELL)</a>	R	•
M	<a href="#">SOURCE OF ADMISSION (HOSPITAL PROVIDER SPELL)</a>	R	•
M	<a href="#">START DATE (HOSPITAL PROVIDER SPELL)</a>	R	•
M	<a href="#">AGE ON ADMISSION</a>	R	•

**CDS DATA GROUP: HOSPITAL PROVIDER SPELL - Discharge Characteristics:**  
To carry the Discharge details of the Spell containing the Birth Episode.  
One occurrence of this Group is permitted.

M	<a href="#">DISCHARGE DESTINATION (HOSPITAL PROVIDER SPELL)</a>		•
M	<a href="#">DISCHARGE METHOD (HOSPITAL PROVIDER SPELL)</a>		•
O	<a href="#">DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL)</a>		•
M	<a href="#">DISCHARGE DATE (HOSPITAL PROVIDER SPELL)</a>		•

**CDS DATA GROUP: CONSULTANT EPISODE - Activity Characteristics:**  
To carry the details of the Birth Episode undergone by the Patient.  
One occurrence of this Group is permitted.

M	<a href="#">EPISODE NUMBER</a>	R	•
M	<a href="#">LAST EPISODE IN SPELL INDICATOR</a>	R	•

*	<a href="#">ADMINISTRATIVE CATEGORY (AT START OF EPISODE)</a> (Not defined or approved by the Information Standards Board)	R	•
M	<a href="#">OPERATION STATUS</a>	R	•
O	<a href="#">NEONATAL LEVEL OF CARE</a>	R	•
M	<a href="#">START DATE (EPISODE)</a> This is the <b>mandatory</b> date used to derive the <b>mandatory</b> <a href="#">CDS ACTIVITY DATE</a>	R	•
M	<a href="#">END DATE (EPISODE)</a>		•
M	<a href="#">AGE AT CDS ACTIVITY DATE</a>	R	•
<b>CDS DATA GROUP: CONSULTANT EPISODE - Service Agreement Details:</b> To carry the details of the Service Agreement for the Birth Episode.			
M	<a href="#">COMMISSIONING SERIAL NUMBER</a>	R	•
O	<a href="#">NHS SERVICE AGREEMENT LINE NUMBER</a>	R	
O	<a href="#">PROVIDER REFERENCE NUMBER</a>		
M	<a href="#">COMMISSIONER REFERENCE NUMBER</a>	R	
M	<a href="#">ORGANISATION CODE (CODE OF PROVIDER)</a>	R	•
M	<a href="#">ORGANISATION CODE (CODE OF COMMISSIONER)</a>	R	•
<b>CDS DATA GROUP: CONSULTANT EPISODE - Person Group (Consultant):</b> To carry the details of the responsible Consultant, Midwife or Nurse. One occurrence of this Group is permitted.			
M	<a href="#">CONSULTANT CODE</a>	R	•
M	<a href="#">MAIN SPECIALTY CODE</a>	R	•
M	<a href="#">TREATMENT FUNCTION CODE</a>	R	•
<b>CDS DATA GROUP: CONSULTANT EPISODE Clinical Diagnosis Group (ICD):</b> To carry the details of the ICD Diagnoses.			
M	<a href="#">DIAGNOSIS SCHEME IN USE</a>		
M	<a href="#">PRIMARY DIAGNOSIS (ICD)</a>		•
M	<a href="#">SECONDARY DIAGNOSIS (ICD)</a> (Multiple occurrences may be recorded)		•
<b>CDS DATA GROUP: CONSULTANT EPISODE Clinical Diagnosis Group (READ):</b> To carry the details of the READ Diagnoses.			
O	<a href="#">DIAGNOSIS SCHEME IN USE</a>		
O	<a href="#">PRIMARY DIAGNOSIS (READ)</a>		
O	<a href="#">SECONDARY DIAGNOSIS (READ)</a> (Multiple occurrences may be recorded)		
<b>CDS DATA GROUP: CONSULTANT EPISODE - Clinical Activity Group (OPCS):</b> To carry the details of the OPCS coded Clinical Activities.			
M	<a href="#">PROCEDURE SCHEME IN USE</a>		
M	<a href="#">PRIMARY PROCEDURE (OPCS)</a>		•
M	<a href="#">PROCEDURE DATE</a>		•
M	(Multiple occurrences of this sub-group may be recorded) <a href="#">PROCEDURE (OPCS)</a>		•
M	<a href="#">PROCEDURE DATE</a>		•
<b>CDS DATA GROUP: CONSULTANT EPISODE - Clinical Activity Group (READ):</b> To carry the details of the READ coded Clinical Activities.			
O	<a href="#">PROCEDURE SCHEME IN USE</a>		
O	<a href="#">PRIMARY PROCEDURE (READ)</a>		
O	<a href="#">PROCEDURE DATE</a>		
O	(Multiple occurrences of this sub-group may be recorded) <a href="#">PROCEDURE (READ)</a>		
O	<a href="#">PROCEDURE DATE</a>		
<b>CDS DATA GROUP: CONSULTANT EPISODE - Location Group At Start Of Episode:</b> To carry the details of the location at the start of the Birth Episode. One occurrence of this Group is permitted.			
M	<a href="#">LOCATION CLASS</a>	R	
M	<a href="#">SITE CODE (OF TREATMENT)</a>	R	•
*	<a href="#">LOCATION TYPE</a> Definition and value list under review	R	

O	<a href="#">INTENDED CLINICAL CARE INTENSITY</a>	R	•
O	<a href="#">AGE GROUP INTENDED</a>	R	•
O	<a href="#">SEX OF PATIENTS</a>	R	•
O	<a href="#">WARD DAY PERIOD AVAILABILITY</a>	R	•
O	<a href="#">WARD NIGHT PERIOD AVAILABILITY</a>	R	•

**CDS DATA GROUP: CONSULTANT EPISODE - Location Group Of Ward Stay:**  
 To carry the details of one or more Ward Stays.  
 Up to 97 occurrences of this Group are permitted.

M	<a href="#">LOCATION CLASS</a>		
M	<a href="#">SITE CODE (OF TREATMENT)</a>		
*	<a href="#">LOCATION TYPE</a> Definition and value list under review		
O	<a href="#">INTENDED CLINICAL CARE INTENSITY</a>		
O	<a href="#">AGE GROUP INTENDED</a>		
O	<a href="#">SEX OF PATIENTS</a>		
O	<a href="#">WARD DAY PERIOD AVAILABILITY</a>		
O	<a href="#">WARD NIGHT PERIOD AVAILABILITY</a>		
O	<a href="#">START DATE</a> (at Start of Ward Stay)		
O	<a href="#">END DATE</a> (at End of Ward Stay)		

**CDS DATA GROUP: CONSULTANT EPISODE - Location Group At End Of Episode:**  
 To carry the details of the location at the end of the Birth Episode.  
 One occurrence of this Group is permitted.

M	<a href="#">LOCATION CLASS</a>		
M	<a href="#">SITE CODE (OF TREATMENT)</a>		
*	<a href="#">LOCATION TYPE</a> Definition and value list under review		
O	<a href="#">INTENDED CLINICAL CARE INTENSITY</a>		
O	<a href="#">AGE GROUP INTENDED</a>		
O	<a href="#">SEX OF PATIENTS</a>		
O	<a href="#">WARD DAY PERIOD AVAILABILITY</a>		
O	<a href="#">WARD NIGHT PERIOD AVAILABILITY</a>		

**CDS DATA GROUP: NEONATAL CRITICAL CARE PERIOD:**  
 To carry the details of the first 9 Critical Care Periods for Neonatal Critical Care.  
 See [CRITICAL CARE PERIOD](#)  
 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 for the Hospital Provider Spell.

**CDS DATA GROUP: NEONATAL CRITICAL CARE PERIOD: Admission Characteristics**  
 To carry the details of the Neonatal Critical Care Admission.  
 One occurrence is permitted for each Critical Care Period recorded.

M	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>	R	•
M	<a href="#">CRITICAL CARE START DATE</a>	R	•
M	<a href="#">CRITICAL CARE START TIME</a>	R	•
M	<a href="#">CRITICAL CARE UNIT FUNCTION</a>	R	•
M	<a href="#">GESTATION LENGTH (AT DELIVERY)</a>	R	•

**CDS DATA GROUP: NEONATAL CRITICAL CARE PERIOD: Care Activity Characteristics**  
 To carry the daily occurrence details of the Neonatal Critical Care Activity.  
 Up to 999 daily occurrences per Critical Care Period are supported.

M	<a href="#">ACTIVITY DATE (CRITICAL CARE)</a>	R	•
M	<a href="#">PERSON WEIGHT</a>	R	•
M	<a href="#">CRITICAL CARE ACTIVITY CODE</a> (up to 20 Codes per daily occurrence may be recorded)	R	•
M	<a href="#">HIGH COST DRUGS (OPCS)</a> (up to 20 Codes per daily occurrence may be recorded)	R	•

<b>CDS DATA GROUP: NEONATAL CRITICAL CARE PERIOD: Discharge Characteristics</b>			
To carry the details of the Discharge from Neonatal Critical Care. One occurrence of this Group is permitted per Critical Care Period.			
M	<a href="#">CRITICAL CARE DISCHARGE DATE</a>	R	•
M	<a href="#">CRITICAL CARE DISCHARGE TIME</a>	R	•
<b>CDS DATA GROUP: PAEDIATRIC CRITICAL CARE PERIOD:</b>			
To carry the details of the first 9 Critical Care Periods for Paediatric Critical Care. See <a href="#">CRITICAL CARE PERIOD</a> 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 for the Hospital Provider Spell.			
<b>CDS DATA GROUP: PAEDIATRIC CRITICAL CARE PERIOD: Admission Characteristics</b>			
To carry the details of the Paediatric Critical Care Admission. One occurrence is permitted for each Critical Care Period recorded.			
M	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>	R	•
M	<a href="#">CRITICAL CARE START DATE</a>	R	•
M	<a href="#">CRITICAL CARE START TIME</a>	R	•
M	<a href="#">CRITICAL CARE UNIT FUNCTION</a>	R	•
<b>CDS DATA GROUP: PAEDIATRIC CRITICAL CARE PERIOD: Care Activity Characteristics</b>			
To carry the daily occurrence details of the Paediatric Critical Care Activity. Up to 999 daily occurrences per Critical Care Period are supported.			
M	<a href="#">ACTIVITY DATE (CRITICAL CARE)</a>	R	•
M	<a href="#">CRITICAL CARE ACTIVITY CODE</a> (up to 20 Codes per daily occurrence may be recorded)	R	•
M	<a href="#">HIGH COST DRUGS (OPCS)</a> (up to 20 Codes per daily occurrence may be recorded)	R	•
<b>CDS DATA GROUP: PAEDIATRIC CRITICAL CARE PERIOD: Discharge Characteristics</b>			
To carry the details of the Discharge from Paediatric Critical Care. One occurrence of this Group per Critical Care Period is permitted.			
M	<a href="#">CRITICAL CARE DISCHARGE DATE</a>	R	•
M	<a href="#">CRITICAL CARE DISCHARGE TIME</a>	R	•
<b>CDS DATA GROUP: ADULT CRITICAL CARE PERIOD:</b>			
To carry the details of the first 9 Critical Care Periods for Adult Critical Care. See <a href="#">CRITICAL CARE PERIOD</a> 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 for the Hospital Provider Spell.			
<b>CDS DATA GROUP: ADULT CRITICAL CARE PERIOD: Admission Characteristics</b>			
To carry the details of the Adult Critical Care Admission. One occurrence is permitted for each Critical Care Period recorded.			
M	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>	R	•
M	<a href="#">CRITICAL CARE START DATE</a>	R	•
O	<a href="#">CRITICAL CARE START TIME</a>	R	•
M	<a href="#">CRITICAL CARE UNIT FUNCTION</a>	R	•
O	<a href="#">CRITICAL CARE UNIT BED CONFIGURATION</a>		
O	<a href="#">CRITICAL CARE ADMISSION SOURCE</a>		
O	<a href="#">CRITICAL CARE SOURCE LOCATION</a>		
O	<a href="#">CRITICAL CARE ADMISSION TYPE</a>		
<b>CDS DATA GROUP: ADULT CRITICAL CARE PERIOD: Care Activity Characteristics</b>			
To carry the details of the Adult Critical Care Activity. One occurrence per Critical Care Period is supported.			
M	<a href="#">ADVANCED RESPIRATORY SUPPORT DAYS</a>		•
M	<a href="#">BASIC RESPIRATORY SUPPORT DAYS</a>		•
M	<a href="#">ADVANCED CARDIOVASCULAR SUPPORT DAYS</a>		•
M	<a href="#">BASIC CARDIOVASCULAR SUPPORT DAYS</a>		•

M	<a href="#">RENAL SUPPORT DAYS</a>		•
M	<a href="#">NEUROLOGICAL SUPPORT DAYS</a>		•
O	<a href="#">GASTRO-INTESTINAL SUPPORT DAYS</a>		•
M	<a href="#">DERMATOLOGICAL SUPPORT DAYS</a>		•
M	<a href="#">LIVER SUPPORT DAYS</a>		•
M	<a href="#">ORGAN SUPPORT MAXIMUM</a>		•
M	<a href="#">CRITICAL CARE LEVEL 2 DAYS</a>		•
M	<a href="#">CRITICAL CARE LEVEL 3 DAYS</a>		•
<b>CDS DATA GROUP: ADULT CRITICAL CARE PERIOD: Discharge Characteristics</b> To carry the details of the Discharge from Adult Critical Care. One occurrence of this Group is permitted.			
M	<a href="#">CRITICAL CARE DISCHARGE DATE</a>	R	•
M	<a href="#">CRITICAL CARE DISCHARGE TIME</a>	R	•
O	<a href="#">CRITICAL CARE DISCHARGE READY DATE</a>		
O	<a href="#">CRITICAL CARE DISCHARGE READY TIME</a>		
O	<a href="#">CRITICAL CARE DISCHARGE STATUS</a>		
O	<a href="#">CRITICAL CARE DISCHARGE DESTINATION</a>		
O	<a href="#">CRITICAL CARE DISCHARGE LOCATION</a>		
<b>CDS DATA GROUP: GP REGISTRATION:</b> To carry the Patient's General Medical Practitioner and General Practice details. One occurrence of this Group is permitted.			
O	<a href="#">GENERAL MEDICAL PRACTITIONER (SPECIFIED)</a>	R	•
M	<a href="#">GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)</a>	R	•
<b>CDS DATA GROUP: REFERRAL:</b> To carry the details of the referrer. One occurrence of this Group is permitted.			
M	<a href="#">REFERRER CODE</a>	R	•
M	<a href="#">REFERRING ORGANISATION CODE</a>	R	•
<b>CDS DATA GROUP: PREGNANCY - Activity Characteristics:</b> To carry the details of the Pregnancy. One occurrence of this Group is permitted.			
M	<a href="#">NUMBER OF BABIES</a>	R	•
<b>CDS DATA GROUP: ANTENATAL CARE - Activity Characteristics:</b> To carry the details of the Antenatal Care. One occurrence of this Group is permitted.			
M	<a href="#">FIRST ANTENATAL ASSESSMENT DATE</a>	R	•
<b>CDS DATA GROUP: ANTENATAL CARE - PERSON GROUP - Responsible Clinician:</b> To carry the details of the Clinician responsible for the Antenatal Care. One occurrence of this Group is permitted.			
M	<a href="#">GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE)</a>	R	
O	<a href="#">GENERAL MEDICAL PRACTITIONER PRACTICE (ANTENATAL CARE)</a>	R	
<b>CDS DATA GROUP: ANTENATAL CARE - LOCATION GROUP - Delivery Place Intended:</b> To carry the details of the intended delivery place. One occurrence of this Group is permitted.			
M	<a href="#">LOCATION CLASS</a>	R	
*	<a href="#">LOCATION TYPE</a> Definition and value list under review	R	
M	<a href="#">DELIVERY PLACE CHANGE REASON</a>	R	•
M	<a href="#">DELIVERY PLACE TYPE (INTENDED)</a>	R	•
<b>CDS DATA GROUP: HOSPITAL LABOUR / DELIVERY - Activity Characteristics:</b> To carry the details of the Labour / Delivery. One occurrence of this Group is permitted.			
M	<a href="#">ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY</a>	R	•
M	<a href="#">ANAESTHETIC GIVEN POST LABOUR OR DELIVERY</a>	R	•
O	<a href="#">GESTATION LENGTH (LABOUR ONSET)</a>	R	•
M	<a href="#">LABOUR OR DELIVERY ONSET METHOD</a>	R	•

M	<a href="#">DELIVERY DATE</a>	R	•
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**CDS DATA GROUP: BIRTH OCCURRENCE - Activity Characteristics:**  
To carry the details of the birth occurrence.  
One occurrence of this Group is permitted.

M	<a href="#">BIRTH ORDER</a>	R	•
M	<a href="#">DELIVERY METHOD</a>	R	•
M	<a href="#">GESTATION LENGTH (ASSESSMENT)</a>	R	•
M	<a href="#">RESUSCITATION METHOD</a>	R	•
M	<a href="#">STATUS OF PERSON CONDUCTING DELIVERY</a>	R	•

**CDS DATA GROUP: BIRTH OCCURRENCE PERSON GROUP - (MOTHER):**  
To carry the identity of the baby's mother.  
One occurrence of this Group is permitted.

O	<a href="#">LOCAL PATIENT IDENTIFIER (MOTHER)</a>	R	
O	<a href="#">ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (MOTHER))</a>	R	
O	<a href="#">NHS NUMBER (MOTHER)</a>	R	
M	<a href="#">NHS NUMBER STATUS INDICATOR (MOTHER)</a>	R	
O	<a href="#">PATIENT USUAL ADDRESS (MOTHER)</a>		
M	<a href="#">POSTCODE OF USUAL ADDRESS (MOTHER)</a>	R	•
<del>M</del>	<del><a href="#">ORGANISATION CODE (PCT OF RESIDENCE (MOTHER))</a></del>	<del>R</del>	<del>•</del>
M	<a href="#">ORGANISATION CODE (PCT OF RESIDENCE (MOTHER))</a>	R	•
M	<a href="#">PERSON BIRTH DATE (MOTHER)</a> (From Commissioning Data Set 6-1)	R	•

**Note:**

Birth Episodes do not carry address details for a baby.  
By local agreement it may be assumed that the baby's address details are those of its mother.

**Note:**

For Security Issues and Patient Confidentiality, the mother's name must not be carried where a valid NHS Number is present.

For patients with sensitive conditions (as defined in Security Issues and Patient Confidentiality), all the mother's identifiable information must be removed from Commissioning Data Set records. This includes LOCAL PATIENT IDENTIFIER (MOTHER), NHS NUMBER (MOTHER), PATIENT USUAL ADDRESS (MOTHER), POSTCODE OF USUAL ADDRESS (MOTHER) and PERSON BIRTH DATE (MOTHER).

**CDS DATA GROUP: BIRTH OCCURRENCE PERSON CHARACTERISTICS - (MOTHER):**  
To carry the characteristics of the baby's mother.  
One occurrence of this Group is permitted.

<del>M</del>	<del><a href="#">PERSON BIRTH DATE (MOTHER)</a></del>	<del>R</del>	<del>•</del>
M	<a href="#">PERSON BIRTH DATE (MOTHER)</a> (Commissioning Data Set 6-0 only)	R	•

**CDS DATA GROUP: BIRTH OCCURRENCE - LOCATION GROUP - Delivery Place Actual:**  
To carry the details of the actual delivery place.  
One occurrence of this Group is permitted.

M	<a href="#">LOCATION CLASS</a>		
*	<a href="#">LOCATION TYPE</a> Definition and value list under review		
M	<a href="#">DELIVERY PLACE TYPE (ACTUAL)</a>	R	•

**CDS DATA GROUP: HEALTHCARE RESOURCE GROUP: - Activity Characteristics:**  
To carry the details of the Healthcare Resource Group.  
One occurrence of this Group is permitted.

O	<a href="#">HEALTHCARE RESOURCE GROUP CODE</a>		•
O	<a href="#">HEALTHCARE RESOURCE GROUP CODE-VERSION NUMBER</a>		•

**CDS DATA GROUP: HEALTHCARE RESOURCE GROUP - Clinical Activity Group:**  
To carry the details of the HRG Dominant Grouping Variable - Procedure. Note that this will not apply when no operation was carried out. In this case, the segment referring to HRG Dominant Grouping Variable - Procedure should be omitted.  
One Procedure, either OPCS or READ, may be specified.

O	<a href="#">PROCEDURE SCHEME IN USE</a>		
O	<a href="#">HRG DOMINANT GROUPING VARIABLE-PROCEDURE</a>		•



## CDS V6 TYPE 190

Change to Data Set: Changed Description

### [CDS V6 TYPE 190 - ADMITTED PATIENT CARE - UNFINISHED GENERAL EPISODE CDS](#)

The Admitted Patient Care Unfinished General Episode Commissioning Data Set Type carries the data for an Unfinished General Consultant/ Midwife/ Nurse Episode.

It covers all NHS and private Admitted Patient Care (day case and inpatient) activity taking place in any acute, community, psychiatric NHS Trust or Primary Care Trust or other NHS hospital under the care of a consultant, midwife or nurse. Additionally, NHS funded Admitted Patient Care taking place in non-NHS hospitals and institutions is required.

An Unfinished General Episode CDS record is required for all Unfinished General Episodes at midnight on 31 March each year. Unfinished General Episode CDS records are also required for short-stay informal psychiatric patients who are resident in hospital or on leave of absence (home leave) on 31 March and who have been in hospital for less than 12 months.

The CDS TYPE 190 consists of the following CDS Data Groups:

INTERCHANGE, MESSAGE and CDS TRANSACTION HEADERS and TRAILERS (shown independently)

PATIENT PATHWAY

PATIENT IDENTITY

PATIENT CHARACTERISTICS

HOSPITAL PROVIDER SPELL

CONSULTANT EPISODE

CRITICAL CARE PERIOD

GP REGISTRATION

REFERRAL

EAL ENTRY

HEALTHCARE RESOURCE GROUP

The markers in the columns "OPT, U/A and HES" indicate the NHS recommendations for the inclusion of data:

**M** = Mandatory - data must be included **where** available

**O** = Optional - data need not be included

**\*** = Must **Not** Be Used

**R** in the column headed **U/A** indicates the data is required in the Unfinished Episode / Annual Census of Unfinished Episode record and on an End of Year Census record.

An entry in the column headed **HES** indicates that the data element is extracted from the SUS database for Hospital Episode Statistics. Data extracted for HES purposes contains some derived items. The CDS/HES Cross Reference Tables show these derivations.

#### CDS V6 TYPE 190 - THE UNFINISHED GENERAL EPISODE CDS

**CDS DATA GROUP: PATIENT PATHWAY:**  
To carry the details of the Patient Pathway.  
One optional occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
O	<a href="#">UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)</a>		
O	<a href="#">PATIENT PATHWAY IDENTIFIER</a>		
O	<a href="#">ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)</a>		
O	<a href="#">REFERRAL TO TREATMENT STATUS</a>		
O	<a href="#">REFERRAL TO TREATMENT PERIOD START DATE</a>		
O	<a href="#">REFERRAL TO TREATMENT PERIOD END DATE</a>		
*	LEAD CARE ACTIVITY INDICATOR (Not defined or approved by the Information Standards Board)		

**CDS DATA GROUP: PATIENT IDENTITY:**  
To carry the identity details of the Patient.  
One occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
M	<a href="#">LOCAL PATIENT IDENTIFIER</a>	R	•
M	<a href="#">ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)</a>	R	
M	<a href="#">NHS NUMBER</a>	R	•
M	<a href="#">NHS NUMBER STATUS INDICATOR</a>	R	•
O	<a href="#">PATIENT NAME</a>	R	

O	<a href="#">PATIENT USUAL ADDRESS</a>	R	
M	<a href="#">POSTCODE OF USUAL ADDRESS</a>	R	•
M	<a href="#">ORGANISATION CODE (PCT OF RESIDENCE)</a>	R	•
M	<a href="#">PERSON BIRTH DATE</a> (from commissioning data set 6-1)	R	•

**Note:**

For reasons of confidentiality, the patient's preferred name and address (not including [POSTCODE OF USUAL ADDRESS](#)) must **not** be carried where a valid NHS Number is present. For patients with sensitive conditions (as defined in DSCN 41/98/P26), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), [ORGANISATION CODE \(PCT OF RESIDENCE\)](#) and [PERSON BIRTH DATE](#) (in Patient Characteristics data group below).

**Note:**

For Security Issues and Patient Confidentiality, the [PATIENT NAME](#) and [PATIENT USUAL ADDRESS](#) (not including [POSTCODE OF USUAL ADDRESS](#)) must not be carried where a valid [NHS NUMBER](#) is present, even if the [NHS NUMBER](#) is not verified.

For patients with sensitive conditions (as defined in Security Issues and Patient Confidentiality), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), and [PERSON BIRTH DATE](#).

**CDS DATA GROUP: PATIENT CHARACTERISTICS:**

To carry the characteristics of the Patient.  
One occurrence of this Group is permitted.

M	<a href="#">PERSON BIRTH DATE</a>	R	•
M	<a href="#">PERSON BIRTH DATE</a> (commissioning data set 6-0 only)	R	•
M	<a href="#">PERSON GENDER CURRENT</a>	R	•
O	<a href="#">CARER SUPPORT INDICATOR</a>	R	•
M	<a href="#">ETHNIC CATEGORY</a>	R	•
M	<a href="#">MARITAL STATUS</a> (psychiatric patients only)	R	•
M	<a href="#">LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)</a> (psychiatric patients only)	R	•

**CDS DATA GROUP: HOSPITAL PROVIDER SPELL - Admission Characteristics:**

To carry the details of the Spell containing the Episode.  
One occurrence of this Group is permitted.

M	<a href="#">HOSPITAL PROVIDER SPELL NUMBER</a>	R	•
M	<a href="#">ADMINISTRATIVE CATEGORY (ON ADMISSION)</a>	R	•
M	<a href="#">PATIENT CLASSIFICATION</a>	R	•
M	<a href="#">ADMISSION METHOD (HOSPITAL PROVIDER SPELL)</a>	R	•
M	<a href="#">SOURCE OF ADMISSION (HOSPITAL PROVIDER SPELL)</a>	R	•
M	<a href="#">START DATE (HOSPITAL PROVIDER SPELL)</a>	R	•
M	<a href="#">AGE ON ADMISSION</a>	R	•

**CDS DATA GROUP: HOSPITAL PROVIDER SPELL - Discharge Characteristics:**

To carry the discharge details of the Spell containing the Episode.  
One occurrence of this Group is permitted.

M	<a href="#">DISCHARGE DESTINATION (HOSPITAL PROVIDER SPELL)</a>		•
M	<a href="#">DISCHARGE METHOD (HOSPITAL PROVIDER SPELL)</a>		•
O	<a href="#">DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL)</a>		•
M	<a href="#">DISCHARGE DATE (HOSPITAL PROVIDER SPELL)</a>		•

**CDS DATA GROUP: CONSULTANT EPISODE - Activity Characteristics:**

To carry the details of the Episode undergone by the Patient.  
One occurrence of this Group is permitted.

M	<a href="#">EPISODE NUMBER</a>	R	•
M	<a href="#">LAST EPISODE IN SPELL INDICATOR</a>	R	•
*	<a href="#">ADMINISTRATIVE CATEGORY (AT START OF EPISODE)</a> (Not defined or approved by the Information Standards Board)	R	•

M	<a href="#">OPERATION STATUS</a>	R	•
O	<a href="#">NEONATAL LEVEL OF CARE</a>	R	•
O	<a href="#">FIRST REGULAR DAY OR NIGHT ADMISSION</a>	R	•
M	<a href="#">PSYCHIATRIC PATIENT STATUS</a>	R	•
*	<a href="#">LEGAL STATUS CLASSIFICATION CODE (AT START OF EPISODE)</a> (Not defined or approved by the Information Standards Board) (psychiatric patients only)	R	•
M	<a href="#">START DATE (EPISODE)</a> This is the <b>mandatory</b> date used to derive the <b>mandatory</b> <a href="#">CDS ACTIVITY DATE</a>	R	•
M	<a href="#">END DATE (EPISODE)</a>		•
M	<a href="#">AGE AT CDS ACTIVITY DATE</a>		•

**CDS DATA GROUP: CONSULTANT EPISODE - Service Agreement Details:**  
To carry the details of the Service Agreement for the Episode.

M	<a href="#">COMMISSIONING SERIAL NUMBER</a>	R	•
O	<a href="#">NHS SERVICE AGREEMENT LINE NUMBER</a>	R	
O	<a href="#">PROVIDER REFERENCE NUMBER</a>		
M	<a href="#">COMMISSIONER REFERENCE NUMBER</a>	R	
M	<a href="#">ORGANISATION CODE (CODE OF PROVIDER)</a>	R	•
M	<a href="#">ORGANISATION CODE (CODE OF COMMISSIONER)</a>	R	•

**CDS DATA GROUP: CONSULTANT EPISODE - Person Group (Consultant):**  
To carry the details of the responsible Consultant, Midwife or Nurse.  
One occurrence of this Group is permitted.

M	<a href="#">CONSULTANT CODE</a>	R	•
M	<a href="#">MAIN SPECIALTY CODE</a>	R	•
M	<a href="#">TREATMENT FUNCTION CODE</a>	R	•

**CDS DATA GROUP: CONSULTANT EPISODE Clinical Diagnosis Group (ICD):**  
To carry the details of the ICD Diagnoses.

M	<a href="#">DIAGNOSIS SCHEME IN USE</a>		
M	<a href="#">PRIMARY DIAGNOSIS (ICD)</a>		•
M	<a href="#">SECONDARY DIAGNOSIS (ICD)</a> (Multiple occurrences may be recorded)		•

**CDS DATA GROUP: CONSULTANT EPISODE Clinical Diagnosis Group (READ):**  
To carry the details of the READ Diagnoses.

O	<a href="#">DIAGNOSIS SCHEME IN USE</a>		
O	<a href="#">PRIMARY DIAGNOSIS (READ)</a>		
O	<a href="#">SECONDARY DIAGNOSIS (READ)</a> (Multiple occurrences may be recorded)		

**CDS DATA GROUP: CONSULTANT EPISODE - Clinical Activity Group (OPCS):**  
To carry the details of the OPCS coded Clinical Activities.

M	<a href="#">PROCEDURE SCHEME IN USE</a>		
M	<a href="#">PRIMARY PROCEDURE (OPCS)</a>		•
M	<a href="#">PROCEDURE DATE</a>		•
M	(Multiple occurrences of this sub-group may be recorded)		•
M	<a href="#">PROCEDURE (OPCS)</a>		•
M	<a href="#">PROCEDURE DATE</a>		•

**CDS DATA GROUP: CONSULTANT EPISODE - Clinical Activity Group (READ):**  
To carry the details of the READ coded Clinical Activities.

O	<a href="#">PROCEDURE SCHEME IN USE</a>		
O	<a href="#">PRIMARY PROCEDURE (READ)</a>		
O	<a href="#">PROCEDURE DATE</a>		
O	(Multiple occurrences of this sub-group may be recorded)		
O	<a href="#">PROCEDURE (READ)</a>		
O	<a href="#">PROCEDURE DATE</a>		

**CDS DATA GROUP: CONSULTANT EPISODE - Location Group At Start Of Episode:**  
To carry the details of the location at the start of the Episode.  
One occurrence of this Group is permitted.

M	<a href="#">LOCATION CLASS</a>	R	
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M	<a href="#">SITE CODE (OF TREATMENT)</a>	R	•
O	<a href="#">LOCATION TYPE</a> This is currently for piloting purposes	R	
O	<a href="#">INTENDED CLINICAL CARE INTENSITY</a>	R	•
O	<a href="#">AGE GROUP INTENDED</a>	R	•
O	<a href="#">SEX OF PATIENTS</a>	R	•
O	<a href="#">WARD DAY PERIOD AVAILABILITY</a>	R	•
O	<a href="#">WARD NIGHT PERIOD AVAILABILITY</a>	R	•

**CDS DATA GROUP: CONSULTANT EPISODE - Location Group Of Ward Stay:**  
To carry the details of one or more Ward Stays.  
Up to 97 occurrences of this Group are permitted.

M	<a href="#">LOCATION CLASS</a>		
M	<a href="#">SITE CODE (OF TREATMENT)</a>		
*	<a href="#">LOCATION TYPE</a> Definition and value list under review		
O	<a href="#">INTENDED CLINICAL CARE INTENSITY</a>		
O	<a href="#">AGE GROUP INTENDED</a>		
O	<a href="#">SEX OF PATIENTS</a>		
O	<a href="#">WARD DAY PERIOD AVAILABILITY</a>		
O	<a href="#">WARD NIGHT PERIOD AVAILABILITY</a>		
O	<a href="#">START DATE</a>		
O	<a href="#">END DATE</a>		

**CDS DATA GROUP: CONSULTANT EPISODE - Location Group At End Of Episode:**  
To carry the details of the location at the end of the Episode.  
One occurrence of this Group is permitted.

M	<a href="#">LOCATION CLASS</a>		
M	<a href="#">SITE CODE (OF TREATMENT)</a>		
*	<a href="#">LOCATION TYPE</a> Definition and value list under review		
O	<a href="#">INTENDED CLINICAL CARE INTENSITY</a>		
O	<a href="#">AGE GROUP INTENDED</a>		
O	<a href="#">SEX OF PATIENTS</a>		
O	<a href="#">WARD DAY PERIOD AVAILABILITY</a>		
O	<a href="#">WARD NIGHT PERIOD AVAILABILITY</a>		

**CDS DATA GROUP: NEONATAL CRITICAL CARE PERIOD:**  
To carry the details of the first 9 Critical Care Periods for Neonatal Critical Care.  
See [CRITICAL CARE PERIOD](#)

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 for the Hospital Provider Spell.

**CDS DATA GROUP: CRITICAL CARE PERIOD - NEONATAL CARE - Admission Characteristics**  
To carry the details of the Admission to Adult Neonatal Care.  
One occurrence is permitted for each Critical Care Period recorded.

M	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>	R	•
M	<a href="#">CRITICAL CARE START DATE</a>	R	•
M	<a href="#">CRITICAL CARE START TIME</a>	R	•
M	<a href="#">CRITICAL CARE UNIT FUNCTION</a>	R	•
M	<a href="#">GESTATION LENGTH (AT DELIVERY)</a>		•

**CDS DATA GROUP: CRITICAL CARE PERIOD - NEONATAL DAILY CARE - Activity Characteristics**  
To carry the details of the Neonatal Critical Care Activity.  
Up to 999 daily occurrences per Critical Care Period are supported.

M	<a href="#">ACTIVITY DATE (CRITICAL CARE)</a>	R	•
O	<a href="#">PERSON WEIGHT</a>	R	•
M	<a href="#">CRITICAL CARE ACTIVITY CODE</a>	R	•

	(up to 20 Codes may be recorded per daily occurrence)		
M	<a href="#">HIGH COST DRUGS (OPCS)</a> (up to 20 Codes may be recorded per daily occurrence)	R	•

**CDS DATA GROUP: CRITICAL CARE PERIOD - NEONATAL CARE - Discharge Characteristics**

To carry the details of the Discharge from Neonatal Critical Care.

One occurrence of this Group is permitted.

M	<a href="#">CRITICAL CARE DISCHARGE DATE</a>	R	•
M	<a href="#">CRITICAL CARE DISCHARGE TIME</a>	R	•

**CDS DATA GROUP: PAEDIATRIC CRITICAL CARE PERIOD:**

To carry the details of the first 9 Critical Care Periods for Paediatric Critical Care.

See [CRITICAL CARE PERIOD](#)

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 for the Hospital Provider Spell.

**CDS DATA GROUP: CRITICAL CARE PERIOD - PAEDIATRIC CARE - Admission Characteristics**

To carry the details of the Admission to Paediatric Critical Care.

One occurrence is permitted for each Critical Care Period recorded.

M	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>	R	•
M	<a href="#">CRITICAL CARE START DATE</a>	R	•
M	<a href="#">CRITICAL CARE START TIME</a>	R	•
M	<a href="#">CRITICAL CARE UNIT FUNCTION</a>	R	•

**CDS DATA GROUP: CRITICAL CARE PERIOD - PAEDIATRIC DAILY CARE - Activity Characteristics**

To carry the details of the Paediatric Critical Care Activity.

Up to 999 daily occurrences per Critical Care Period are supported.

M	<a href="#">ACTIVITY DATE (CRITICAL CARE)</a>	R	•
M	<a href="#">CRITICAL CARE ACTIVITY CODE</a> (up to 20 Codes may be recorded per daily occurrence)	R	•
M	<a href="#">HIGH COST DRUGS (OPCS)</a> (up to 20 Codes may be recorded per daily occurrence)	R	•

**CDS DATA GROUP: CRITICAL CARE PERIOD - PAEDIATRIC CARE - Discharge Characteristics**

To carry the details of the Discharge from Paediatric Critical Care.

One occurrence of this Group is permitted for each Critical Care Period.

M	<a href="#">CRITICAL CARE DISCHARGE DATE</a>	R	•
M	<a href="#">CRITICAL CARE DISCHARGE TIME</a>	R	•

**CDS DATA GROUP: CRITICAL CARE PERIOD - ADULT CARE:**

To carry the details of the first 9 Critical Care Periods for Adult Critical Care.

See [CRITICAL CARE PERIOD](#)

Where there are multiple Critical Care Periods within the Consultant Episode then only the first 9 Critical Care Periods should be included.

The Critical Care Period may overlap Consultant/ Midwife/ Nurse 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 Consultant/ Midwife/ Nurse Episode.

CRITICAL CARE START DATE, CRITICAL CARE LOCAL IDENTIFIER and CRITICAL CARE UNIT FUNCTION must always be present. 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 for the Hospital Provider Spell.

**CDS DATA GROUP: CRITICAL CARE PERIOD - ADULT CARE - Admission Characteristics**

To carry the details of the Admission to Adult Critical Care.

One occurrence is permitted for each Critical Care Period recorded.

M	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>	R	•
M	<a href="#">CRITICAL CARE START DATE</a>	R	•
O	<a href="#">CRITICAL CARE START TIME</a>	R	•
M	<a href="#">CRITICAL CARE UNIT FUNCTION</a>	R	•
O	<a href="#">CRITICAL CARE UNIT BED CONFIGURATION</a>		•
O	<a href="#">CRITICAL CARE ADMISSION SOURCE</a>		•
O	<a href="#">CRITICAL CARE SOURCE LOCATION</a>		•

O	CRITICAL CARE ADMISSION TYPE			•
<b>CDS DATA GROUP: CRITICAL CARE PERIOD - ADULT CARE - Activity Characteristics</b> To carry the details of the Adult Critical Care Activity. Up to 9 occurrences are supported.				
M	ADVANCED RESPIRATORY SUPPORT DAYS			•
M	BASIC RESPIRATORY SUPPORT DAYS			•
M	ADVANCED CARDIOVASCULAR SUPPORT DAYS			•
M	BASIC CARDIOVASCULAR SUPPORT DAYS			•
M	RENAL SUPPORT DAYS			•
M	NEUROLOGICAL SUPPORT DAYS			•
O	GASTRO-INTESTINAL SUPPORT DAYS			•
M	DERMATOLOGICAL SUPPORT DAYS			•
M	LIVER SUPPORT DAYS			•
M	ORGAN SUPPORT MAXIMUM			•
M	CRITICAL CARE LEVEL 2 DAYS			•
M	CRITICAL CARE LEVEL 3 DAYS			•
<b>CDS DATA GROUP: CRITICAL CARE PERIOD - ADULT CARE - Discharge Characteristics</b> To carry the details of the Discharge from Adult Critical Care. One occurrence of this Group is permitted.				
M	CRITICAL CARE DISCHARGE DATE	R		•
M	CRITICAL CARE DISCHARGE TIME	R		•
O	CRITICAL CARE DISCHARGE READY DATE	R		•
O	CRITICAL CARE DISCHARGE READY TIME	R		•
O	CRITICAL CARE DISCHARGE STATUS	R		•
O	CRITICAL CARE DISCHARGE DESTINATION	R		•
O	CRITICAL CARE DISCHARGE LOCATION	R		•
<b>CDS DATA GROUP: GP REGISTRATION:</b> To carry the Patient's General Medical Practitioner and General Practice details. One occurrence of this Group is permitted.				
O	GENERAL MEDICAL PRACTITIONER (SPECIFIED)	R		•
M	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	R		•
<b>CDS DATA GROUP: REFERRAL:</b> To carry the details of the referrer. One occurrence of this Group is permitted.				
M	REFERRER CODE	R		•
M	REFERRING ORGANISATION CODE	R		•
<b>CDS DATA GROUP: ELECTIVE ADMISSION LIST:</b> To carry the details of the Elective Admission List Entry. One occurrence of this Group is permitted.				
M	DURATION OF ELECTIVE WAIT	R		•
M	INTENDED MANAGEMENT	R		•
M	DECIDED TO ADMIT DATE	R		•
O	EARLIEST REASONABLE OFFER DATE	R		•
<b>CDS DATA GROUP: HEALTHCARE RESOURCE GROUP - Activity Characteristics:</b> To carry the details of the Healthcare Resource Group. One occurrence of this Group is permitted.				
O	HEALTHCARE RESOURCE GROUP CODE			•
O	HEALTHCARE RESOURCE GROUP CODE-VERSION NUMBER			•
<b>CDS DATA GROUP: HEALTHCARE RESOURCE GROUP - Clinical Activity Group:</b> To carry the details of the HRG Dominant Grouping Variable - Procedure. Note that this will not apply when no operation was carried out. In this case, the segment referring to HRG Dominant Grouping Variable - Procedure should be omitted. One Procedure, either OPCS or READ, may be specified.				
O	PROCEDURE SCHEME IN USE			
O	HRG DOMINANT GROUPING VARIABLE-PROCEDURE			•

## CDS V6 TYPE 200 - ADMITTED PATIENT CARE - UNFINISHED DELIVERY EPISODE CDS

The Admitted Patient Care Unfinished Delivery Episode Commissioning Data Set Type carries the data for an Unfinished Delivery Episode. This may take place in either NHS Hospitals or in non-NHS organisations funded by the NHS. The information is taken from the birth notification for each baby born.

An Unfinished Delivery Episode CDS record is required for all Unfinished Birth Episodes at midnight on 31 March each year.

The CDS TYPE 200 consists of the following CDS Data Groups:

INTERCHANGE, MESSAGE and CDS TRANSACTION HEADERS and TRAILERS (defined independently)

PATIENT PATHWAY

PATIENT IDENTITY

PATIENT CHARACTERISTICS

PATIENT DELIVERY CHARACTERISTICS

HOSPITAL PROVIDER SPELL

CONSULTANT EPISODE

CRITICAL CARE PERIOD

GP REGISTRATION

REFERRAL

PREGNANCY

ANTENATAL CARE

HOSPITAL LABOUR / DELIVERY

BIRTH OCCURRENCE

HEALTHCARE RESOURCE GROUP

The markers in the columns "OPT, U/A and HES" indicate the NHS recommendations for the inclusion of data:

**M** = Mandatory - data must be included **where** available

**O** = Optional - data need not be included

**\*** = Must **Not** Be Used

**R** in the column headed **U/A** indicates the data is required in the Unfinished Episode / Annual Census of Unfinished Episode record and on an End of Year Census record.

An entry in the column headed **HES** indicates that the data element is extracted from the SUS database for Hospital Episode Statistics.

Data extracted for HES purposes contains some derived items. The CDS/HES Cross Reference Tables show these derivations.

### CDS V6 TYPE 200 - THE UNFINISHED DELIVERY EPISODE CDS

**CDS DATA GROUP: PATIENT PATHWAY:**  
To carry the details of the Patient Pathway.  
One optional occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
O	<a href="#">UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)</a>		
O	<a href="#">PATIENT PATHWAY IDENTIFIER</a>		
O	<a href="#">ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)</a>		
O	<a href="#">REFERRAL TO TREATMENT STATUS</a>		
O	<a href="#">REFERRAL TO TREATMENT PERIOD START DATE</a>		
O	<a href="#">REFERRAL TO TREATMENT PERIOD END DATE</a>		
*	LEAD CARE ACTIVITY INDICATOR (Not defined or approved by the Information Standards Board)		

**CDS DATA GROUP: PATIENT IDENTITY:**  
To carry Identity details of the Patient (the MOTHER).  
One occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
M	<a href="#">LOCAL PATIENT IDENTIFIER</a>	R	•
M	<a href="#">ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)</a>	R	
M	<a href="#">NHS NUMBER</a>	R	•
M	<a href="#">NHS NUMBER STATUS INDICATOR</a>	R	•
O	<a href="#">PATIENT NAME</a>	R	
O	<a href="#">PATIENT USUAL ADDRESS</a>	R	

M	<a href="#">POSTCODE OF USUAL ADDRESS</a>	R	•
M	<a href="#">ORGANISATION CODE (PCT OF RESIDENCE)</a>	R	•
M	<a href="#">PERSON BIRTH DATE</a> (from commissioning data set 6-1)	R	•

**Note:-**

For reasons of confidentiality, the patient's preferred name and address (not including [POSTCODE OF USUAL ADDRESS](#)) must not be carried where a valid NHS Number is present. For patients with sensitive conditions (as defined in DSCN 41/98/P26), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), [ORGANISATION CODE \(PCT OF RESIDENCE\)](#) and [PERSON BIRTH DATE](#) (in Patient Characteristics data group below).

**Note:**

For Security Issues and Patient Confidentiality, the [PATIENT NAME](#) and [PATIENT USUAL ADDRESS](#) (not including [POSTCODE OF USUAL ADDRESS](#)) must not be carried where a valid [NHS NUMBER](#) is present, even if the [NHS NUMBER](#) is not verified.

For patients with sensitive conditions (as defined in Security Issues and Patient Confidentiality), all patient identifiable information must be removed from Commissioning Data Set records. This includes [LOCAL PATIENT IDENTIFIER](#), [NHS NUMBER](#), [PATIENT NAME](#), [PATIENT USUAL ADDRESS](#), [POSTCODE OF USUAL ADDRESS](#), and [PERSON BIRTH DATE](#).

**CDS DATA GROUP: PATIENT CHARACTERISTICS:**  
To carry Characteristics of the Patient (the MOTHER).  
One occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
M	<a href="#">PERSON BIRTH DATE</a>	R	•
M	<a href="#">PERSON BIRTH DATE</a> (commissioning data set 6-0 only)	R	•
M	<a href="#">PERSON GENDER CURRENT</a>	R	•
O	<a href="#">CARER SUPPORT INDICATOR</a>	R	•
M	<a href="#">ETHNIC CATEGORY</a>	R	•
M	<a href="#">PERSON MARITAL STATUS</a> (psychiatric patients only)	R	•
M	<a href="#">LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)</a> (psychiatric patients only)	R	•

**CDS DATA GROUP: PATIENT CHARACTERISTICS - DELIVERY:**  
To carry the Characteristics of the Patient (the MOTHER).  
One occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
M	<a href="#">PREGNANCY TOTAL PREVIOUS PREGNANCIES</a>	R	•

**CDS DATA GROUP: HOSPITAL PROVIDER SPELL - Admission Characteristics:**  
To carry the Admission details of the Spell containing the Delivery Episode.  
One occurrence of this Group is permitted.

M	<a href="#">HOSPITAL PROVIDER SPELL NUMBER</a>	R	•
M	<a href="#">ADMINISTRATIVE CATEGORY (ON ADMISSION)</a>	R	•
M	<a href="#">PATIENT CLASSIFICATION</a>	R	•
M	<a href="#">ADMISSION METHOD (HOSPITAL PROVIDER SPELL)</a>	R	•
M	<a href="#">SOURCE OF ADMISSION (HOSPITAL PROVIDER SPELL)</a>	R	•
M	<a href="#">START DATE (HOSPITAL PROVIDER SPELL)</a>	R	•
M	<a href="#">AGE ON ADMISSION</a>	R	•

**CDS DATA GROUP: HOSPITAL PROVIDER SPELL - Discharge Characteristics:**  
To carry the Discharge details of the Spell containing the Delivery Episode.  
One occurrence of this Group is permitted.

M	<a href="#">DISCHARGE DESTINATION (HOSPITAL PROVIDER SPELL)</a>		•
M	<a href="#">DISCHARGE METHOD (HOSPITAL PROVIDER SPELL)</a>		•
O	<a href="#">DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL)</a>		•
M	<a href="#">DISCHARGE DATE (HOSPITAL PROVIDER SPELL)</a>		•

**CDS DATA GROUP: CONSULTANT EPISODE - Activity Characteristics:**  
To carry the details of the Delivery Episode undergone by the Patient.



One occurrence of this Group is permitted.			
M	<a href="#">EPISODE NUMBER</a>	R	•
M	<a href="#">LAST EPISODE IN SPELL INDICATOR</a>	R	•
*	<a href="#">ADMINISTRATIVE CATEGORY (AT START OF EPISODE)</a> (Not defined or approved by the Information Standards Board)	R	•
M	<a href="#">OPERATION STATUS</a>	R	•
M	<a href="#">PSYCHIATRIC PATIENT STATUS</a>	R	•
*	<a href="#">LEGAL STATUS CLASSIFICATION CODE (AT START OF EPISODE)</a> (Not defined or approved by the Information Standards Board) (psychiatric patients only)	R	•
M	<a href="#">START DATE (EPISODE)</a> This is the <b>mandatory</b> date used to derive the <b>mandatory</b> <a href="#">CDS ACTIVITY DATE</a>	R	•
M	<a href="#">END DATE (EPISODE)</a>		•
M	<a href="#">AGE AT CDS ACTIVITY DATE</a>		•
CDS DATA GROUP: CONSULTANT EPISODE - Service Agreement Details: To carry the details of the Service Agreement for the Birth Episode.			
M	<a href="#">COMMISSIONING SERIAL NUMBER</a>	R	•
O	<a href="#">NHS SERVICE AGREEMENT LINE NUMBER</a>	R	
O	<a href="#">PROVIDER REFERENCE NUMBER</a>		
M	<a href="#">COMMISSIONER REFERENCE NUMBER</a>	R	
M	<a href="#">ORGANISATION CODE (CODE OF PROVIDER)</a>	R	•
M	<a href="#">ORGANISATION CODE (CODE OF COMMISSIONER)</a>	R	•
CDS DATA GROUP: CONSULTANT EPISODE - Person Group (Consultant): To carry the details of the responsible Consultant, Midwife or Nurse. One occurrence of this Group is permitted.			
M	<a href="#">CONSULTANT CODE</a>	R	•
M	<a href="#">MAIN SPECIALTY CODE</a>	R	•
M	<a href="#">TREATMENT FUNCTION CODE</a>	R	•
CDS DATA GROUP: CONSULTANT EPISODE - Clinical Diagnosis Group (ICD): To carry the details of the ICD Diagnoses.			
M	<a href="#">DIAGNOSIS SCHEME IN USE</a>		
M	<a href="#">PRIMARY DIAGNOSIS (ICD)</a>		•
M	<a href="#">SECONDARY DIAGNOSIS (ICD)</a> (Multiple occurrences may be recorded)		•
CDS DATA GROUP: CONSULTANT EPISODE - Clinical Diagnosis Group (READ): To carry the details of the READ Diagnoses.			
O	<a href="#">DIAGNOSIS SCHEME IN USE</a>		
O	<a href="#">PRIMARY DIAGNOSIS (READ)</a>		
O	<a href="#">SECONDARY DIAGNOSIS (READ)</a> (Multiple occurrences may be recorded)		
CDS DATA GROUP: CONSULTANT EPISODE - Clinical Activity Group (OPCS): To carry the details of the OPCS coded Clinical Activities.			
M	<a href="#">PROCEDURE SCHEME IN USE</a>		
M	<a href="#">PRIMARY PROCEDURE (OPCS)</a>		•
M	<a href="#">PROCEDURE DATE</a>		•
M	(Multiple occurrences of this sub-group may be recorded) <a href="#">PROCEDURE (OPCS)</a>		•
M	<a href="#">PROCEDURE DATE</a>		•
CDS DATA GROUP: CONSULTANT EPISODE - Clinical Activity Group (READ): To carry the details of the READ coded Clinical Activities.			
O	<a href="#">PROCEDURE SCHEME IN USE</a>		
O	<a href="#">PRIMARY PROCEDURE (READ)</a>		
O	<a href="#">PROCEDURE DATE</a>		
O	(Multiple occurrences of this sub-group may be recorded) <a href="#">PROCEDURE (READ)</a>		
O	<a href="#">PROCEDURE DATE</a>		

**CDS DATA GROUP: CONSULTANT EPISODE - Location Group At Start Of Episode:**  
 To carry the details of the location at the start of the Delivery Episode.  
 One occurrence of this Group is permitted.

M	<a href="#">LOCATION CLASS</a>	R	
M	<a href="#">SITE CODE (OF TREATMENT)</a>	R	•
*	<a href="#">LOCATION TYPE</a> Definition and value list under review	R	
O	<a href="#">INTENDED CLINICAL CARE INTENSITY</a>	R	•
O	<a href="#">AGE GROUP INTENDED</a>	R	•
O	<a href="#">SEX OF PATIENTS</a>	R	•
O	<a href="#">WARD DAY PERIOD AVAILABILITY</a>	R	•
O	<a href="#">WARD NIGHT PERIOD AVAILABILITY</a>	R	•

**CDS DATA GROUP: CONSULTANT EPISODE - Location Group Of Ward Stay:**  
 To carry the details of one or more Ward Stays.  
 Up to 97 occurrences of this Group are permitted.

O	<a href="#">LOCATION CLASS</a>		
O	<a href="#">SITE CODE (OF TREATMENT)</a>		
*	<a href="#">LOCATION TYPE</a> Definition and value list under review		
O	<a href="#">INTENDED CLINICAL CARE INTENSITY</a>		
O	<a href="#">AGE GROUP INTENDED</a>		
O	<a href="#">SEX OF PATIENTS</a>		
O	<a href="#">WARD DAY PERIOD AVAILABILITY</a>		
O	<a href="#">WARD NIGHT PERIOD AVAILABILITY</a>		
O	<a href="#">START DATE</a>		
O	<a href="#">END DATE</a>		

**CDS DATA GROUP: CONSULTANT EPISODE - Location Group At End Of Episode:**  
 To carry the details of the location at the end of the Delivery Episode.  
 One occurrence of this Group is permitted.

O	<a href="#">LOCATION CLASS</a>		
O	<a href="#">SITE CODE (OF TREATMENT)</a> (at End of Episode)		
*	<a href="#">LOCATION TYPE</a> Definition and value list under review		
O	<a href="#">INTENDED CLINICAL CARE INTENSITY</a>		
O	<a href="#">AGE GROUP INTENDED</a>		
O	<a href="#">SEX OF PATIENTS</a>		
O	<a href="#">WARD DAY PERIOD AVAILABILITY</a>		
O	<a href="#">WARD NIGHT PERIOD AVAILABILITY</a>		

**CDS DATA GROUP: PAEDIATRIC CRITICAL CARE PERIOD:**  
 To carry the details of the first 9 Critical Care Periods for Paediatric Critical Care.  
 See [CRITICAL CARE PERIOD](#)  
 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 for the Hospital Provider Spell.

**CDS DATA GROUP: CRITICAL CARE PERIOD - PAEDIATRIC CARE - Admission Characteristics**  
 To carry the details of the Paediatric Critical Care Admission.  
 One occurrence is permitted for each Critical Care Period recorded.

M	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>	R	•
M	<a href="#">CRITICAL CARE START DATE</a>	R	•
M	<a href="#">CRITICAL CARE START TIME</a>	R	•
M	<a href="#">CRITICAL CARE UNIT FUNCTION</a>	R	•

**CDS DATA GROUP: CRITICAL CARE PERIOD - PAEDIATRIC DAILY CARE - Activity Characteristics**  
 To carry the details of the Paediatric Critical Care Activity.  
 Up to 999 daily occurrences per Critical Care Period are supported.

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M	<a href="#">ACTIVITY DATE (CRITICAL CARE)</a>	R	•
M	<a href="#">CRITICAL CARE ACTIVITY CODE</a> (up to 20 codes per daily activity occurrence may be recorded)	R	•
M	<a href="#">HIGH COST DRUGS (OPCS)</a> (up to 20 codes per daily activity occurrence may be recorded)	R	•

**CDS DATA GROUP: CRITICAL CARE PERIOD - PAEDIATRIC CARE - Discharge Characteristics**

To carry the details of the Discharge from Paediatric Critical Care.

One occurrence of this Group is permitted for each Critical Care Period.

M	<a href="#">CRITICAL CARE DISCHARGE DATE</a>	R	•
M	<a href="#">CRITICAL CARE DISCHARGE TIME</a>	R	•

**CDS DATA GROUP: ADULT CRITICAL CARE PERIOD:**

To carry the details of the first 9 Critical Care Periods for Adult Critical Care.

See [CRITICAL CARE PERIOD](#)

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 for the Hospital Provider Spell.

**CDS DATA GROUP: CRITICAL CARE PERIOD - ADULT CARE - Admission Characteristics**

To carry the details of the Admission to Adult Critical Care.

One occurrence of this Group is permitted for each Critical Care Period.

M	<a href="#">CRITICAL CARE LOCAL IDENTIFIER</a>	R	•
M	<a href="#">CRITICAL CARE START DATE</a>	R	•
O	<a href="#">CRITICAL CARE START TIME</a>	R	•
M	<a href="#">CRITICAL CARE UNIT FUNCTION</a>	R	•
O	<a href="#">CRITICAL CARE UNIT BED CONFIGURATION</a>		•
O	<a href="#">CRITICAL CARE ADMISSION SOURCE</a>		•
O	<a href="#">CRITICAL CARE SOURCE LOCATION</a>		•
O	<a href="#">CRITICAL CARE ADMISSION TYPE</a>		•

**CDS DATA GROUP: CRITICAL CARE PERIOD - ADULT CARE - Activity Characteristics**

To carry the details of the Adult Critical Care Activity.

Up to 9 occurrences are supported.

M	<a href="#">ADVANCED RESPIRATORY SUPPORT DAYS</a>		•
M	<a href="#">BASIC RESPIRATORY SUPPORT DAYS</a>		•
M	<a href="#">ADVANCED CARDIOVASCULAR SUPPORT DAYS</a>		•
M	<a href="#">BASIC CARDIOVASCULAR SUPPORT DAYS</a>		•
M	<a href="#">RENAL SUPPORT DAYS</a>		•
M	<a href="#">NEUROLOGICAL SUPPORT DAYS</a>		•
O	<a href="#">GASTRO-INTESTINAL SUPPORT DAYS</a>		•
M	<a href="#">DERMATOLOGICAL SUPPORT DAYS</a>		•
M	<a href="#">LIVER SUPPORT DAYS</a>		•
M	<a href="#">ORGAN SUPPORT MAXIMUM</a>		•
M	<a href="#">CRITICAL CARE LEVEL 2 DAYS</a>		•
M	<a href="#">CRITICAL CARE LEVEL 3 DAYS</a>		•

**CDS DATA GROUP: CRITICAL CARE PERIOD - ADULT CARE - Discharge Characteristics**

To carry the details of the Discharge from Adult Critical Care.

One occurrence of this Group is permitted for each Critical Care Period.

M	<a href="#">CRITICAL CARE DISCHARGE DATE</a>	R	•
M	<a href="#">CRITICAL CARE DISCHARGE TIME</a>	R	•
O	<a href="#">CRITICAL CARE DISCHARGE READY DATE</a>	R	•
O	<a href="#">CRITICAL CARE DISCHARGE READY TIME</a>	R	•
O	<a href="#">CRITICAL CARE DISCHARGE STATUS</a>	R	•
O	<a href="#">CRITICAL CARE DISCHARGE DESTINATION</a>	R	•
O	<a href="#">CRITICAL CARE DISCHARGE LOCATION</a>	R	•

**CDS DATA GROUP: GP REGISTRATION:**

To carry the Patient's General Medical Practitioner and General Practice details.

One occurrence of this Group is permitted.

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O	<a href="#">GENERAL MEDICAL PRACTITIONER (SPECIFIED)</a>	R	•
M	<a href="#">GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)</a>	R	•
<b>CDS DATA GROUP: REFERRAL:</b> To carry the details of the referrer. One occurrence of this Group is permitted.			
M	<a href="#">REFERRER CODE</a>	R	•
M	<a href="#">REFERRING ORGANISATION CODE</a>	R	•
<b>CDS DATA GROUP: PREGNANCY - Activity Characteristics:</b> To carry the details of the Pregnancy. One occurrence of this Group is permitted.			
M	<a href="#">NUMBER OF BABIES</a>	R	•
<b>CDS DATA GROUP: ANTENATAL CARE - Activity Characteristics:</b> To carry the details of the Antenatal Care. One occurrence of this Group is permitted.			
M	<a href="#">FIRST ANTENATAL ASSESSMENT DATE</a>	R	•
<b>CDS DATA GROUP: ANTENATAL CARE - PERSON GROUP - Responsible Clinician:</b> To carry the details of the Clinician responsible for the Antenatal Care. One occurrence of this Group is permitted.			
M	<a href="#">GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE)</a>	R	
O	<a href="#">GENERAL MEDICAL PRACTITIONER PRACTICE (ANTENATAL CARE)</a>	R	
<b>CDS DATA GROUP: ANTENATAL CARE - LOCATION GROUP - Delivery Place Intended:</b> To carry the details of the intended delivery place. One occurrence of this Group is permitted.			
M	<a href="#">LOCATION CLASS</a>	R	
*	<a href="#">LOCATION TYPE</a> Definition and value list under review	R	
M	<a href="#">DELIVERY PLACE CHANGE REASON</a>	R	•
M	<a href="#">DELIVERY PLACE TYPE (INTENDED)</a>	R	•
<b>CDS DATA GROUP: HOSPITAL LABOUR / DELIVERY - Activity Characteristics:</b> To carry the details of the Labour / Delivery. One occurrence of this Group is permitted.			
M	<a href="#">ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY</a>	R	•
M	<a href="#">ANAESTHETIC GIVEN POST LABOUR OR DELIVERY</a>	R	•
O	<a href="#">GESTATION LENGTH (LABOUR ONSET)</a>	R	
M	<a href="#">LABOUR OR DELIVERY ONSET METHOD</a>	R	•
M	<a href="#">DELIVERY DATE</a>	R	
<b>CDS DATA GROUP: BIRTH OCCURRENCE GROUP</b> To carry the details of the birth occurrence(s). Up to 9 Birth Occurrence Data Groups are permitted. Each Data Group consists of the following Sub-Groups: ACTIVITY CHARACTERISTICS PERSON GROUP (BABY IDENTITY) PERSON GROUP (BABY CHARACTERISTICS) LOCATION GROUP			
<b>CDS DATA GROUP: BIRTH OCCURRENCE - Activity Characteristics:</b> To carry the details of the birth occurrence(s). One occurrence of this Group is permitted for each Birth Occurrence Group.			
M	<a href="#">BIRTH ORDER</a>	R	•
M	<a href="#">DELIVERY METHOD</a>	R	•
M	<a href="#">GESTATION LENGTH (ASSESSMENT)</a>	R	•
M	<a href="#">RESUSCITATION METHOD</a>	R	•
M	<a href="#">STATUS OF PERSON CONDUCTING DELIVERY</a>	R	•
<b>CDS DATA GROUP: BIRTH OCCURRENCE - PERSON IDENTITY (BABY):</b> To carry the Identity details of the baby. One occurrence of this Group is permitted for each Birth Occurrence Group, one per Baby.			
O	<a href="#">LOCAL PATIENT IDENTIFIER (BABY)</a>	R	
O	<a href="#">ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (BABY))</a>	R	
O	<a href="#">NHS NUMBER (BABY)</a>	R	

M	<del>NHS NUMBER STATUS INDICATOR (BABY)</del>	R	
M	NHS NUMBER STATUS INDICATOR (BABY)	R	
M	PERSON BIRTH DATE (BABY) (From Commissioning Data Set 6-1)	R	
	<p><b>Note:</b> For Security Issues and Patient Confidentiality, the baby's name must not be carried where a valid NHS Number is present.</p> <p>For patients with sensitive conditions (as defined in Security Issues and Patient Confidentiality), all the baby's identifiable information must be removed from Commissioning Data Set records. This includes LOCAL PATIENT IDENTIFIER (BABY), NHS NUMBER (BABY) and PERSON BIRTH DATE (BABY)</p>		

**CDS DATA GROUP: BIRTH OCCURRENCE - PERSON CHARACTERISTICS (BABY):**  
To carry the Characteristics of the baby.  
One occurrence of this Group is permitted for each Birth Occurrence Group, one per Baby.

M	<del>PERSON BIRTH DATE (BABY)</del>	R	
M	PERSON BIRTH DATE (BABY) (Commissioning Data Set 6-0 only)	R	
M	PERSON GENDER CURRENT (BABY)	R	
M	LIVE OR STILL BIRTH	R	
M	BIRTH WEIGHT	R	

**CDS DATA GROUP: BIRTH OCCURRENCE - LOCATION GROUP:**  
To carry the details of the Actual delivery Place.  
One occurrence of this Group is permitted for each Baby.

M	LOCATION CLASS	R	
*	LOCATION TYPE Definition and value list under review	R	
M	DELIVERY PLACE TYPE (ACTUAL)	R	•

**CDS DATA GROUP: HEALTHCARE RESOURCE GROUP: - Activity Characteristics:**  
To carry the details of the Healthcare Resource Group.  
One occurrence of this Group is permitted.

O	HEALTHCARE RESOURCE GROUP CODE		•
O	HEALTHCARE RESOURCE GROUP CODE-VERSION NUMBER		•

**CDS DATA GROUP: HEALTHCARE RESOURCE GROUP - Clinical Activity Group:**  
To carry the details of the HRG Dominant Grouping Variable - Procedure. Note that this will not apply when no operation was carried out. In this case, the segment referring to HRG Dominant Grouping Variable - Procedure should be omitted.  
One Procedure, either OPCS or READ, may be specified.

O	PROCEDURE SCHEME IN USE		
O	HRG DOMINANT GROUPING VARIABLE-PROCEDURE		•

**ELECTIVE ADMISSION LIST CDS TYPE 030 - END OF PERIOD CENSUS (STANDARD) (RETIRED)\_ renamed from ELECTIVE ADMISSION LIST CDS TYPE 030 - END OF PERIOD CENSUS (STANDARD)**

Change to Data Set: Changed status to Retired, Name

- Retired ELECTIVE ADMISSION LIST CDS TYPE 030 - END OF PERIOD CENSUS (STANDARD)
- Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.ELECTIVE\_ADMISSION\_LIST\_CDS\_TYPE\_030\_-\_END\_OF\_PERIOD\_CENSUS\_(STANDARD) to Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.ELECTIVE\_ADMISSION\_LIST\_CDS\_TYPE\_030\_-\_END\_OF\_PERIOD\_CENSUS\_(STANDARD)

**ELECTIVE ADMISSION LIST CDS TYPE 040 - END OF PERIOD CENSUS (OLD) (RETIRED)\_ renamed from ELECTIVE ADMISSION LIST CDS TYPE 040 - END OF PERIOD CENSUS (OLD)**

Change to Data Set: Changed status to Retired, Name

- Retired ELECTIVE ADMISSION LIST CDS TYPE 040 - END OF PERIOD CENSUS (OLD)
- Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.ELECTIVE\_ADMISSION\_LIST\_CDS\_TYPE\_040\_-\_END\_OF\_PERIOD\_CENSUS\_(OLD) to

Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.ELECTIVE\_ADMISSION\_LIST\_CDS\_TYPE\_040\_-  
\_END\_OF\_PERIOD\_CENSUS\_(OLD)

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**ELECTIVE ADMISSION LIST CDS TYPE 050 - END OF PERIOD CENSUS (NEW) (RETIRED)\_ renamed from ELECTIVE ADMISSION LIST CDS TYPE 050 - END OF PERIOD CENSUS (NEW)**

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Change to Data Set: Changed status to Retired, Name

- Retired ELECTIVE ADMISSION LIST CDS TYPE 050 - END OF PERIOD CENSUS (NEW)
  - Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.ELECTIVE\_ADMISSION\_LIST\_CDS\_TYPE\_050\_-  
\_END\_OF\_PERIOD\_CENSUS\_(NEW) to  
Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.ELECTIVE\_ADMISSION\_LIST\_CDS\_TYPE\_050\_-  
\_END\_OF\_PERIOD\_CENSUS\_(NEW)
- 

**ELECTIVE ADMISSION LIST CDS TYPE 060 - EVENT DURING PERIOD (ADD) (RETIRED)\_ renamed from ELECTIVE ADMISSION LIST CDS TYPE 060 - EVENT DURING PERIOD (ADD)**

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Change to Data Set: Changed status to Retired, Name

- Retired ELECTIVE ADMISSION LIST CDS TYPE 060 - EVENT DURING PERIOD (ADD)
  - Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.ELECTIVE\_ADMISSION\_LIST\_CDS\_TYPE\_060\_-  
\_EVENT\_DURING\_PERIOD\_(ADD) to  
Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.ELECTIVE\_ADMISSION\_LIST\_CDS\_TYPE\_060\_-  
\_EVENT\_DURING\_PERIOD\_(ADD)
- 

**ELECTIVE ADMISSION LIST CDS TYPE 070 - EVENT DURING PERIOD (REMOVE) (RETIRED)\_ renamed from ELECTIVE ADMISSION LIST CDS TYPE 070 - EVENT DURING PERIOD (REMOVE)**

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Change to Data Set: Changed status to Retired, Name

- Retired ELECTIVE ADMISSION LIST CDS TYPE 070 - EVENT DURING PERIOD (REMOVE)
  - Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.ELECTIVE\_ADMISSION\_LIST\_CDS\_TYPE\_070\_-  
\_EVENT\_DURING\_PERIOD\_(REMOVE) to  
Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.ELECTIVE\_ADMISSION\_LIST\_CDS\_TYPE\_070\_-  
\_EVENT\_DURING\_PERIOD\_(REMOVE)
- 

**ELECTIVE ADMISSION LIST CDS TYPE 080 - EVENT DURING PERIOD (OFFER) (RETIRED)\_ renamed from ELECTIVE ADMISSION LIST CDS TYPE 080 - EVENT DURING PERIOD (OFFER)**

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Change to Data Set: Changed status to Retired, Name

- Retired ELECTIVE ADMISSION LIST CDS TYPE 080 - EVENT DURING PERIOD (OFFER)
  - Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.ELECTIVE\_ADMISSION\_LIST\_CDS\_TYPE\_080\_-  
\_EVENT\_DURING\_PERIOD\_(OFFER) to  
Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.ELECTIVE\_ADMISSION\_LIST\_CDS\_TYPE\_080\_-  
\_EVENT\_DURING\_PERIOD\_(OFFER)
- 

**ELECTIVE ADMISSION LIST CDS TYPE 090 - EVENT DURING PERIOD (AVAILABLE/UNAVAILABLE) (RETIRED)\_ renamed from ELECTIVE ADMISSION LIST CDS TYPE 090 - EVENT DURING PERIOD (AVAILABLE/UNAVAILABLE)**

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Change to Data Set: Changed status to Retired, Name

- Retired ELECTIVE ADMISSION LIST CDS TYPE 090 - EVENT DURING PERIOD (AVAILABLE/UNAVAILABLE)
  - Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.ELECTIVE\_ADMISSION\_LIST\_CDS\_TYPE\_090\_-  
\_EVENT\_DURING\_PERIOD\_(AVAILABLE/UNAVAILABLE) to  
Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.ELECTIVE\_ADMISSION\_LIST\_CDS\_TYPE\_090\_-  
\_EVENT\_DURING\_PERIOD\_(AVAILABLE/UNAVAILABLE)
- 

**ELECTIVE ADMISSION LIST CDS TYPE 100 - EVENT DURING PERIOD (OLD SERVICE AGREEMENT) (RETIRED)\_ renamed from ELECTIVE ADMISSION LIST CDS TYPE 100 - EVENT DURING PERIOD (OLD SERVICE AGREEMENT)**

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Change to Data Set: Changed status to Retired, Name

- Retired ELECTIVE ADMISSION LIST CDS TYPE 100 - EVENT DURING PERIOD (OLD SERVICE AGREEMENT)
- Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.ELECTIVE\_ADMISSION\_LIST\_CDS\_TYPE\_100\_-\_EVENT\_DURING\_PERIOD\_(OLD\_SERVICE\_AGREEMENT) to Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.ELECTIVE\_ADMISSION\_LIST\_CDS\_TYPE\_100\_-\_EVENT\_DURING\_PERIOD\_(OLD\_SERVICE\_AGREEMENT)

**ELECTIVE ADMISSION LIST CDS TYPE 110 - EVENT DURING PERIOD (NEW SERVICE AGREEMENT) (RETIRED)\_ renamed from ELECTIVE ADMISSION LIST CDS TYPE 110 - EVENT DURING PERIOD (NEW SERVICE AGREEMENT)**

Change to Data Set: Changed status to Retired, Name

- Retired ELECTIVE ADMISSION LIST CDS TYPE 110 - EVENT DURING PERIOD (NEW SERVICE AGREEMENT)
- Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.ELECTIVE\_ADMISSION\_LIST\_CDS\_TYPE\_110\_-\_EVENT\_DURING\_PERIOD\_(NEW\_SERVICE\_AGREEMENT) to Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.ELECTIVE\_ADMISSION\_LIST\_CDS\_TYPE\_110\_-\_EVENT\_DURING\_PERIOD\_(NEW\_SERVICE\_AGREEMENT)

**OLD VERSION 3 ADMITTED PATIENT CARE CDS TYPE - BIRTH EPISODE (RETIRED)\_ renamed from OLD VERSION 3 ADMITTED PATIENT CARE CDS TYPE - BIRTH EPISODE**

Change to Data Set: Changed status to Retired, Name

- Retired Old Version 3 ADMITTED PATIENT CARE CDS TYPE - BIRTH EPISODE
- Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.Old\_Version\_3\_ADMITTED\_PATIENT\_CARE\_CDS\_TYPE\_-\_BIRTH\_EPISODE to Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.Old\_Version\_3\_ADMITTED\_PATIENT\_CARE\_CDS\_TYPE\_-\_BIRTH\_EPISODE

**OLD VERSION 3 ADMITTED PATIENT CARE CDS TYPE - DELIVERY EPISODE (RETIRED)\_ renamed from OLD VERSION 3 ADMITTED PATIENT CARE CDS TYPE - DELIVERY EPISODE**

Change to Data Set: Changed status to Retired, Name

- Retired Old Version 3 ADMITTED PATIENT CARE CDS TYPE - DELIVERY EPISODE
- Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.Old\_Version\_3\_ADMITTED\_PATIENT\_CARE\_CDS\_TYPE\_-\_DELIVERY\_EPISODE to Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.Old\_Version\_3\_ADMITTED\_PATIENT\_CARE\_CDS\_TYPE\_-\_DELIVERY\_EPISODE

**OLD VERSION 3 ADMITTED PATIENT CARE CDS TYPE - GENERAL EPISODE (RETIRED)\_ renamed from OLD VERSION 3 ADMITTED PATIENT CARE CDS TYPE - GENERAL EPISODE**

Change to Data Set: Changed status to Retired, Name

- Retired Old Version 3 ADMITTED PATIENT CARE CDS TYPE - GENERAL EPISODE
- Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.Old\_Version\_3\_ADMITTED\_PATIENT\_CARE\_CDS\_TYPE\_-\_GENERAL\_EPISODE to Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.Old\_Version\_3\_ADMITTED\_PATIENT\_CARE\_CDS\_TYPE\_-\_GENERAL\_EPISODE

**OUT-PATIENT ATTENDANCE CDS TYPE (RETIRED)\_ renamed from OUT-PATIENT ATTENDANCE CDS TYPE**

Change to Data Set: Changed status to Retired, Name

- Retired OUT-PATIENT ATTENDANCE CDS TYPE
- Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.OUT-PATIENT\_ATTENDANCE\_CDS\_TYPE to Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.OUT-PATIENT\_ATTENDANCE\_CDS\_TYPE

**WARD ATTENDANCE CDS TYPE (RETIRED)\_ renamed from WARD ATTENDANCE CDS TYPE**

Change to Data Set: Changed status to Retired, Name

- Retired WARD ATTENDANCE CDS TYPE
- Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set.WARD\_ATTENDANCE\_CDS\_TYPE to Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set.WARD\_ATTENDANCE\_CDS\_TYPE

## CDS VERSION CDS006 TYPE LIST

Change to Supporting Information: Changed Description

### ~~COMMISSIONING DATA SET VERSION CDS006 - CDS TYPE LIST~~ COMMISSIONING DATA SET VERSION CDS006 TYPE LIST

#### ~~EDS Interchange and Message Controls - Mandatory for every Interchange:~~

~~[CDS V6 TYPE 001 - CDS INTERCHANGE HEADER](#)~~

~~[CDS V6 TYPE 002 - CDS INTERCHANGE TRAILER](#)~~

~~[CDS V6 TYPE 003 - CDS MESSAGE HEADER](#)~~

~~[CDS V6 TYPE 004 - CDS MESSAGE TRAILER](#)~~ Includes Commissioning Data Set 6-0 and 6-1

#### ~~EDS Transaction Header Group - Mandatory for every CDS:~~ [CDS V6 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL](#)

#### Accident and Emergency Commissioning Data Set Type:

~~[CDS V6 TYPE 005B - CDS TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL](#)~~ [CDS V6 TYPE 010 - ACCIDENT AND EMERGENCY CDS](#)  
or

~~[CDS V6 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL](#)~~

#### Accident and Emergency CDS Type:

~~[CDS V6 TYPE 010 - ACCIDENT AND EMERGENCY CDS](#)~~

#### ~~Care Activity CDS Types:~~ Care Activity Commissioning Data Set Types:

~~[CDS V6 TYPE 020 - OUTPATIENT CDS](#) (Known as Care Activity CDS in the Schema)~~ [CDS V6 TYPE 020 - OUTPATIENT CDS](#) (Known as Care Activity Commissioning Data Set in the Schema)

~~[CDS V6 TYPE 021 - FUTURE OUTPATIENT CDS](#) (Known as Future Care Activity CDS in the Schema)~~ [CDS V6 TYPE 021 - FUTURE OUTPATIENT CDS](#) (Known as Future Care Activity Commissioning Data Set in the Schema)

#### ~~Admitted Patient Care CDS Types:~~ Admitted Patient Care Commissioning Data Set Types:

~~[CDS V6 TYPE 120 - ADMITTED PATIENT CARE - FINISHED BIRTH EPISODE CDS](#)~~

~~[CDS V6 TYPE 130 - ADMITTED PATIENT CARE - FINISHED GENERAL EPISODE CDS](#)~~

~~[CDS V6 TYPE 140 - ADMITTED PATIENT CARE - FINISHED DELIVERY EPISODE CDS](#)~~

~~[CDS V6 TYPE 150 - ADMITTED PATIENT CARE - OTHER BIRTH EVENT CDS](#)~~

~~[CDS V6 TYPE 160 - ADMITTED PATIENT CARE - OTHER DELIVERY EVENT CDS](#)~~

~~[CDS V6 TYPE 170 - ADMITTED PATIENT CARE - DETAINED AND/OR LONG TERM PSYCHIATRIC CENSUS CDS](#)~~

~~[CDS V6 TYPE 180 - ADMITTED PATIENT CARE - UNFINISHED BIRTH EPISODE CDS](#)~~

~~[CDS V6 TYPE 190 - ADMITTED PATIENT CARE - UNFINISHED GENERAL EPISODE CDS](#)~~

~~[CDS V6 TYPE 200 - ADMITTED PATIENT CARE - UNFINISHED DELIVERY EPISODE CDS](#)~~

#### ~~Elective Admission List CDS Types - End Of Period Census Types:~~ Elective Admission List Commissioning Data Set Types - End Of Period Census Types:

~~[CDS V6 TYPE 030 - EAL - END OF PERIOD CENSUS STANDARD CDS](#)~~

~~[CDS V6 TYPE 040 - EAL - END OF PERIOD CENSUS OLD CDS](#)~~

~~[CDS V6 TYPE 050 - EAL - END OF PERIOD CENSUS NEW CDS](#)~~

#### ~~Elective Admission List CDS Types - Event During Period Types:~~ Elective Admission List Commissioning Data Set Types - Event During Period Types:

~~[CDS V6 TYPE 060 - EAL - EVENT DURING PERIOD - ADD CDS](#)~~

~~[CDS V6 TYPE 070 - EAL - EVENT DURING PERIOD - REMOVE CDS](#)~~

~~[CDS V6 TYPE 080 - EAL - EVENT DURING PERIOD - OFFER CDS](#)~~

~~[CDS V6 TYPE 090 - EAL - EVENT DURING PERIOD - AVAILABLE / UNAVAILABLE CDS](#)~~

~~[CDS V6 TYPE 100 - EAL - EVENT DURING PERIOD - OLD SERVICE AGREEMENT CDS](#)~~

~~[CDS V6 TYPE 110 - EAL - NEW SERVICE AGREEMENT CDS](#)~~

#### Commissioning Data Set Interchange and Message Controls - Mandatory for every Interchange:



[CDS V6 TYPE 001 - CDS INTERCHANGE HEADER](#)

[CDS V6 TYPE 002 - CDS INTERCHANGE TRAILER](#)

[CDS V6 TYPE 003 - CDS MESSAGE HEADER](#)

[CDS V6 TYPE 004 - CDS MESSAGE TRAILER](#)

**Commissioning Data Set Transaction Header Group - Mandatory for every Commissioning Data Set:**

[CDS V6 TYPE 005B - CDS TRANSACTION HEADER GROUP - BULK UPDATE PROTOCOL](#)

or

[CDS V6 TYPE 005N - CDS TRANSACTION HEADER GROUP - NET CHANGE PROTOCOL](#)

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**CDS VERSION NHS003 AND 4 TYPE LIST (RETIRED)\_ renamed from CDS VERSION NHS003 AND 4 TYPE LIST**

Change to Supporting Information: Changed status to Retired, Name

- Retired CDS Version NHS003 and 4 Type List
- Changed Name from `Web_Site_Content.Pages.CDS_and_HES_Indices.CDS_Version_NHS003_and_4_Type_List` to `Retired.Web_Site_Content.Pages.CDS_and_HES_Indices.CDS_Version_NHS003_and_4_Type_List`

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**CDS VERSION NHS005 TYPE LIST (RETIRED)\_ renamed from CDS VERSION NHS005 TYPE LIST**

Change to Supporting Information: Changed status to Retired, Name

- Retired CDS Version NHS005 Type List
- Changed Name from `Web_Site_Content.Pages.CDS_and_HES_Indices.CDS_Version_NHS005_Type_List` to `Retired.Web_Site_Content.Pages.CDS_and_HES_Indices.CDS_Version_NHS005_Type_List`

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**COMMISSIONING DATA SET VERSIONS**

Change to Supporting Information: Changed Description

**Commissioning Data Set Versions**

The NHS Data Model and Dictionary contains current and previous versions of the Commissioning Data Sets. The list below contains the Commissioning Data Sets since 2001.

**Current versions**

The tables listing the elements in each data set are available in the following type lists.

- ~~December 2007:~~ [CDS Version CDS006 Type List](#)
- December 2007: [CDS Version CDS006 Type List](#) (incorporates Version CDS 6-1)
- ~~April 2005:~~ [CDS Version NHS005 Type List](#)

**Retired versions**

- ~~April 2001 to March 2005:~~ [CDS Version NHS003 and 4 Type List](#)
  - April 2005 to March 2008: [CDS Version NHS005 Type List](#)
  - April 2001 to March 2005: [CDS Version NHS003 and 4 Type List](#)

The message schema are listed in [Commissioning Data Set Message Schema Versions](#)

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**DEFINITIONS MENU**

Change to Supporting Information: Changed Description

- [Classes](#)
- [Attributes](#)
- [Data Elements](#)
- [NHS Business Definitions](#)

- [All Items Index](#)
- [All items index](#)

## META MODEL

Change to Supporting Information: Changed Description

- [Meta Model Attributes](#)
- [Meta Model Classes](#)
- [Meta Model Diagrams](#)
- [All Items Index](#)
- [All Items Index](#)

## SECURITY ISSUES AND PATIENT CONFIDENTIALITY

Change to Supporting Information: Changed Description

### ~~SECURITY ISSUES AND PATIENT CONFIDENTIALITY~~

### Security Issues and Patient Confidentiality

#### A. Removal of name and address where the NHS Number is present

- From 1 April 1999, [PATIENT NAME](#) and [PATIENT USUAL ADDRESS](#) (not [POSTCODE OF USUAL ADDRESS](#)) must be removed from all commissioning data sets where a valid [NHS NUMBER](#) is present. This applies to all nationally defined Commissioning Data Sets Types (CDS) and any additional locally agreed flows from service providers to commissioning bodies.
- A valid [NHS NUMBER](#) is one that has passed the check digit calculation on entry into the source system. If an [NHS NUMBER](#) is not valid (i.e. does not conform with the check digit algorithm) then [PATIENT NAMES](#) and [PATIENT USUAL ADDRESSES](#) should not be removed, as the reliability of the [NHS NUMBER](#) will not be known.
- The [NHS NUMBER STATUS INDICATOR](#) is a mandatory part of the CDS. [PATIENT NAMES](#) and [PATIENT USUAL ADDRESSES](#) should be removed when a valid [NHS NUMBER](#) is present, even if the NHS Number Status Indicator does not have a status of 01, *Number present and verified*.

#### B. Marital Status

- Following the recommendations of the Data Protection Registrar, Providers should not record [MARITAL STATUS](#) in any CDS Type, except in respect of the psychiatric specialities in the Admitted Patient Care CDS Types, where it will continue to be recorded.

#### C. Sensitive data

- The Human Fertilisation and Embryology Act 1990 as amended by the Human Fertilisation and Embryology (Disclosure of Information) Act 1992 imposes statutory restrictions on the disclosure of information about identifiable individuals in connection with certain infertility treatments. A list of the relevant codes is given in Table 1. In these cases the [NHS NUMBER](#), [LOCAL PATIENT IDENTIFIER](#), [PATIENT NAMES](#), [POSTCODE OF USUAL ADDRESS](#) and [BIRTH DATE](#) should be omitted from the CDS Types.
- Other statutory restrictions on the disclosure of patient information do not prohibit the disclosure to individuals involved with the treatment and prevention of certain specific diseases (HIV/AIDS and venereal diseases) in the population.

**TABLE 1: TREATMENTS PROVIDED UNDER THE LICENCE OF THE HUMAN FERTILISATION AND EMBRYOLOGY AUTHORITY**

Description	OPCS-4	ICD-10
Standard In Vitro Fertilisation (IVF)	Q13.- <sup>1</sup> Introduction of gamete into uterine cavity, <b>or</b> Q38.3 Endoscopic intrafallopian transfer of gamete	Z31.2 <i>In vitro</i> fertilization
IVF with donor sperm	Q13.- <sup>1</sup> Introduction of gamete into uterine cavity, <b>or</b> Q38.3 Endoscopic intrafallopian transfer of gamete	Z31.2 <i>In vitro</i> fertilization
IVF with donor eggs	Q13.- <sup>1</sup> Introduction of gamete into uterine cavity, <b>or</b>	Z31.2 <i>In vitro</i> fertilization

	Q38.3 Endoscopic intrafallopian transfer of gamete	
Donor insemination (DI)	Q13.3 Intrauterine artificial insemination, <b>or</b> Q13.2 Intracervical artificial insemination	Z31.1 Artificial insemination
Gamete intrafallopian transfer (GIFT) with donor sperm	Q38.3 Endoscopic intrafallopian transfer of gamete	Z31.3 Other assisted fertilization method
Gamete intrafallopian transfer (GIFT) with donor eggs	Q38.3 Endoscopic intrafallopian transfer of gamete	Z31.3 Other assisted fertilization method
Intracytoplasmic sperm injection (ICSI)		
Sub-zonal insemination (SUZI)		
Zygote intrafallopian transfer (ZIFT)	Q38.3 Endoscopic intrafallopian transfer of gamete	Z31.2 <i>In vitro</i> fertilization
Partial Zona Dissection (PZD)		
Zona drilling		
Hamster- egg penetration test		
Assisted hatching		
Pre-implantation Genetic Diagnosis (PGD)		
Storage of sperm		
Storage of embryos		
Use and storage of testicular tissue		
Transport/satellite IVF/ICSI		
Embryo donation		Z31.8 Other procreative management
Research		

<sup>1</sup>.- means all fourth characters of this rubric should be included.

8. **All records containing patient identifiable information, other than those covered by the Human Fertilisation & Embryology Acts, as outlined in the Table above, should be treated as sensitive.** Organisations may continue to exchange records containing [NHS NUMBER](#), [POSTCODE OF USUAL ADDRESS](#) and [BIRTH DATE](#) in these cases, but receiving organisations must ensure that only those staff with legitimate need have access to this information, e.g. public health departments, and strictly on a need to know basis. No-one should have unrestricted access unless fully justified in accordance with the principles of the Caldicott Committee Report.
9. Where patient level data is required for other purposes within an organisation, it should be anonymised/aggregated prior to disclosure by someone with legitimate access. If this is not practicable, local protocols defining which CDS Types are particularly sensitive (including, but not necessarily restricted to HIV/AIDS and venereal disease) agreed by the organisation Caldicott Guardian, should be put in place and identifiers stripped from these records.
10. Your Caldicott Guardian will be able to advise you further on all issues relating to patient confidentiality.
11. Where appropriate, further information about confidentiality is contained within the notes for individual data items.

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## ETHNIC CATEGORY CODE

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Change to Attribute: Changed Description

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

Note: [ETHNIC CATEGORY](#) is the classification used for the 2001 census, replacing [ETHNIC GROUP](#) in the flows through the NHS-wide Clearing Service. The Office of National Statistics has developed a further breakdown of the group from that given, which may be used locally.

*National Codes:*

White

- A British
- B Irish
- C Any other White background

## Mixed

- D White and Black Caribbean
- E White and Black African
- F White and Asian
- G Any other mixed background

## Asian or Asian British

- H Indian
- J Pakistani
- K Bangladeshi
- L Any other Asian background

## Black or Black British

- M Caribbean
- N African
- P Any other Black background

## Other Ethnic Groups

- R Chinese
- S Any other ethnic group
  
- Z Not stated

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

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## ETHNIC CATEGORY

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Change to Data Element: Changed Description

Format/length:	an2
HES item:	ETHNOS
<del>National Codes:</del>	
National Codes:	See the attribute <a href="#">ETHNIC CATEGORY CODE</a>
Default Codes:	99 - Not known

### Notes:

[ETHNIC CATEGORY](#) is the same as attribute [ETHNIC CATEGORY CODE](#).

~~The 16+1 new ethnic data categories defined in the 2001 census will become the national mandatory standard for the collection of ethnicity. From 1/4/2001, they must be used for the collection of all statistical datasets in England, NHS and PSS, including the Admitted Patient Care CDS and Hospital Episode Statistics. (See [DSCN 21/2000](#) and [DSCN 02/2001](#)).~~ The 16+1 ethnic data categories defined in the 2001 census is the national mandatory standard for the collection and analysis of ethnicity.

~~The new national code must be entered as the first character in the 2 character field. The second character is an optional field only required for use locally.~~ The national code must be transmitted as the first character in the 2 character field. The second character is optional for use locally. It must, however, be able to be grouped consistently with the 16 main categories.

The information recorded about [ETHNIC CATEGORIES](#) must be obtained by asking the [PATIENT](#).

~~All provider units must collect and record data on the [ETHNIC CATEGORIES](#) of [PATIENTS](#) for inclusion in the Admitted Patient Care CDS; it will also be extracted for HES. Note that the mandatory requirement to collect and record the [ETHNIC CATEGORIES](#) of admitted patients does not extend to newborn babies (i.e. birth episodes) but providers and commissioners may decide locally to collect this data. [ETHNIC CATEGORY](#) = newborn = is not extracted and passed back to HES.~~ National code Z should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to. Default code 99 should be used where the PERSON's ETHNIC CATEGORY is not known.

See also [ETHNIC GROUP](#).

## ATTRIBUTES

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Change to Package: Changed Description

- [Classes](#)
  - [Diagrams](#)
  - [All Items Index](#)
  - [All items index](#)
- 

## CDS AND HES INDICES

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Change to Package: New Package

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## CLASSES

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Change to Package: Changed Description

- [Attributes](#)
  - [Diagrams](#)
  - [All Items Index](#)
  - [All items index](#)
- 

## COMMISSIONING DATA SET (RETIRED)\_ renamed from COMMISSIONING DATA SET

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Change to Package: Changed status to Retired, Name

- Retired Commissioning Data Set
  - Changed Name from Data\_Dictionary.Messages.Commissioning\_Data\_Set to Retired.Data\_Dictionary.Messages.Commissioning\_Data\_Set
- 

## DIAGRAMS

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Change to Package: Changed Description

- [Classes](#)
  - [Attributes](#)
  - [All Items Index](#)
  - [All items index](#)
- 

## META MODEL

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Change to Package: Changed Description

### Meta Model:

- [Attributes](#)
- [Classes](#)
- [Diagrams](#)

~~[All Items Index](#)~~ [All items index](#)

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For further details e-mail [datastandards@nhs.net](mailto:datastandards@nhs.net)