DSC Notice: 25/2008 Version 1.1
Date of Issue: November 2008

Information Standards Board for Health and Social Care
IMPLEMENTABILITY INTEROPERABILITY SAFETY

Sponsoring Organisation:	Implementation Date:	1 April 2009
Department of Health	Subject: **Critical Care Minimum Data Set**	

DATA SET CHANGE NOTICE

This DSCN informs users of the approval of changes to an information requirement or information standard by the Information Standards Board for Health and Social Care (ISB HaSC).

This was approved by ISB HaSC at its meeting on 27 August 2008.

The burden of collection has been agreed by the Review of Central Returns Steering Committee (ROCR) - ROCR No: ROCR/OR/0163/FT6/002.

Summary:

DSCNs 01/2005, 02/2005 and 13/2005 introduced the Critical Care Minimum Data Set (CCMDS). Since then a number of queries have arisen from users and other stakeholders. This led to a review of contents, guidance and definitions. These have now been amended and this DSCN gives details of those amendments.

The key changes are to the descriptions associated with:

- Critical Care Period
- Critical Care Admission Type
- Critical Care Discharge
- Basic Respiratory Support
- Advanced Respiratory Support
- Advanced Cardiovascular Support
- Hepatic (Liver) Organ Support
- Organ Support Maximum (deleted field)

This DSCN is in two parts:

1. Part 1 provides detailed policy information needed to implement the change.
2. Part 2 provides the definitional, technical, and modelling detail that will be included in the NHS Data Model and Dictionary.

Datasets / return affected:

Critical Care Minimum Dataset

Related DSCNs:

Impact of Change:

Service: Minor / ~~Major~~ **System Suppliers:** Minor / ~~Major~~

The Information Standards Board for Health and Social Care (ISB HaSC) is responsible for approving information standards. Submission documents and the ISB HaSC Board output relating to the approval of this standard can be found at:

www.isb.nhs.uk/docs/critical-care/

DATA SET CHANGE NOTICE

Reference No:	ROCR/OR/0163/FT6/002
Version No:	1.1
Subject:	Critical Care Minimum Dataset (CCMDS)
Type of Change:	Clarification to the NHS Data Model and Dictionary
Implementation Date:	1 April 2009
Business Justification:	Following publication of the CCMDS a number of queries arose regarding definitions and guidance that needed clarification.

Introduction

The purpose of these changes is to clarify some of the definitions and guidance notes included in the Dataset aimed at reducing data collection queries, achieving greater consistency in the way some fields have been completed and reducing the data collection burden on data collectors in Trusts. External examination of CCMDS returns (done in connection with PbR) has demonstrated that the CCMDS has achieved a high degree of compliance and accurate completion. However, queries raised on guidance associated with a number of the data fields has required a review and update to the CCMDS Dataset.

Background

The adult CCMDS was first implemented from 1 April 2006. It is mainly completed in critical care (sometimes known as 'Intensive Care' and 'High Dependency Care') units providing care for adults. It summarises key clinical and activity data related to episodes of critical care including the source of the patient prior to admission to the critical care area and the outcome for the patient when critical care is concluded. The Dataset also provides core activity data necessary to support the proposed application of 'Payment by Results' to critical care and the development of critical care tariffs.

CCMDS has been operational now since April 2006. In connection with PbR developments, some 50,000 2006-07 data records were external checked. It was found that Trusts were achieving 94% accuracy during that time. This level of accuracy has been achieved with a new Dataset from the time that it was first rolled out and should be still further improved upon following the application of these proposed amendments to the dataset notes.

Scope

Use of the CCMDS is confined to all Acute and Tertiary Trusts that provide some level (as defined by the Intensive Care Society - 'Levels of Care 2002'). 14 of the 33 field have been mandated by Department of Health Ministers and Monitor for collection by all Trusts, including Foundation Trusts, providing critical care services.

Out of Scope

Only designated critical care is included within the scope of this Standard. Ward care - even complex clinical care involving some degree of organ support is not included within the scope of CCMDS unless this is designated as 'critical care' and meets the clinical and operational criteria agreed for a critical care service as described by the Intensive Care Society.

Details of Change

Included in the appendix

Timescales for Implementation / Change

FRAMEWORK		Health and Social Care Personnel	Organisation[1]	IT Suppliers[2]
Effective Date[3] "may use"		1 January 2009	1 January 2009	1 January 2009
Implementation Date[4] "must use"	***Collection Start Date***[5]	1 April 2009	1 April 2009	1 April 2009
	First Submission Date[6]	31 May 2009	31 May 2009	31 May 2009
	Reporting Period / Submission Cycle[7]	Monthly	Monthly	Monthly
Conformance Date[8] "must be used effectively and assessed for use"		1 October 2009	1 October 2009	1 October 2009
Superseded Date (of prior standard)[9] "stop using prior standard"		31 March 2009	31 March 2009	31 March 2009

Notes:

1. Relevant organisations are those organisations as defined in the standard who must take direct action to implement the standard
2. IT Suppliers are all suppliers to the organisations listed at [1] who supply functionality pertinent to that standard
3. **Effective Date** is the date from which a new standard can be used but may not be mandatory. This might facilitate piloting, for example, or enable time for system functionality development. At this point, ***you "may use" the standard*.**
4. **Implementation Date** is the point from which the new standard becomes mandatory. Ideally, it inherently implies organisations use appropriate systems i.e. the date is the same for organisations and suppliers. However, there maybe circumstances where interim workarounds are required i.e. the date is different for organisations and suppliers. At this date, ***you "must use" the standard***. Where the standard demands data is submitted centrally, sub components of implementation date (and possibly 'effective date') are:
   - **Collection Start Date** – this is the date collection of data must begin
   - **First Submission Date** – this is the date of first submission of data centrally
   - **Reporting Period / Submission Cycle** – If the standard calls for further collection and submission at defined intervals, this cell provides text of the reporting period (e.g. calendar month, financial year) and the submission cycle (e.g. submit data monthly on the 10th working day of the subsequent month).
5. **Conformance Date** is the date from which the service and IT system suppliers must use the standard as envisaged i.e. using appropriate IT solutions rather than interim workarounds and, if the standard requires it, an independent, authoritative body or legitimate internal audit would conduct a conformity assessment with the expectation of full conformance by all relevant parties. It is the ***"must use standard effectively and assessed for use"*** date

6. **Superseded Date** of the prior standard sets the date at which the prior standard is replaced by the new standard i.e. the prior standard must no longer be used. This date will apply only where there was a pre-existing standard made redundant by the new standard. It might be different from preceding dates in the framework if, for example, a new and old standard run in parallel for a period. It is the date from which you ***"stop using the prior standard"***.

Effects on Other Information Standards

None

Sponsor Details

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On behalf of the Critical Care Information Advisory Group (CCIAG)

NB. CCIAG is a multi-professional group of critical care clinicians representing critical care interests. It also includes representatives from the NHS Information Centre and Department of Health. It provides authoritative advice on critical care information and data issues. It developed the CCMDS and these subsequent amendments.

Further Information and Support

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Appendices

Appendix 1 - Critical Care Minimum Dataset Revised November 2008

APPENDIX 1: Critical Care Minimum Dataset Full Specification

Critical Care Minimum Dataset

November 2008

SECTION 1 – Data available from PAS for Admitted Patient Care CDS (Commissioning Data Set)

Item	Variable	Suggested Source of Existing Data	Outline Description
1	NHS NUMBER	GP/NHS Trust APC CDS*	Unique identifier for transferable patient records and other NHS data sets
2	LOCAL PATIENT IDENTIFIER	NHS Trust APC CDS	Unique identifier for other patient data held within a hospital, e.g.*PAS/HISS* hospital number
3	SITE CODE (OF TREATMENT)	NHSIA/NHS TRUST APC CDS	Unique identifier for Hospital to allow Network and Commissioning analyses. This allows the hospital to be identified if there is more than one hospital with critical care facilities in the Trust.
4	CODE OF GP PRACTICE (REGISTERED GMP)	GP/NHS Trust APC CDS	Registered GP from patient medical record system. (Note that patients now register with a GP practice rather than an individual GP).

* APC CDS = Admitted Patient Care Commissioning Data Set. However, there may be other more easily accessible sources, e.g. the Patient Administration System.

5	TREATMENT FUNCTION CODE	NHSIA/NHS Trust APC CDS	The treatment function of the consultant with primary responsibility for the patient at the beginning of the hospital episode that contains the critical care period. (NB this is not the same as the original ACPSPEF that referred to the specialty of the critical care team). Note that treatment function is the particular specialty that the patient is treated under and not necessarily the main specialty of the consultant. E.g. colorectal surgery compared to general surgery. .
6	PERSON BIRTH DATE	NHS Trust APC CDS	To provide age and an additional patient identifier.
7	POSTCODE OF USUAL ADDRESS	Post Office/ NHS Trust APC CDS	Postcode of patient's address, to track source of patient in relation to PCTs, networks and SHAs.

SECTION 2 – Specific Items to be collected by Critical Care Staff.

The fourteen mandatory Critical Care HRG subset items that replaced the ACP are indicated 'M1 to M14' in column three and are in bold type. All remaining data items are optional.

Item	Variable	M)andatory / (O)ptional	Source of Data Definition	DEFINITIONS AND GUIDANCE FOR USE
8	**CRITICAL CARE LOCAL IDENTIFIER**	**M1**	Previously labelled as ACP local identifier	This locally defined variable should, as a minimum, include a sequential numerical component that can discriminate two or more critical care periods occurring on the same calendar day for the same patient.

Item	Variable	(M)andatory / (O)ptional	Sources of Data Definition	DEFINITIONS AND GUIDANCE FOR USE
9	**CRITICAL CARE START DATE**	**M2**	Revised ACP, e-gif	REASON FOR COLLECTION • **The data in the CCMDS primarily relates to any part of the patient's hospital spell that requires care in a designated critical care bed**. At present, a designated bed needs to be approved by the organisation's Critical Care Delivery Group, ratified by the Chief Executive and conform to the guidance contained in *Guidelines on Admission and Discharge for Intensive and High Dependency Care, DH 1996.* These are conventionally grouped into Critical Care Areas, e.g. ICU, ITU, HDU, or level 2 and 3 beds, but may include occasional, non-standard locations when conventional critical care beds are not available. • Data collection should commence from the date and time that the patient first occupies the designated bed. • Outreach activity, although part of critical care, should not be recorded in a CCMDS record. Separate developments are planned to address this area. Occasional cases where outreach staff have been involved in supporting a patient pending agreed admission to a critical care bed may be recorded as a CCMDS, using a temporary location code if the duration of support is greater than four hours. • Resuscitation conducted outside designated critical care areas e.g. as part of conventional care in operating theatres and emergency medicine departments should not be recorded in a CCMDS even though many aspects of the care given may satisfy level 2 or 3 critical care definitions. • Emergency Department (ED), At present, the CCMDS can only be attached to admitted patient care, therefore time spent by the critical care service in the ED cannot be captured. • Cardiac ('coronary') Care Units. It is not the intention to collect CCMDS data from these units. • If there are repeated admissions to the same unit or transfers to different critical care areas within the same hospital, these should be given separate CCMDS records identified by different start dates or locations. • As the focus of the CCMDS is on the patient's acute illness, changes of consultant or brief transfers for investigations and treatment should be ignored and a single CCMDS kept running until the patient leaves the critical care area. FORMAT; CCYY-MM-DD (e-gif)

Item	Variable	(M)andatory / (O)ptional	Sources of Data Definition	DEFINITIONS AND GUIDANCE FOR USE
10	CRITICAL CARE START TIME	O	Revised ACP, e-gif	FORMAT; HH:MM:SS (e-gif)
11	CRITICAL CARE UNIT FUNCTION	M3	Revised ACP	REASON FOR COLLECTION: The category of unit may be used in workload analysis examining the facilities in which patients received care both within large trusts, networks and nationally. The permutations of different types of critical care area are based on descriptions contained in '*Comprehensive Critical Care'* but are enhanced by condensing the previous ACP list into a flexible series of two linked codes; critical care (unit) function and unit bed configuration. The options from 90 onwards are available to retain compatibility with the ACP format that permitted non-standard locations to be recorded as a separate period of critical care. Temporary (e.g. greater than four hours) delivery of level 2 and 3 care to patients in non-designated critical care areas may be recorded here, i.e. care that would ideally have been provided in a designated critical care area if there had been sufficient capacity. The 04 Paediatric option is included as a non-specific option for units that primarily care for children. It is anticipated that specific data sets will be developed in the NHS for these areas in the future. Neonatal units caring for babies less than 28 days old are currently excluded as a defined location for the CCMDS because the data items are not aligned to neonatal care.

Item	Variable	(M)andatory / (O)ptional	Sources of Data Definition	DEFINITIONS AND GUIDANCE FOR USE
				DEFINITIONS: Type of critical care area to which the patient was admitted. Options chosen should reflect the principal clinical service provided within the area; **01** = non-specific, general adult critical care. **02** = surgical adult patients (unspecified specialty) **03** = medical adult patients (unspecified specialty) **04 =** paediatric critical care (includes infants greater than 28 days old on Neonatal Intensive Care Unit) **05 =** neurosciences patients predominate **06 =** cardiac surgical patients predominate **07 =** thoracic surgical patients predominate **08 =** burns and plastic surgery patients predominate **09 =** spinal patients predominate **10 =** renal patients predominate **11 =** liver patients predominate **12 =** obstetric patients predominate **90** = non standard location using a ward area **91** = non-standard location using the operating department.
12	UNIT BED CONFIGURATION	O	New	DEFINITION: The composition of bed types for your unit based on maximum funded and intended use, e.g. some units plan to use staff and beds flexibly whilst others are organized to take a full complement of level three patients or only 'HDU' patients. **02** = level 2 beds only where patients require more detailed observation or intervention including support for a single failing organ or post-operative care and those 'stepping down' from higher levels of care **03** = level 3 beds only. Level 3 care is defined as patients needing advanced respiratory support alone or two or more organs system support. NB Basic respiratory and basic cardiovascular support occurring on one day count as one organ. This level includes beds for all complex patients requiring support for multi-organ failure.

Item	Variable	(M)andatory / (O)ptional	Sources of Data Definition	DEFINITIONS AND GUIDANCE FOR USE
				05 = flexible critical care beds where there is a mix of level 2 and level 3 beds **90** = Temporary use of non critical care beds
13	CRITICAL CARE ADMISSION SOURCE	O	Revised ICNARC/ACP	REASON FOR COLLECTION: Information on the source of the patient is of use in analyzing unit workload and outcomes. Exactly the same classification is used as developed in collaboration with ICNARC. Admission sequences are captured in two stages, i.e. there are **two** variables collected before unit admission, the critical care admission source and the location associated with the source. DEFINITIONS: **01** Same NHS hospital site **02** Other NHS hospital site (same or different NHS Trust) **03** Independent Hospital Provider in the UK **04** Non-hospital source within the UK (e.g. home) **05** Non UK source such as repatriation, military personnel or foreign national)
14	CRITICAL CARE SOURCE LOCATION	O	Revised ICNARC/ACP	Specific location in the admission source DEFINITIONS: **01** Theatre and Recovery (following surgical and /or anaesthetic procedure) **02** Recovery only (when used to provide temporary critical care facility) **03** Other Ward (not critical care) **04** Imaging department **05** Accident and Emergency **06** Other intermediate care or specialist treatment areas including endoscopy units and catheter suites. **07** Obstetrics area **08** Clinic

Item	Variable	(M)andatory / (O)ptional	Sources of Data Definition	DEFINITIONS AND GUIDANCE FOR USE
				09 Home or other residence (including nursing home, H.M. Prison or other residential care) **10**Adult level 3 critical care bed (ICU bed, including a flexibly configured unit) **11** Adult level 2 critical care bed (HDU bed) **12** Paediatric critical care area (neonatal and paediatric care)
15	CRITICAL CARE ADMISSION TYPE	O	revised ACP and ICNARC planned/unplanned	REASON FOR COLLECTION: Information on the proportion of a critical care unit's workload that can be planned ahead and the proportion that is unpredictable is useful information for management and audit. Information is also required on the numbers and types of transfers. There is also interest in the distinction between patients from the local area rather than a wider area. For this purpose, the local area is defined as hospitals within the Trust together with neighbouring community units and services. DEFINITIONS: **01** = UNPLANNED LOCAL ADMISSION. All emergency or urgent patients referred to the unit only as a result of an unexpected acute illness occurring in the local area **02** = UNPLANNED TRANSFER IN. All emergency or urgent patients referred to the unit as a result of an unexpected acute illness occurring outside the hospital local area (including private and overseas Health Care providers). **03** = PLANNED TRANSFER IN (tertiary referral). A pre-arranged admission to the unit after treatment or initial stabilisation at another Health Care provider (including private and overseas Health Care providers) but requiring specialist or higher-level care that cannot be provided at the source hospital or unit. **04** = PLANNED LOCAL SURGICAL ADMISSION. A pre-arranged surgical admission from the local area to the Critical Care Unit, acceptance by unit must have occurred prior to the start of the surgical procedure and the procedure will usually have been of an elective or scheduled nature. For example, following a major procedure, for a high risk medical condition associated with any level

Item	Variable	(M)andatory / (O)ptional	Sources of Data Definition	DEFINITIONS AND GUIDANCE FOR USE
				of surgery, admitted prior to elective surgery for optimisation, admitted for monitoring of pain control e.g. epidurals or obstetric surgical cases admitted on a planned basis. **05** = PLANNED LOCAL MEDICAL ADMISSION from the local area. Booked medical admission, for example, planned investigation or high risk medical treatment. **06 =** REPATRIATION. The patient is normally resident in your local area and is being admitted or readmitted to your unit from another hospital (including overseas healthcare providers). This situation will normally arise when a patient is returning from tertiary or specialist care.
16	**ADVANCED RESPIRATORY SUPPORT DAYS**	**M4**	modified ACP	REASON FOR COLLECTION: (also *applies to organ support items 16 to 24*). Research has demonstrated that patients can be classified into homogeneous resource requirement groups according to the number and types of organ system supported. (Note, this is not necessarily the same as the number of failing organs). These data may also be useful in analysing workloads and equipment management. As with ACP, organ support is collected as any occurrence, noted once only on each calendar day. DEFINITION: Three digit code for up to 997 days of advanced respiratory support, e.g. 000 none 001 occurred during one calendar day 030 occurred on 30 calendar days NB 998 = 998 or more days of advanced respiratory support 999 = support occurred but number of days not known. FORMAT; 000 – 999 days **Advanced Respiratory Support** Indicated by; • Invasive mechanical ventilatory support (excluding mask / hood continuous positive airway pressure (CPAP) or mask pressure support ventilation (BiPAP) or CPAP applied via a trans-laryngeal tracheal tube).

Item	Variable	(M)andatory / (O)ptional	Sources of Data Definition	DEFINITIONS AND GUIDANCE FOR USE
				• Extracorporeal respiratory support. Note: Basic respiratory support will frequently occur prior to advanced respiratory support and should not lead to both ARS and BRS being recorded during the same calendar day. ARS supersedes BRS where this occurs.
17	**BASIC RESPIRATORY SUPPORT DAYS**	**M5**	Revised	DEFINITION: Three digit code for up to 997 days of basic respiratory support, e.g. 000 none 001 occurred during one calendar day 030 occurred on 30 calendar days NB 998 = 998 or more days of basic respiratory support 999 = support occurred but number of days not known FORMAT; 000 – 999 days Basic Respiratory Support. Indicated by one or more of the following: • More than **50%** oxygen delivered by face mask. *(Note, 50% has been chosen to identify the more seriously ill patients in a hospital and should not be recorded for short term increases in FiO2 such as for transfers or physiotherapy).* • Close observation due to the potential for acute deterioration to the point of needing advanced respiratory support. *(e.g. severely compromised airway or deteriorating respiratory muscle function).* • Physiotherapy or suction to clear secretions at least two hourly, whether via tracheostomy, minitracheostomy, or in the absence of an artificial airway. • Patients extubated for a period ≤24rs after a period of intubation and/or mechanical ventilation via an endotracheal tube for more than 24hrs, • Mask CPAP or non invasive ventilation. • Patients who are intubated to protect the airway but needing no ventilatory support and who are otherwise stable.

Item	Variable	(M)andatory / (O)ptional	Sources of Data Definition	DEFINITIONS AND GUIDANCE FOR USE
18	**ADVANCED CARDIOVASCULAR SUPPORT DAYS**	**M6**	Revised	DEFINITION: Three digit code for up to 997 calendar days of advanced cardiovascular support e.g. 000 none 001 occurred during one calendar day 030 occurred on 30 calendar days NB 998 = 998 or more days of advanced cardiovascular support 999 = support occurred but number of days not known. FORMAT; 000 – 999 days Advanced Cardiovascular Support: Indicated by one or more of the following: • Multiple intravenous vasoactive and/or rhythm controlling drugs when used simultaneously to support or control arterial pressure, cardiac output or organ / tissue perfusion, *(e.g. inotropes, amiodarone, nitrates).* • Patients resuscitated after cardiac arrest where critical care is considered clinically appropriate. • Continuous observation of cardiac output and derived indices *(e.g. pulmonary artery catheter, lithium dilution, pulse contour analyses, oesophageal Doppler, impedance and conductance methods).* • Intra aortic balloon pumping and other assist devices. ▪ Insertion of a temporary cardiac pacemaker (criteria valid for each day of therapeutic connection to a functioning external pacemaker unit). Note: Basic Cardiovascular support will frequently occur prior to Advanced Cardiovascular support and should not lead to both ACVS and BCVS being recorded at the same calendar day. ACVS supersede BCVS where this occurs.

Item	Variable	(M)andatory / (O)ptional	Sources of Data Definition	DEFINITIONS AND GUIDANCE FOR USE
19	**BASIC CARDIOVASCULAR SUPPORT DAYS**	**M7**	Revised	DEFINITION: Three digit code for up to 997 calendar days of basic cardiovascular support, e.g. 000 none 001 occurred during one calendar day 030 occurred on 30 calendar days NB 998 = 998 or more days of basic cardiovascular support 999 = support occurred but number of days not known. FORMAT; 000 – 999 days Basic Cardiovascular Support. Indicated by one or more of the following: • Use of a CVP line for monitoring of central venous pressure and /or provision of central venous access to deliver titrated fluids to treat hypovolaemia. • Use of an arterial line for monitoring the arterial pressure and/or sampling of arterial blood. • Single intravenous vasoactive drug used to support or control arterial pressure, cardiac output or organ perfusion • Intravenous drugs to control cardiac arrhythmias

Item	Variable	(M)andatory / (O)ptional	Sources of Data Definition	DEFINITIONS AND GUIDANCE FOR USE
20	**RENAL SUPPORT DAYS**	**M8**	modified ACP	DEFINITION: Three digit code for up to 997 calendar days of renal support, e.g. 000 none 001 occurred during one calendar day 030 occurred on 30 calendar days NB 998 = 998 or more days of renal support 999 = support occurred but number of days not known. FORMAT; 000 – 999 days Renal Support. Indicated by: Acute renal replacement therapy (e.g.haemodialysis, haemofiltration etc.) or provision of renal replacement therapy to a chronic renal failure patient who is requiring other acute organ support in a critical care bed.
21	**NEUROLOGICAL SUPPORT DAYS**	**M9**	Revised	DEFINITION; Three digit code for up to 997 calendar days of neurological support, e.g. 000 none 001 occurred during one calendar day 030 occurred on 30 calendar days NB 998 = 998 or more days of neurological support 999 = support occurred but number of days not known. FORMAT; 000 – 999 days Neurological Support. Indicated by one or more of the following: • Central nervous system depression sufficient to prejudice the airway and protective reflexes, excluding that caused by sedation prescribed to facilitate mechanical ventilation or poisoning (e.g. self administered overdose, alcohol, drugs etc.). • Invasive neurological monitoring or treatment e.g. ICP, jugular bulb sampling, external ventricular drain.

Item	Variable	(M)andatory / (O)ptional	Sources of Data Definition	DEFINITIONS AND GUIDANCE FOR USE
				• Continuous intravenous medication to control seizures and / or continuous cerebral monitoring. -Therapeutic hypothermia using cooling protocols or devices
22	GASTRO-INTESTINAL SUPPORT DAYS	O	New	DEFINITION; Three digit code for up to 997 calendar days gastrointestinal support, e.g. 000 none 001 occurred during one calendar day 030 occurred on 30 calendar days NB 998 = 998 or more days of gastro-intestinal support 999 = support occurred but number of days not known. FORMAT; 000 – 999 days Gastrointestinal Support Indicated by: Feeding with parenteral or enteral nutrition. (*implies methods of feeding other than normal oral intake).*
23	**DERMATOLOGICAL SUPPORT DAYS**	**M10**	New	DEFINITION; Three digit code for up to 997 calendar days of dermatological support, e.g. 000 none 001 occurred during one calendar day 030 occurred on 30 calendar days NB 998 = 998 or more days of dermatological support 999 = support occurred but number of days not known. FORMAT; 000 – 999 days Dermatological Support. Indicated by one or more of the following • Patients with major skin rashes, exfoliation or burns. *(e.g. greater than 30% body surface area affected).* • Use of complex dressings *(e.g. large skin area greater than 30% of body surface area, open abdomen, vacuum dressings or, large trauma such as multiple limb or limb and head dressings).*

Item	Variable	(M)andatory / (O)ptional	Sources of Data Definition	DEFINITIONS AND GUIDANCE FOR USE
24	**LIVER SUPPORT DAYS**	**M11**	Revised and new	DEFINITION: Three digit code for up to 997 calendar days of liver support, e.g. 000 none 001 occurred during one calendar day 030 occurred on 30 calendar days NB 998 = 998 or more days of liver support 999 = support occurred but number of days not known. FORMAT; 000 – 999 days Liver Support. Patients should fulfil one of the following categories: a) Acute on chronic Hepatocellular failure requiring management of coagulopathy and/or portal hypertension (including hepatic purification and detoxification techniques). or b) Primary Acute Hepatocellular failure patients who are being considered for transplantation and require management of coagulopathy and / or portal hypertension (including hepatic purification and detoxification techniques).

25	ORGAN SUPPORT MAXIMUM	O	ACP	REASON FOR COLLECTION: This variable is associated with the total costs of critical care but also implies severity of illness. It can be derived easily from the individual organ support incidences observed for the period between critical care start and end points. DEFINITION: Maximum number of organ systems supported at any one time, at any point in the critical care period. (NB both basic and advanced categories cannot be counted at the same time). This may not be the same as the total number or organssupported throughout the critical care admission. The minimum for this variable is **00** and the maximum is **07** for the full data set**.**

26	**CRITICAL CARE LEVEL 2 DAYS**	**M12**	new, using DoH / ICS levels of care	Total calendar days during which Level 2 care alone was provided during the period. FORMAT; 000 TO 999 DAYS 998 = 998 or more level 2 days 999 = one or more level 2 days occurred but number is not known.
27	**CRITICAL CARE LEVEL 3 DAYS**	**M13**	new, using DoH / ICS levels of care	Total calendar days during which level 3 care was provided during the period FORMAT; 000 TO 999 DAYS 998 = 998 or more level 3 days 999 = one or more level 3 days occurred but number is not known.

Item	**Variable**	**(M)andatory / (O)ptional**	Sources of Data Definition	DEFINITIONS AND GUIDANCE FOR USE
28	CRITICAL CARE DISCHARGE STATUS	O	updated (same as ICNARC v3.0)	DEFINITIONS: **01** fully ready for discharge **02** discharge for palliative care **03** early discharge due to shortage of critical care beds. **04** delayed discharge due to shortage of other ward beds **05** current level of care continuing in another location **06** more specialised care in another location **07** self discharge against medical advice. **08** patient died (no organs donated) **09** patient died and became heart beating organ donor for heart, lungs, kidneys, liver or other solid internal organ. **10** patient died and provided cadaveric tissue donation.
29	CRITICAL CARE DISCHARGE DESTINATION	O	updated (same as ICNARC v 3.0)	DEFINITIONS: **01** Same NHS hospital site **02** Other NHS hospital site (can be same Trust or a different NHS Trust) **03** Independent Hospital Provider in the UK **04** Non-hospital destination within the UK (e.g. home as coded in Location) **05** Non United Kingdom destination (e.g. repatriation) **06** No discharge destination, patient died in unit.
30	CRITICAL CARE DISCHARGE	O	updated (same as ICNARC v 3.0)	DEFINITIONS: The principle location that the patient is being discharged to for

	LOCATION			further care. **01** Ward **02** Recovery only (when used to provide temporary critical care facility) **03** Other intermediate care or specialised treatment area but excluding temporary visits en route, e.g. imaging, endoscopy, catheter suites and operating departments. **04** Adult level 3 critical care bed *(including care in a flexibly configured unit)* **05** Adult level 2 critical care bed *(e.g. including care in a flexibly configured unit)* **06** No discharge destination, patient died in unit **07** Obstetrics area
Item	**Variable**	**(M)andatory / (O)ptional**	Sources of Data Definition	DEFINITIONS AND GUIDANCE FOR USE
				08 Paediatric critical care area (neonatal and paediatric care) **09** Home or other residence *(e.g. nursing home, H.M. Prison, residential care).* **10** Other non-hospital location.
31	CRITICAL CARE DISCHARGE READY DATE	O	new	REASON FOR COLLECTION: To identify and quantify significant problems in discharging patients from the unit. It is assumed for the purposes of these data that even under ideal conditions, most discharges will take a reasonable amount of time to arrange and complete. Before normal discharge can occur two conditions must be satisfied, a clinician must assess the patient as suitable for discharge and somebody has to arrange an appropriate destination. From this point onwards, the patient is awaiting discharge, usually awaiting confirmation that the bed is available. The simplest way to monitor this aspect of critical care is to allow the 'discharge period' to be derived from the raw data and to allow users to analyse the information against whichever local or national criteria prevail at the time. In order to capture the raw data a point in time has to be identified as the start of the discharge period. DEFINITION: The discharge period begins when the following conditions have been met: • The patient has been declared clinically ready for discharge or transfer.

				• AND a formal request has been made to the hospital bed management system, (or appropriate staff with authority to admit at the intended destination). • AND the date and time of this status is recorded as such in the clinical record. (It may facilitate data collection if there is a recognized place for recording the request date and time either in the patient's notes or within the data collection system for the CCMDS). Note that discharge planning may occur in advance of and in the expectation that a patient will become fit for discharge at a certain time in the future. For the purposes of these data, the start time will remain the point at which both conditions are fully satisfied.

Item	**Variable**	**(M)andatory / (O)ptional**	Sources of Data Definition	DEFINITIONS AND GUIDANCE FOR USE
				If a discharge is deemed a premature discharge this field should not be filled in. Thus, the discharge period is the number of hours between the start of the period and the actual time of departure from your unit as recorded elsewhere in the dataset. FORMAT; CCYY/MM/DD
32	CRITICAL CARE DISCHARGE READY TIME	O	new	REASON FOR COLLECTION; As for discharge ready date. Format; HH:MM:SS
33	**CRITICAL CARE DISCHARGE DATE**	**M14**	NHS Data Dictionary	Discharge date from Unit if alive, Date of Death or Date of declaration of brain stem death.
34	CRITICAL CARE DISCHARGE TIME	O	ICNARC	Discharge time from unit Format; HH:MM:SS

Change Request

NHS Connecting for Health

NHS Data Model and Dictionary Service

Reference:	Change Request 1017
Version No:	1
Subject:	Critical Care Minimum Data Set
Effective Date:	1 April 2009
Reason for Change:	Change to NHS data standards
Publication Date:	5 November 2008

Background:

The Critical Care Minimum Data Set was implemented from April 2006.

The Critical Care Information Advisory Group (CCIAG) is a multi professional group representing clinicians and information and data collectors working in critical care. The Critical Care Information Advisory Group also includes representatives from the Information Centre for Health and Social Care and the Department of Health. Following queries from users and stakeholders a review of contents, guidance and definitions has been carried out by the Critical Care Information Advisory Group and the Critical Care Minimum Data Set has been revised.

In addition to changes to definitions, the reporting requirement for the data element Organ Support Maximum has been changed from mandatory to optional in the Commissioning Data Set Version 6-1 Tables.

Summary of changes:

Data Set	
CDS V6 TYPE 120	Changed Description
CDS V6 TYPE 130	Changed Description
CDS V6 TYPE 140	Changed Description
CDS V6 TYPE 180	Changed Description
CDS V6 TYPE 190	Changed Description
CDS V6 TYPE 200	Changed Description
Class Definitions	
CRITICAL CARE PERIOD	Changed Description
Attribute Definitions	
CRITICAL CARE ADMISSION TYPE	Changed Description
CRITICAL CARE DISCHARGE READY DATE	Changed Description
ORGAN SYSTEM SUPPORTED	Changed Description
UNIT BED CONFIGURATION	Changed Description
Data Elements	
CRITICAL CARE DISCHARGE DATE	Changed Description

Date: 5 November 2008

Sponsor: K Young, Urgent and Emergency Care Team, Department of Health on behalf of the Critical Care Information Advisory Group.

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.

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	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 personal details of the Patient (the BABY).
One occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
M	LOCAL PATIENT IDENTIFIER	R	•
M	ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	R	
O	NHS NUMBER	R	•
M	NHS NUMBER STATUS INDICATOR	R	•

O	PATIENT NAME	R	
M	PERSON BIRTH DATE (from commissioning data set 6-1)	R	•

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**
M	PERSON BIRTH DATE (commissioning data set 6-0 only)	R	•
M	PERSON GENDER CURRENT	R	•
M	ETHNIC CATEGORY	R	
M	LIVE OR STILL BIRTH	R	•
M	BIRTH WEIGHT	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	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 Birth 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 Birth 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	•
M	START DATE (EPISODE)	R	•
M	END DATE (EPISODE) This is the ***mandatory*** date used to derive the ***mandatory*** 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 Birth 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	ORGANISATION CODE (CODE OF COMMISSIONER)	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	CONSULTANT CODE	R	•
M	MAIN SPECIALTY CODE	R	•
M	TREATMENT FUNCTION CODE	R	•
CDS DATA GROUP: CONSULTANT EPISODE Clinical Diagnosis Group (ICD): To carry the details of the ICD Diagnoses.			
M	DIAGNOSIS SCHEME IN USE		
M	PRIMARY DIAGNOSIS (ICD)		•
M	SECONDARY DIAGNOSIS (ICD) (Multiple occurrences may be recorded)		•
CDS DATA GROUP: CONSULTANT EPISODE Clinical Diagnosis Group (READ): To carry the details of the READ Diagnoses.			
O	DIAGNOSIS SCHEME IN USE		
O	PRIMARY DIAGNOSIS (READ)		
O	SECONDARY DIAGNOSIS (READ) (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	PROCEDURE SCHEME IN USE		
M M	PRIMARY PROCEDURE (OPCS) PROCEDURE DATE		• •
 M M	(Multiple occurrences of this sub-group may be recorded) PROCEDURE (OPCS) PROCEDURE DATE		 • •
CDS DATA GROUP: CONSULTANT EPISODE - Clinical Activity Group (READ): To carry the details of the READ coded Clinical Activities.			
O	PROCEDURE SCHEME IN USE		
O O	PRIMARY PROCEDURE (READ) PROCEDURE DATE		
 O O	(Multiple occurrences of this sub-group may be recorded) PROCEDURE (READ) PROCEDURE DATE		
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	LOCATION CLASS	R	
M	SITE CODE (OF TREATMENT)	R	•
*	LOCATION TYPE Definition and value list under review	R	
O	INTENDED CLINICAL CARE INTENSITY	R	•
O	AGE GROUP INTENDED	R	•
O	SEX OF PATIENTS	R	•
O	WARD DAY PERIOD AVAILABILITY	R	•
O	WARD NIGHT PERIOD AVAILABILITY	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	LOCATION CLASS		
M	SITE CODE (OF TREATMENT)		
*	LOCATION TYPE Definition and value list under review		
O	INTENDED CLINICAL CARE INTENSITY		
O	AGE GROUP INTENDED		
O	SEX OF PATIENTS		
O	WARD DAY PERIOD AVAILABILITY		
O	WARD NIGHT PERIOD AVAILABILITY		
O	START DATE		
O	END DATE		
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	LOCATION CLASS		
M	SITE CODE (OF TREATMENT)		
*	LOCATION TYPE Definition and value list under review		
O	INTENDED CLINICAL CARE INTENSITY		
O	AGE GROUP INTENDED		
O	SEX OF PATIENTS		
O	WARD DAY PERIOD AVAILABILITY		
O	WARD NIGHT PERIOD AVAILABILITY		
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	CRITICAL CARE LOCAL IDENTIFIER	R	•
M	CRITICAL CARE START DATE	R	•
M	CRITICAL CARE START TIME	R	•
M	CRITICAL CARE UNIT FUNCTION	R	•
M	GESTATION LENGTH (AT DELIVERY)	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	ACTIVITY DATE (CRITICAL CARE)	R	•
M	PERSON WEIGHT	R	•
M	CRITICAL CARE ACTIVITY CODE (up to 20 codes per daily activity occurrence may be recorded)	R	•
M	HIGH COST DRUGS (OPCS) (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	CRITICAL CARE DISCHARGE DATE	R	•
M	CRITICAL CARE DISCHARGE TIME	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	CRITICAL CARE LOCAL IDENTIFIER	R	•
M	CRITICAL CARE START DATE	R	•
M	CRITICAL CARE START TIME	R	•
M	CRITICAL CARE UNIT FUNCTION	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	ACTIVITY DATE (CRITICAL CARE)	R	•
M	CRITICAL CARE ACTIVITY CODE (up to 20 codes per daily activity occurrence may be recorded)	R	•
M	HIGH COST DRUGS (OPCS) (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	CRITICAL CARE DISCHARGE DATE	R	•
M	CRITICAL CARE DISCHARGE TIME	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	CRITICAL CARE LOCAL IDENTIFIER	R	•
M	CRITICAL CARE START DATE	R	•
O	CRITICAL CARE START TIME	R	•
M	CRITICAL CARE UNIT FUNCTION	R	•
O	CRITICAL CARE UNIT BED CONFIGURATION		•
O	CRITICAL CARE ADMISSION SOURCE		•
O	CRITICAL CARE SOURCE LOCATION		•
O	CRITICAL CARE ADMISSION TYPE		•

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	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~~		~~•~~
O	ORGAN SUPPORT MAXIMUM		•
M	CRITICAL CARE LEVEL 2 DAYS		•
M	CRITICAL CARE LEVEL 3 DAYS		•
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	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	•
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)	R	•
M	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	R	•
CDS DATA GROUP: REFERRAL: To carry the details of the referrer. One occurrence of this Group is permitted.			
M	REFERRER CODE	R	•
M	REFERRING ORGANISATION CODE	R	•
CDS DATA GROUP: PREGNANCY - Activity Characteristics: To carry the details of the Pregnancy. One occurrence of this Group is permitted.			
M	NUMBER OF BABIES	R	•
CDS DATA GROUP: ANTENATAL CARE - Activity Characteristics: To carry the details of the Antenatal Care. One occurrence of this Group is permitted.			
M	FIRST ANTENATAL ASSESSMENT DATE	R	•
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.			
M	GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE)	R	
O	GENERAL MEDICAL PRACTITIONER PRACTICE (ANTENATAL CARE)	R	
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.			
M	LOCATION CLASS	R	
*	LOCATION TYPE Definition and value list under review	R	
M	DELIVERY PLACE CHANGE REASON	R	•
M	DELIVERY PLACE TYPE (INTENDED)	R	•
CDS DATA GROUP: HOSPITAL LABOUR / DELIVERY - Activity Characteristics: To carry the details of the Labour / Delivery.			

One occurrence of this Group is permitted.			
M	ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY	R	•
M	ANAESTHETIC GIVEN POST LABOUR OR DELIVERY	R	•
O	GESTATION LENGTH (LABOUR ONSET)	R	•
M	LABOUR OR DELIVERY ONSET METHOD	R	•
M	DELIVERY DATE	R	•
CDS DATA GROUP: BIRTH OCCURRENCE - Activity Characteristics: To carry the details of the birth occurrence. One occurrence of this Group is permitted.			
M	BIRTH ORDER	R	•
M	DELIVERY METHOD	R	•
M	GESTATION LENGTH (ASSESSMENT)	R	•
M	RESUSCITATION METHOD	R	•
M	STATUS OF PERSON CONDUCTING DELIVERY	R	•
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.			
O	LOCAL PATIENT IDENTIFIER (MOTHER)	R	
O	ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (MOTHER))	R	
O	NHS NUMBER (MOTHER)	R	
M	NHS NUMBER STATUS INDICATOR (MOTHER)	R	
O	PATIENT USUAL ADDRESS (MOTHER)		
M	POSTCODE OF USUAL ADDRESS (MOTHER)	R	•
M	ORGANISATION CODE (PCT OF RESIDENCE (MOTHER))	R	•
M	PERSON BIRTH DATE (MOTHER) (from commissioning data set 6-1)	R	•

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. (commissioning data set 6-0 only)			
M	PERSON BIRTH DATE (MOTHER) (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	LOCATION CLASS		
*	LOCATION TYPE Definition and value list under review		
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.			
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 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	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 of the Patient. One occurrence of this Group is permitted.			
Opt	**CDS data element**	**U/A**	**HES**
M	LOCAL PATIENT IDENTIFIER	R	•
M	ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	R	
M	NHS NUMBER	R	•
M	NHS NUMBER STATUS INDICATOR	R	•
O	PATIENT NAME	R	
O	PATIENT USUAL ADDRESS	R	
M	POSTCODE OF USUAL ADDRESS	R	•
M	ORGANISATION CODE (PCT OF RESIDENCE)	R	•
M	PERSON BIRTH DATE (from commissioning data set 6-1)	R	•

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**
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 ***mandatory*** date used to derive the ***mandatory*** 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	ORGANISATION CODE (CODE OF COMMISSIONER)	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	CONSULTANT CODE	R	•
M	MAIN SPECIALTY CODE	R	•
M	TREATMENT FUNCTION CODE	R	•
CDS DATA GROUP: CONSULTANT EPISODE Clinical Diagnosis Group (ICD): To carry the details of the ICD Diagnoses.			
M	DIAGNOSIS SCHEME IN USE		
M	PRIMARY DIAGNOSIS (ICD)		•
M	SECONDARY DIAGNOSIS (ICD) (Multiple occurrences may be recorded)		•
CDS DATA GROUP: CONSULTANT EPISODE Clinical Diagnosis Group (READ): To carry the details of the READ Diagnoses.			
O	DIAGNOSIS SCHEME IN USE		
O	PRIMARY DIAGNOSIS (READ)		
O	SECONDARY DIAGNOSIS (READ) (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	PROCEDURE SCHEME IN USE		
M M	PRIMARY PROCEDURE (OPCS) PROCEDURE DATE		• •
 M M	(Multiple occurrences of this sub-group may be recorded) PROCEDURE (OPCS) PROCEDURE DATE		 • •
CDS DATA GROUP: CONSULTANT EPISODE - Clinical Activity Group (READ): To carry the details of the READ coded Clinical Activities.			
O	PROCEDURE SCHEME IN USE		

O O	PRIMARY PROCEDURE (READ) PROCEDURE DATE		
O O	(Multiple occurrences of this sub-group may be recorded) PROCEDURE (READ) PROCEDURE DATE		
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	LOCATION CLASS	R	
M	SITE CODE (OF TREATMENT)	R	•
*	LOCATION TYPE Definition and value list under review	R	
O	INTENDED CLINICAL CARE INTENSITY	R	•
O	AGE GROUP INTENDED	R	•
O	SEX OF PATIENTS	R	•
O	WARD DAY PERIOD AVAILABILITY	R	•
O	WARD NIGHT PERIOD AVAILABILITY	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	LOCATION CLASS		
M	SITE CODE (OF TREATMENT)		
*	LOCATION TYPE Definition and value list under review		
O	INTENDED CLINICAL CARE INTENSITY		
O	AGE GROUP INTENDED		
O	SEX OF PATIENTS		
O	WARD DAY PERIOD AVAILABILITY		
O	WARD NIGHT PERIOD AVAILABILITY		
O	START DATE		
O	END DATE		
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	LOCATION CLASS		
M	SITE CODE (OF TREATMENT)		
*	LOCATION TYPE Definition and value list under review		
O	INTENDED CLINICAL CARE INTENSITY		
O	AGE GROUP INTENDED		
O	SEX OF PATIENTS		
O	WARD DAY PERIOD AVAILABILITY		
O	WARD NIGHT PERIOD AVAILABILITY		
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	CRITICAL CARE LOCAL IDENTIFIER	R	•

M	CRITICAL CARE START DATE	R	•
M	CRITICAL CARE START TIME	R	•
M	CRITICAL CARE UNIT FUNCTION	R	•
M	GESTATION LENGTH (AT DELIVERY)	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	ACTIVITY DATE (CRITICAL CARE)	R	•
M	PERSON WEIGHT	R	•
M	CRITICAL CARE ACTIVITY CODE (up to 20 codes per daily activity occurrence may be recorded)	R	•
M	HIGH COST DRUGS (OPCS) (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	CRITICAL CARE DISCHARGE DATE	R	•
M	CRITICAL CARE DISCHARGE TIME	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	CRITICAL CARE LOCAL IDENTIFIER	R	•
M	CRITICAL CARE START DATE	R	•
M	CRITICAL CARE START TIME	R	•
M	CRITICAL CARE UNIT FUNCTION	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	ACTIVITY DATE (CRITICAL CARE)	R	•
M	CRITICAL CARE ACTIVITY CODE (up to 20 codes per daily activity occurrence may be recorded)	R	•
M	HIGH COST DRUGS (OPCS) (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	CRITICAL CARE DISCHARGE DATE	R	•
M	CRITICAL CARE DISCHARGE TIME	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	CRITICAL CARE LOCAL IDENTIFIER	R	•
M	CRITICAL CARE START DATE	R	•
O	CRITICAL CARE START TIME	R	•
M	CRITICAL CARE UNIT FUNCTION	R	•
O	CRITICAL CARE UNIT BED CONFIGURATION		•
O	CRITICAL CARE ADMISSION SOURCE		•
O	CRITICAL CARE SOURCE LOCATION		•
O	CRITICAL CARE ADMISSION TYPE		•
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	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~~		~~•~~
O	ORGAN SUPPORT MAXIMUM		•
M	CRITICAL CARE LEVEL 2 DAYS		•
M	CRITICAL CARE LEVEL 3 DAYS		•
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	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	•
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)	R	•
M	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	R	•
CDS DATA GROUP: REFERRAL: To carry the details of the referrer. One occurrence of this Group is permitted.			
M	REFERRER CODE	R	•
M	REFERRING ORGANISATION CODE	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	DURATION OF ELECTIVE WAIT	R	•
M	INTENDED MANAGEMENT	R	•
M	DECIDED TO ADMIT DATE	R	•
O	EARLIEST REASONABLE OFFER DATE	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	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 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	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 MOTHER). One occurrence of this Group is permitted.			
Opt	**CDS data element**	**U/A**	**HES**
M	LOCAL PATIENT IDENTIFIER	R	•
M	ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	R	
M	NHS NUMBER	R	•
M	NHS NUMBER STATUS INDICATOR	R	•
O	PATIENT NAME	R	
O	PATIENT USUAL ADDRESS	R	
M	POSTCODE OF USUAL ADDRESS	R	•
M	ORGANISATION CODE (PCT OF RESIDENCE)	R	•
M	PERSON BIRTH DATE (from commissioning data set 6-1)	R	•

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	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: DELIVERY CHARACTERISTICS: To carry the delivery characteristics of the Patient (the MOTHER). One occurrence of this Group is permitted.			
M	PREGNANCY TOTAL PREVIOUS PREGNANCIES		•

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	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 Delivery 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 Delivery 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	•
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 ***mandatory*** date used to derive the ***mandatory*** 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 Birth 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	ORGANISATION CODE (CODE OF COMMISSIONER)	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	CONSULTANT CODE	R	•
M	MAIN SPECIALTY CODE	R	•
M	TREATMENT FUNCTION CODE	R	•
CDS DATA GROUP: CONSULTANT EPISODE Clinical Diagnosis Group (ICD): To carry the details of the ICD Diagnoses.			
M	DIAGNOSIS SCHEME IN USE		
M	PRIMARY DIAGNOSIS (ICD)		•
M	SECONDARY DIAGNOSIS (ICD) (Multiple occurrences may be recorded)		•
CDS DATA GROUP: CONSULTANT EPISODE Clinical Diagnosis Group (READ): To carry the details of the READ Diagnoses.			
O	DIAGNOSIS SCHEME IN USE		
O	PRIMARY DIAGNOSIS (READ)		
O	SECONDARY DIAGNOSIS (READ) (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	PROCEDURE SCHEME IN USE		
M M	PRIMARY PROCEDURE (OPCS) PROCEDURE DATE		• •

	(Multiple occurrences of this sub-group may be recorded)		
M	PROCEDURE (OPCS)		•
M	PROCEDURE DATE		•
CDS DATA GROUP: CONSULTANT EPISODE - Clinical Activity Group (READ): To carry the details of the READ coded Clinical Activities.			
O	PROCEDURE SCHEME IN USE		
O	PRIMARY PROCEDURE (READ)		
O	PROCEDURE DATE		
	(Multiple occurrences of this sub-group may be recorded)		
O	PROCEDURE (READ)		
O	PROCEDURE DATE		
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	LOCATION CLASS	R	
M	SITE CODE (OF TREATMENT)	R	•
*	LOCATION TYPE Definition and value list under review	R	
O	INTENDED CLINICAL CARE INTENSITY	R	•
O	AGE GROUP INTENDED	R	•
O	SEX OF PATIENTS	R	•
O	WARD DAY PERIOD AVAILABILITY	R	•
O	WARD NIGHT PERIOD AVAILABILITY	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	LOCATION CLASS		
O	SITE CODE (OF TREATMENT)		
*	LOCATION TYPE Definition and value list under review		
O	INTENDED CLINICAL CARE INTENSITY		
O	AGE GROUP INTENDED		
O	SEX OF PATIENTS		
O	WARD DAY PERIOD AVAILABILITY		
O	WARD NIGHT PERIOD AVAILABILITY		
O	START DATE		
O	END DATE		
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	LOCATION CLASS		
O	SITE CODE (OF TREATMENT)		
*	LOCATION TYPE Definition and value list under review		
O	INTENDED CLINICAL CARE INTENSITY		
O	AGE GROUP INTENDED		
O	SEX OF PATIENTS		
O	WARD DAY PERIOD AVAILABILITY		
O	WARD NIGHT PERIOD AVAILABILITY		
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	CRITICAL CARE LOCAL IDENTIFIER	R	•
M	CRITICAL CARE START DATE	R	•
M	CRITICAL CARE START TIME	R	•
M	CRITICAL CARE UNIT FUNCTION	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	ACTIVITY DATE (CRITICAL CARE)	R	•
M	CRITICAL CARE ACTIVITY CODE (up to 20 codes per daily activity occurrence may be recorded)	R	•
M	HIGH COST DRUGS (OPCS) (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	CRITICAL CARE DISCHARGE DATE	R	•
M	CRITICAL CARE DISCHARGE TIME	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	CRITICAL CARE LOCAL IDENTIFIER	R	•
M	CRITICAL CARE START DATE	R	•
O	CRITICAL CARE START TIME	R	•
M	CRITICAL CARE UNIT FUNCTION	R	•
O	CRITICAL CARE UNIT BED CONFIGURATION		•
O	CRITICAL CARE ADMISSION SOURCE		•
O	CRITICAL CARE SOURCE LOCATION		•
O	CRITICAL CARE ADMISSION TYPE		•
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 per Critical Care Period is permitted.			
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~~		~~•~~
O	ORGAN SUPPORT MAXIMUM		•
M	CRITICAL CARE LEVEL 2 DAYS		•
M	CRITICAL CARE LEVEL 3 DAYS		•
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 per Critical Care Period 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	•
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)	R	•
M	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	R	•
CDS DATA GROUP: REFERRAL: To carry the details of the referrer. One occurrence of this Group is permitted.			
M	REFERRER CODE	R	•
M	REFERRING ORGANISATION CODE	R	•
CDS DATA GROUP: PREGNANCY - Activity Characteristics: To carry the details of the Pregnancy. One occurrence of this Group is permitted.			
M	NUMBER OF BABIES	R	•
CDS DATA GROUP: ANTENATAL CARE - Activity Characteristics: To carry the details of the Antenatal Care. One occurrence of this Group is permitted.			
M	FIRST ANTENATAL ASSESSMENT DATE	R	•
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.			
M	GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE)	R	
O	GENERAL MEDICAL PRACTITIONER PRACTICE (ANTENATAL CARE)	R	
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.			
M	LOCATION CLASS	R	
*	LOCATION TYPE Definition and value list under review	R	
M	DELIVERY PLACE CHANGE REASON	R	•
M	DELIVERY PLACE TYPE (INTENDED)	R	•
CDS DATA GROUP: HOSPITAL LABOUR / DELIVERY - Activity Characteristics: To carry the details of the Labour / Delivery. One occurrence of this Group is permitted.			
M	ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY	R	•
M	ANAESTHETIC GIVEN POST LABOUR OR DELIVERY	R	•
O	GESTATION LENGTH (LABOUR ONSET)	R	
M	LABOUR OR DELIVERY ONSET METHOD	R	•
M	DELIVERY DATE	R	
CDS DATA GROUP: BIRTH OCCURRENCE GROUP			

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)			
CDS DATA GROUP: BIRTH OCCURRENCE - Activity Characteristics: 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	BIRTH ORDER	R	•
M	DELIVERY METHOD	R	•
M	GESTATION LENGTH (ASSESSMENT)	R	•
M	RESUSCITATION METHOD	R	•
M	STATUS OF PERSON CONDUCTING DELIVERY	R	•
CDS DATA GROUP: BIRTH OCCURRENCE - PERSON PATIENT IDENTITY (BABY): To carry the personal details of the baby. One occurrence of this Group is permitted for each Birth Occurrence Group, one per Baby.			
O	LOCAL PATIENT IDENTIFIER (BABY)	R	
O	ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (BABY))	R	
O	NHS NUMBER (BABY)	R	
M	NHS NUMBER STATUS INDICATOR (BABY)	R	
M	PERSON BIRTH DATE (BABY) (From Commissioning Data Set 6-1)	R	•
	Note: For Security Issues and Patient Confidentiality, the baby'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 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)		
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	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.			
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 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	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 of the Patient (the BABY).
One occurrence of this Group is permitted.

Opt	CDS data element	U/A	HES
M	LOCAL PATIENT IDENTIFIER	R	•
M	ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	R	
O	NHS NUMBER	R	•

M	NHS NUMBER STATUS INDICATOR	R	•
O	PATIENT NAME	R	
M	PERSON BIRTH DATE (from commissioning data set 6-1)	R	•

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**
M	PERSON BIRTH DATE (commissioning data set 6-0 only)	R	•
M	PERSON GENDER CURRENT	R	•
M	ETHNIC CATEGORY	R	
M	LIVE OR STILL BIRTH	R	•
M	BIRTH WEIGHT	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	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 Birth 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 Birth 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	•
M	START DATE (EPISODE) This is the ***mandatory*** date used to derive the ***mandatory*** CDS ACTIVITY DATE	R	•
M	END DATE (EPISODE)		•
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 Birth 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	ORGANISATION CODE (CODE OF COMMISSIONER)	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	CONSULTANT CODE	R	•
M	MAIN SPECIALTY CODE	R	•
M	TREATMENT FUNCTION CODE	R	•
CDS DATA GROUP: CONSULTANT EPISODE Clinical Diagnosis Group (ICD): To carry the details of the ICD Diagnoses.			
M	DIAGNOSIS SCHEME IN USE		
M	PRIMARY DIAGNOSIS (ICD)		•
M	SECONDARY DIAGNOSIS (ICD) (Multiple occurrences may be recorded)		•
CDS DATA GROUP: CONSULTANT EPISODE Clinical Diagnosis Group (READ): To carry the details of the READ Diagnoses.			
O	DIAGNOSIS SCHEME IN USE		
O	PRIMARY DIAGNOSIS (READ)		
O	SECONDARY DIAGNOSIS (READ) (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	PROCEDURE SCHEME IN USE		
M M	PRIMARY PROCEDURE (OPCS) PROCEDURE DATE		• •
 M M	(Multiple occurrences of this sub-group may be recorded) PROCEDURE (OPCS) PROCEDURE DATE		 • •
CDS DATA GROUP: CONSULTANT EPISODE - Clinical Activity Group (READ): To carry the details of the READ coded Clinical Activities.			
O	PROCEDURE SCHEME IN USE		
O O	PRIMARY PROCEDURE (READ) PROCEDURE DATE		
 O O	(Multiple occurrences of this sub-group may be recorded) PROCEDURE (READ) PROCEDURE DATE		
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	LOCATION CLASS	R	
M	SITE CODE (OF TREATMENT)	R	•
*	LOCATION TYPE Definition and value list under review	R	
O	INTENDED CLINICAL CARE INTENSITY	R	•
O	AGE GROUP INTENDED	R	•
O	SEX OF PATIENTS	R	•
O	WARD DAY PERIOD AVAILABILITY	R	•
O	WARD NIGHT PERIOD AVAILABILITY	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	LOCATION CLASS		
M	SITE CODE (OF TREATMENT)		
*	LOCATION TYPE Definition and value list under review		
O	INTENDED CLINICAL CARE INTENSITY		
O	AGE GROUP INTENDED		
O	SEX OF PATIENTS		
O	WARD DAY PERIOD AVAILABILITY		
O	WARD NIGHT PERIOD AVAILABILITY		
O	START DATE (at Start of Ward Stay)		
O	END DATE (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	LOCATION CLASS		
M	SITE CODE (OF TREATMENT)		
*	LOCATION TYPE Definition and value list under review		
O	INTENDED CLINICAL CARE INTENSITY		
O	AGE GROUP INTENDED		
O	SEX OF PATIENTS		
O	WARD DAY PERIOD AVAILABILITY		
O	WARD NIGHT PERIOD AVAILABILITY		
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	CRITICAL CARE LOCAL IDENTIFIER	R	•
M	CRITICAL CARE START DATE	R	•
M	CRITICAL CARE START TIME	R	•
M	CRITICAL CARE UNIT FUNCTION	R	•
M	GESTATION LENGTH (AT DELIVERY)	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	ACTIVITY DATE (CRITICAL CARE)	R	•
M	PERSON WEIGHT	R	•
M	CRITICAL CARE ACTIVITY CODE (up to 20 Codes per daily occurrence may be recorded)	R	•
M	HIGH COST DRUGS (OPCS) (up to 20 Codes per daily occurrence may be recorded)	R	•
CDS DATA GROUP: NEONATAL CRITICAL CARE PERIOD: Discharge Characteristics To carry the details of the Discharge from Neonatal Critical Care. One occurrence of this Group is permitted per Critical Care Period.			
M	CRITICAL CARE DISCHARGE DATE	R	•

M	CRITICAL CARE DISCHARGE TIME	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: PAEDIATRIC CRITICAL CARE PERIOD: Admission Characteristics **To carry the details of the Paediatric Critical Care Admission.** **One occurrence is permitted for each Critical Care Period recorded.**			
M	CRITICAL CARE LOCAL IDENTIFIER	R	•
M	CRITICAL CARE START DATE	R	•
M	CRITICAL CARE START TIME	R	•
M	CRITICAL CARE UNIT FUNCTION	R	•
CDS DATA GROUP: PAEDIATRIC CRITICAL CARE PERIOD: Care Activity Characteristics **To carry the daily occurrence details of the Paediatric Critical Care Activity.** **Up to 999 daily occurrences per Critical Care Period are supported.**			
M	ACTIVITY DATE (CRITICAL CARE)	R	•
M	CRITICAL CARE ACTIVITY CODE (up to 20 Codes per daily occurrence may be recorded)	R	•
M	HIGH COST DRUGS (OPCS) (up to 20 Codes per daily occurrence may be recorded)	R	•
CDS DATA GROUP: PAEDIATRIC CRITICAL CARE PERIOD: Discharge Characteristics **To carry the details of the Discharge from Paediatric Critical Care.** **One occurrence of this Group per Critical Care Period is permitted.**			
M	CRITICAL CARE DISCHARGE DATE	R	•
M	CRITICAL CARE DISCHARGE TIME	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: ADULT CRITICAL CARE PERIOD: Admission Characteristics **To carry the details of the Adult Critical Care Admission.** **One occurrence is permitted for each Critical Care Period recorded.**			
M	CRITICAL CARE LOCAL IDENTIFIER	R	•
M	CRITICAL CARE START DATE	R	•
O	CRITICAL CARE START TIME	R	•
M	CRITICAL CARE UNIT FUNCTION	R	•
O	CRITICAL CARE UNIT BED CONFIGURATION		
O	CRITICAL CARE ADMISSION SOURCE		
O	CRITICAL CARE SOURCE LOCATION		
O	CRITICAL CARE ADMISSION TYPE		
CDS DATA GROUP: ADULT CRITICAL CARE PERIOD: Care Activity Characteristics **To carry the details of the Adult Critical Care Activity.** **One occurrence per Critical Care Period is 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~~		~~•~~
O	ORGAN SUPPORT MAXIMUM		•
M	CRITICAL CARE LEVEL 2 DAYS		•
M	CRITICAL CARE LEVEL 3 DAYS		•
CDS DATA GROUP: ADULT CRITICAL CARE PERIOD: Discharge Characteristics 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		
O	CRITICAL CARE DISCHARGE READY TIME		
O	CRITICAL CARE DISCHARGE STATUS		
O	CRITICAL CARE DISCHARGE DESTINATION		
O	CRITICAL CARE DISCHARGE LOCATION		
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)	R	•
M	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	R	•
CDS DATA GROUP: REFERRAL: To carry the details of the referrer. One occurrence of this Group is permitted.			
M	REFERRER CODE	R	•
M	REFERRING ORGANISATION CODE	R	•
CDS DATA GROUP: PREGNANCY - Activity Characteristics: To carry the details of the Pregnancy. One occurrence of this Group is permitted.			
M	NUMBER OF BABIES	R	•
CDS DATA GROUP: ANTENATAL CARE - Activity Characteristics: To carry the details of the Antenatal Care. One occurrence of this Group is permitted.			
M	FIRST ANTENATAL ASSESSMENT DATE	R	•
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.			
M	GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE)	R	
O	GENERAL MEDICAL PRACTITIONER PRACTICE (ANTENATAL CARE)	R	
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.			
M	LOCATION CLASS	R	
*	LOCATION TYPE Definition and value list under review	R	
M	DELIVERY PLACE CHANGE REASON	R	•
M	DELIVERY PLACE TYPE (INTENDED)	R	•
CDS DATA GROUP: HOSPITAL LABOUR / DELIVERY - Activity Characteristics: To carry the details of the Labour / Delivery. One occurrence of this Group is permitted.			
M	ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY	R	•
M	ANAESTHETIC GIVEN POST LABOUR OR DELIVERY	R	•

O	GESTATION LENGTH (LABOUR ONSET)	R	•
M	LABOUR OR DELIVERY ONSET METHOD	R	•
M	DELIVERY DATE	R	•
CDS DATA GROUP: BIRTH OCCURRENCE - Activity Characteristics: To carry the details of the birth occurrence. One occurrence of this Group is permitted.			
M	BIRTH ORDER	R	•
M	DELIVERY METHOD	R	•
M	GESTATION LENGTH (ASSESSMENT)	R	•
M	RESUSCITATION METHOD	R	•
M	STATUS OF PERSON CONDUCTING DELIVERY	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	LOCAL PATIENT IDENTIFIER (MOTHER)	R	
O	ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (MOTHER))	R	
O	NHS NUMBER (MOTHER)	R	
M	NHS NUMBER STATUS INDICATOR (MOTHER)	R	
O	PATIENT USUAL ADDRESS (MOTHER)		
M	POSTCODE OF USUAL ADDRESS (MOTHER)	R	•
M	ORGANISATION CODE (PCT OF RESIDENCE (MOTHER))	R	•
M	PERSON BIRTH DATE (MOTHER) (From Commissioning Data Set 6-1)	R	•

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.			
M	PERSON BIRTH DATE (MOTHER) (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	LOCATION CLASS		
*	LOCATION TYPE Definition and value list under review		
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		•

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	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.** **One occurrence of this Group is permitted.**			
Opt	**CDS data element**	**U/A**	**HES**

M	LOCAL PATIENT IDENTIFIER	R	•
M	ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	R	
M	NHS NUMBER	R	•
M	NHS NUMBER STATUS INDICATOR	R	•
O	PATIENT NAME	R	
O	PATIENT USUAL ADDRESS	R	
M	POSTCODE OF USUAL ADDRESS	R	•
M	ORGANISATION CODE (PCT OF RESIDENCE)	R	•
M	PERSON BIRTH DATE (from commissioning data set 6-1)	R	•

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	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	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 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)	R	•

	(Not defined or approved by the Information Standards Board)		
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) This is the ***mandatory*** date used to derive the ***mandatory*** CDS ACTIVITY DATE	R	•
M	END DATE (EPISODE)		•
M	AGE AT CDS ACTIVITY DATE		•
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	ORGANISATION CODE (CODE OF COMMISSIONER)	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	CONSULTANT CODE	R	•
M	MAIN SPECIALTY CODE	R	•
M	TREATMENT FUNCTION CODE	R	•
CDS DATA GROUP: CONSULTANT EPISODE Clinical Diagnosis Group (ICD): To carry the details of the ICD Diagnoses.			
M	DIAGNOSIS SCHEME IN USE		
M	PRIMARY DIAGNOSIS (ICD)		•
M	SECONDARY DIAGNOSIS (ICD) (Multiple occurrences may be recorded)		•
CDS DATA GROUP: CONSULTANT EPISODE Clinical Diagnosis Group (READ): To carry the details of the READ Diagnoses.			
O	DIAGNOSIS SCHEME IN USE		
O	PRIMARY DIAGNOSIS (READ)		
O	SECONDARY DIAGNOSIS (READ) (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	PROCEDURE SCHEME IN USE		
M M	PRIMARY PROCEDURE (OPCS) PROCEDURE DATE		• •
 M M	(Multiple occurrences of this sub-group may be recorded) PROCEDURE (OPCS) PROCEDURE DATE		 • •
CDS DATA GROUP: CONSULTANT EPISODE - Clinical Activity Group (READ): To carry the details of the READ coded Clinical Activities.			
O	PROCEDURE SCHEME IN USE		
O O	PRIMARY PROCEDURE (READ) PROCEDURE DATE		
 O O	(Multiple occurrences of this sub-group may be recorded) PROCEDURE (READ) PROCEDURE DATE		

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	LOCATION CLASS	R	
M	SITE CODE (OF TREATMENT)	R	•
O	LOCATION TYPE This is currently for piloting purposes	R	
O	INTENDED CLINICAL CARE INTENSITY	R	•
O	AGE GROUP INTENDED	R	•
O	SEX OF PATIENTS	R	•
O	WARD DAY PERIOD AVAILABILITY	R	•
O	WARD NIGHT PERIOD AVAILABILITY	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	LOCATION CLASS		
M	SITE CODE (OF TREATMENT)		
*	LOCATION TYPE Definition and value list under review		
O	INTENDED CLINICAL CARE INTENSITY		
O	AGE GROUP INTENDED		
O	SEX OF PATIENTS		
O	WARD DAY PERIOD AVAILABILITY		
O	WARD NIGHT PERIOD AVAILABILITY		
O	START DATE		
O	END DATE		
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	LOCATION CLASS		
M	SITE CODE (OF TREATMENT)		
*	LOCATION TYPE Definition and value list under review		
O	INTENDED CLINICAL CARE INTENSITY		
O	AGE GROUP INTENDED		
O	SEX OF PATIENTS		
O	WARD DAY PERIOD AVAILABILITY		
O	WARD NIGHT PERIOD AVAILABILITY		
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	CRITICAL CARE LOCAL IDENTIFIER	R	•
M	CRITICAL CARE START DATE	R	•
M	CRITICAL CARE START TIME	R	•
M	CRITICAL CARE UNIT FUNCTION	R	•
M	GESTATION LENGTH (AT DELIVERY)		•

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	ACTIVITY DATE (CRITICAL CARE)	R	•
O	PERSON WEIGHT	R	•
M	CRITICAL CARE ACTIVITY CODE (up to 20 Codes may be recorded per daily occurrence)	R	•
M	HIGH COST DRUGS (OPCS) (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	CRITICAL CARE DISCHARGE DATE	R	•
M	CRITICAL CARE DISCHARGE TIME	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	CRITICAL CARE LOCAL IDENTIFIER	R	•
M	CRITICAL CARE START DATE	R	•
M	CRITICAL CARE START TIME	R	•
M	CRITICAL CARE UNIT FUNCTION	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	ACTIVITY DATE (CRITICAL CARE)	R	•
M	CRITICAL CARE ACTIVITY CODE (up to 20 Codes may be recorded per daily occurrence)	R	•
M	HIGH COST DRUGS (OPCS) (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	CRITICAL CARE DISCHARGE DATE	R	•
M	CRITICAL CARE DISCHARGE TIME	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	CRITICAL CARE LOCAL IDENTIFIER	R	•
M	CRITICAL CARE START DATE	R	•
O	CRITICAL CARE START TIME	R	•
M	CRITICAL CARE UNIT FUNCTION	R	•
O	CRITICAL CARE UNIT BED CONFIGURATION		•
O	CRITICAL CARE ADMISSION SOURCE		•
O	CRITICAL CARE SOURCE LOCATION		•
O	CRITICAL CARE ADMISSION TYPE		•
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	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~~		~~•~~
O	ORGAN SUPPORT MAXIMUM		•
M	CRITICAL CARE LEVEL 2 DAYS		•
M	CRITICAL CARE LEVEL 3 DAYS		•
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	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	•
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)	R	•
M	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	R	•
CDS DATA GROUP: REFERRAL: To carry the details of the referrer. One occurrence of this Group is permitted.			
M	REFERRER CODE	R	•
M	REFERRING ORGANISATION CODE	R	•
CDS DATA GROUP: ELECTIVE ADMISSION LIST: 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	•
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		•

CDS V6 TYPE 200

Change to Data Set: Changed Description

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	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 Identity details of the Patient (the MOTHER).
One occurrence of this Group is permitted.

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

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	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: 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	PREGNANCY TOTAL PREVIOUS PREGNANCIES	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	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 Delivery 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 Delivery 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	•
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) This is the ***mandatory*** date used to derive the ***mandatory*** CDS ACTIVITY DATE	R	•
M	END DATE (EPISODE)		•
M	AGE AT CDS ACTIVITY DATE		•
CDS DATA GROUP: CONSULTANT EPISODE - Service Agreement Details: To carry the details of the Service Agreement for the Birth 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	ORGANISATION CODE (CODE OF COMMISSIONER)	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	CONSULTANT CODE	R	•
M	MAIN SPECIALTY CODE	R	•
M	TREATMENT FUNCTION CODE	R	•
CDS DATA GROUP: CONSULTANT EPISODE - Clinical Diagnosis Group (ICD): To carry the details of the ICD Diagnoses.			
M	DIAGNOSIS SCHEME IN USE		
M	PRIMARY DIAGNOSIS (ICD)		•
M	SECONDARY DIAGNOSIS (ICD) (Multiple occurrences may be recorded)		•
CDS DATA GROUP: CONSULTANT EPISODE - Clinical Diagnosis Group (READ): To carry the details of the READ Diagnoses.			
O	DIAGNOSIS SCHEME IN USE		
O	PRIMARY DIAGNOSIS (READ)		
O	SECONDARY DIAGNOSIS (READ) (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	PROCEDURE SCHEME IN USE		
M M	PRIMARY PROCEDURE (OPCS) PROCEDURE DATE		• •
 M M	(Multiple occurrences of this sub-group may be recorded) PROCEDURE (OPCS) PROCEDURE DATE		 • •
CDS DATA GROUP: CONSULTANT EPISODE - Clinical Activity Group (READ): **To carry the details of the READ coded Clinical Activities.**			
O	PROCEDURE SCHEME IN USE		
O O	PRIMARY PROCEDURE (READ) PROCEDURE DATE		
 O O	(Multiple occurrences of this sub-group may be recorded) PROCEDURE (READ) PROCEDURE DATE		
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	LOCATION CLASS	R	
M	SITE CODE (OF TREATMENT)	R	•
*	LOCATION TYPE Definition and value list under review	R	
O	INTENDED CLINICAL CARE INTENSITY	R	•
O	AGE GROUP INTENDED	R	•
O	SEX OF PATIENTS	R	•
O	WARD DAY PERIOD AVAILABILITY	R	•
O	WARD NIGHT PERIOD AVAILABILITY	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	LOCATION CLASS		
O	SITE CODE (OF TREATMENT)		
*	LOCATION TYPE Definition and value list under review		
O	INTENDED CLINICAL CARE INTENSITY		
O	AGE GROUP INTENDED		
O	SEX OF PATIENTS		
O	WARD DAY PERIOD AVAILABILITY		
O	WARD NIGHT PERIOD AVAILABILITY		
O	START DATE		
O	END DATE		
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	LOCATION CLASS		
O	SITE CODE (OF TREATMENT) (at End of Episode)		
*	LOCATION TYPE Definition and value list under review		
O	INTENDED CLINICAL CARE INTENSITY		
O	AGE GROUP INTENDED		
O	SEX OF PATIENTS		
O	WARD DAY PERIOD AVAILABILITY		
O	WARD NIGHT PERIOD AVAILABILITY		
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	CRITICAL CARE LOCAL IDENTIFIER	R	•
M	CRITICAL CARE START DATE	R	•
M	CRITICAL CARE START TIME	R	•
M	CRITICAL CARE UNIT FUNCTION	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	ACTIVITY DATE (CRITICAL CARE)	R	•
M	CRITICAL CARE ACTIVITY CODE (up to 20 codes per daily activity occurrence may be recorded)	R	•
M	HIGH COST DRUGS (OPCS) (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	CRITICAL CARE DISCHARGE DATE	R	•
M	CRITICAL CARE DISCHARGE TIME	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	CRITICAL CARE LOCAL IDENTIFIER	R	•
M	CRITICAL CARE START DATE	R	•
O	CRITICAL CARE START TIME	R	•
M	CRITICAL CARE UNIT FUNCTION	R	•
O	CRITICAL CARE UNIT BED CONFIGURATION		•
O	CRITICAL CARE ADMISSION SOURCE		•
O	CRITICAL CARE SOURCE LOCATION		•
O	CRITICAL CARE ADMISSION TYPE		•
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	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~~		~~•~~
O	ORGAN SUPPORT MAXIMUM		•
M	CRITICAL CARE LEVEL 2 DAYS		•
M	CRITICAL CARE LEVEL 3 DAYS		•
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	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	•
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)	R	•
M	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	R	•
CDS DATA GROUP: REFERRAL: To carry the details of the referrer. One occurrence of this Group is permitted.			
M	REFERRER CODE	R	•
M	REFERRING ORGANISATION CODE	R	•
CDS DATA GROUP: PREGNANCY - Activity Characteristics: To carry the details of the Pregnancy. One occurrence of this Group is permitted.			
M	NUMBER OF BABIES	R	•
CDS DATA GROUP: ANTENATAL CARE - Activity Characteristics: To carry the details of the Antenatal Care. One occurrence of this Group is permitted.			
M	FIRST ANTENATAL ASSESSMENT DATE	R	•
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.			
M	GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE)	R	
O	GENERAL MEDICAL PRACTITIONER PRACTICE (ANTENATAL CARE)	R	
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.			
M	LOCATION CLASS	R	
*	LOCATION TYPE Definition and value list under review	R	
M	DELIVERY PLACE CHANGE REASON	R	•
M	DELIVERY PLACE TYPE (INTENDED)	R	•
CDS DATA GROUP: HOSPITAL LABOUR / DELIVERY - Activity Characteristics: To carry the details of the Labour / Delivery. One occurrence of this Group is permitted.			
M	ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY	R	•
M	ANAESTHETIC GIVEN POST LABOUR OR DELIVERY	R	•
O	GESTATION LENGTH (LABOUR ONSET)	R	
M	LABOUR OR DELIVERY ONSET METHOD	R	•

M	DELIVERY DATE	R	
CDS DATA GROUP: BIRTH OCCURRENCE GROUP 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			
CDS DATA GROUP: BIRTH OCCURRENCE - Activity Characteristics: To carry the details of the birth occurrence(s). One occurrence of this Group is permitted for each Birth Occurrence Group.			
M	BIRTH ORDER	R	•
M	DELIVERY METHOD	R	•
M	GESTATION LENGTH (ASSESSMENT)	R	•
M	RESUSCITATION METHOD	R	•
M	STATUS OF PERSON CONDUCTING DELIVERY	R	•
CDS DATA GROUP: BIRTH OCCURRENCE - PERSON IDENTITY (BABY): To carry the Identity details of the baby. One occurrence of this Group is permitted for each Birth Occurrence Group, one per Baby.			
O	LOCAL PATIENT IDENTIFIER (BABY)	R	
O	ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (BABY))	R	
O	NHS NUMBER (BABY)	R	
M	NHS NUMBER STATUS INDICATOR (BABY)	R	
M	PERSON BIRTH DATE (BABY) (From Commissioning Data Set 6-1)	R	
	Note: For Security Issues and Patient Confidentiality, the baby'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 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)		
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	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		•

CRITICAL CARE PERIOD

Change to Class: Changed Description

This is an ACTIVITY GROUP.

A period of time within a Hospital Provider Spell during which a PATIENT receives critical care.

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

a) All PATIENTS on a WARD with a CRITICAL CARE UNIT FUNCTION *Neonatal Intensive Care Unit* regardless of care being delivered.

or

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

For PATIENTS treated in 'adult facilities' or 'other facilities', that is, WARDS with a CRITICAL CARE UNIT FUNCTION of 01-03, 05-12, 90 or 91, the following applies;

- ~~Outreach activity and resuscitation conducted outside designated critical care areas should not be recorded as a CRITICAL CARE PERIOD. Also excluded from this is care provided on general wards (except as an occasional non-standard location), A&E, Radiology Departments and labour wards.~~
- Outreach activity and resuscitation conducted outside designated critical care areas should not be recorded as a CRITICAL CARE PERIOD. The only exception is outreach activity involving the delivery of Level 2 or Level 3 care to a PATIENT in a non standard location for a period of more than four hours prior to agreed admission to a critical care bed. This exception may be recorded as a CRITICAL CARE PERIOD, using a temporary location and the CRITICAL CARE LEVEL National Code 02 *'Level 2'* or 03 *'Level 3'*.

- A new CRITICAL CARE PERIOD starts when the PATIENT is admitted to a critical care location regardless of CRITICAL CARE LEVEL. Repeated admissions to the same unit, transfers to a different critical care location and transfers from a non-standard location to a critical care unit within the same Hospital Provider Spell trigger a new CRITICAL CARE PERIOD identified by different start dates or CRITICAL CARE UNIT FUNCTIONS. A change of Consultant Episode (Hospital Provider) or brief transfers for investigation or treatment do not end the CRITICAL CARE PERIOD.

- A CRITICAL CARE PERIOD ends when the PATIENT is discharged from the critical care location or dies or the care that is being delivered in a non-standard location (see below) is CRITICAL CARE LEVEL National Code 00 *'Level 0'* or 01 *'Level 1'*.

- Critical care locations are described by CRITICAL CARE UNIT FUNCTION and UNIT BED CONFIGURATION. Critical Care beds may include occasional non-standard locations using a ward area or operating department when conventional critical care beds are not available. Non standard locations may only be recorded if the CRITICAL CARE LEVEL is National Code 02 *'Level 2'* or 03 *'Level 3'* and the delivery of care is greater than four hours.

- The type of ORGAN SYSTEM SUPPORTED is recorded and the duration of each organ system support is calculated from the ACTIVITY PROPERTY EFFECTIVE DATE and the ACTIVITY PROPERTY END DATE.

- A CRITICAL CARE PERIOD does not include the following:
  a. Surgical and anaesthetic intra-operative care
  b. Post-operative care within an operating department except where level 2 or level 3 care are provided for more than 4 hours
  c. Cardiac (coronary) Care
  d. Imaging procedures
  e. Endoscopy procedures

CRITICAL CARE ADMISSION TYPE

Change to Attribute: Changed Description

An indication of whether a CRITICAL CARE PERIOD was initiated as a result of a non-emergency treatment plan, for example, for elective major surgery. This relates only to the period of critical care and not to the nature of the hospital admission. ~~For example, a planned hospital admission may unexpectedly require an emergency ICU admission, in which case the classification will be '01'.~~ For example, a planned hospital admission may unexpectedly require an emergency intensive care unit admission, in which case the classification will be '01'.

National Codes:

~~01~~ ~~Unplanned local admission. All emergency or urgent patients referred to the unit only as a result of an unexpected acute illness occurring within the hospital or local area.~~

01 Unplanned local admission. All emergency or urgent patients referred to the unit only as a result of an unexpected acute illness occurring within the local area (hospitals within the Trust together with neighbouring community units and services).

~~02~~ ~~Unplanned transfer in. All emergency or urgent patients referred to the unit as a result of an unexpected acute illness occurring outside the hospital local area.~~

02 Unplanned transfer in. All emergency or urgent patients referred to the unit as a result of an unexpected acute illness occurring outside the local area (including private and overseas Health Care Providers).

~~03~~ ~~Planned transfer in (tertiary referral). A pre-arranged admission to the unit after treatment or initial stabilisation at another hospital but requiring specialist or higher-level care that cannot be provided at the source hospital.~~

03 Planned transfer in (tertiary referral). A pre-arranged admission to the unit after treatment or initial stabilisation at another Health Care Provider (including private and overseas Health Care Providers) but requiring specialist or higher-level care that cannot be provided at the source hospital or unit.

~~04~~ ~~Planned local surgical admission. A pre-arranged surgical admission to the unit, acceptance by the unit must have occurred prior to the start of the surgical procedure and the procedure will usually have been of an elective or scheduled nature. For example, following a major procedure, for a high risk medical condition associated with any level of surgery, admitted prior to elective surgery for optimization, admitted for monitoring of pain control eg epidurals, or obstetric surgical cases admitted on a planned basis.~~

04 Planned local surgical admission. A pre-arranged surgical admission from the local area to the to the unit, acceptance by the unit must have occurred prior to the start of the surgical procedure and the procedure will usually have been of an elective or scheduled nature. For example, following a major procedure, for a high risk medical condition associated with any level of surgery, admitted prior to elective surgery for optimisation, admitted for monitoring of pain control eg epidurals, or obstetric surgical cases admitted on a planned basis.

~~05~~ ~~Planned local medical admission. Booked medical admission, for example, planned investigation or high risk medical treatment.~~

05 Planned local medical admission from the local area. Booked medical admission, for example, planned investigation or high risk medical treatment.

~~06~~ ~~Repatriation. The patient is returning to the unit from another hospital after being transferred there for either medical or non-medical reasons.~~

06 Repatriation. The patient is normally resident in your local area and is being admitted or readmitted to your unit from another hospital (including overseas Health Care Providers). This situation will normally arise when a patient is returning from tertiary or specialist care.

CRITICAL CARE DISCHARGE READY DATE

Change to Attribute: Changed Description

The date on which the PATIENT has been declared clinically ready for discharge or transfer from the CRITICAL CARE PERIOD and a formal request has been made to the hospital bed management system (or appropriate staff with authority to admit at the intended destination) and the date and time of this status is recorded as such in the clinical record.

CRITICAL CARE DISCHARGE READY DATE should not be completed if it is deemed the PATIENT has been declared clinically ready for discharge or transfer from the CRITICAL CARE PERIOD prematurely.

CRITICAL CARE DISCHARGE READY DATE and CRITICAL CARE DISCHARGE READY TIME are recorded to identify and quantify significant problems in discharging patients from critical care units.

ORGAN SYSTEM SUPPORTED

Change to Attribute: Changed Description

The type of organ system supported within a CRITICAL CARE PERIOD. This may not necessarily be support for a failing organ. ~~Basic respiratory support is likely to occur simultaneously with advanced respiratory support. If they are both required on the same day, only advanced respiratory support should be recorded. Basic cardiovascular support is likely to occur simultaneously with advanced cardiovascular support. If they are both required on the same day, only advanced cardiovascular support should be recorded.~~ Basic respiratory support will frequently occur prior to advanced respiratory support. If they are both required on the same day, only advanced respiratory support must be recorded. Basic cardiovascular support will frequently occur prior to advanced cardiovascular support. If they are both required on the same day, only advanced cardiovascular support must be recorded.

National Codes:

~~01~~	~~Basic Respiratory Support. Indicated by one or more of the following:~~ ~~More than 50% oxygen delivered by face mask.~~ ~~Close observation due to the potential for acute deterioration to the point of needing advanced respiratory support (eg severely compromised airway or deteriorating respiratory muscle function).~~ ~~Physiotherapy or suction to clear secretions at least two hourly, whether via tracheostomy, minitracheostomy, or in the absence of an artificial airway.~~ ~~Patients recently extubated after a prolonged period of intubation and mechanical ventilation, (e.g. more than 24 hours of tracheal intubation).~~ ~~Mask CPAP or non-invasive ventilation.~~ ~~Patients who are intubated to protect the airway but needing no ventilatory support and who are otherwise stable.~~
01	Basic Respiratory Support. Indicated by one or more of the following: More than 50% oxygen delivered by face mask. Close observation due to the potential for acute deterioration to the point of needing advanced respiratory support (eg severely compromised airway or deteriorating respiratory muscle function). Physiotherapy or suction to clear secretions at least two hourly, whether via tracheostomy, minitracheostomy, or in the absence of an artificial airway. Patients recently extubated after a prolonged period of intubation and mechanical ventilation via an endotracheal tube for more than 24 hours. Mask continuous positive airway pressure or non-invasive ventilation. Patients who are intubated to protect the airway but needing no ventilatory support and who are otherwise stable.
~~02~~	~~Advanced Respiratory Support. Indicated by:~~ ~~Invasive mechanical ventilatory support (excluding mask (CPAP) or non-invasive methods e.g. mask ventilation but including BIPAP or CPAP applied via a tracheal tube).~~ ~~Extracorporeal respiratory support~~
02	Advanced Respiratory Support. Indicated by: Invasive mechanical ventilatory support (excluding mask / hood continuous positive airway pressure (CPAP) or mask pressure support ventilation (BiPAP) or CPAP applied via a trans-laryngeal tracheal tube).
~~03~~	~~Basic Cardiovascular Support. Indicated by one or more of the following:~~ ~~Treatment of circulatory instability due to hypovolaemia from any cause~~ ~~Use of a CVP line for basic monitoring or central venous access to deliver therapeutic agents.~~ ~~Use of an arterial line for basic monitoring of arterial pressure or sampling of arterial blood.~~ ~~Single intravenous vasoactive drug used to support arterial pressure, cardiac output or organ perfusion.~~ ~~Intravenous drugs to control cardiac arrhythmias.~~ ~~Non-invasive measurement of cardiac output (e.g. echocardiography, thoracic impedance)~~
03	Basic Cardiovascular Support. Indicated by one or more of the following: Treatment of circulatory instability due to hypovolaemia from any cause Use of a central venous pressure line for monitoring of central venous pressure and/or the provision of central venous access to deliver titrated fluids to treat hypovolaemia. Use of an arterial line for basic monitoring of arterial pressure or sampling of arterial blood. Single intravenous vasoactive drug used to support arterial pressure, cardiac output or organ perfusion. Intravenous drugs to control cardiac arrhythmias. Non-invasive measurement of cardiac output (e.g. echocardiography, thoracic impedance)
~~04~~	~~Advanced Cardiovascular Support. Indicated by one or more of the following:~~ ~~Multiple intravenous vasoactive and/or rhythm controlling drugs used to support arterial pressure, cardiac output or organ perfusion (eg inotropes, amiodarone, nitrates).~~ ~~Patients resuscitated after cardiac arrest where intensive therapy is considered clinically appropriate.~~ ~~Observation of cardiac output and derived indices (e.g. pulmonary artery catheter, lithium dilution, pulse contour analyses, oesophageal doppler).~~ ~~Intra-aortic balloon pumping.~~ ~~Insertion of a temporary cardiac pacemaker (criteria valid for each day of connection to a functioning external pacemaker unit).~~ ~~Placement of a gastrointestinal tonometer~~
04	Advanced Cardiovascular Support. Indicated by one or more of the following: Multiple intravenous vasoactive and/or rhythm controlling drugs when used simultaneously to support or control arterial pressure, cardiac output or organ perfusion (eg inotropes, amiodarone, nitrates). Patients resuscitated after cardiac arrest where critical care is considered clinically appropriate.

Observation of cardiac output and derived indices (e.g. pulmonary artery catheter, lithium dilution, pulse contour analyses, oesophageal doppler).
Intra aortic balloon pumping and other assist devices.
Insertion of a temporary cardiac pacemaker (criteria valid for each day of connection to a functioning external pacemaker unit).
Placement of a gastrointestinal tonometer

~~05~~ ~~Renal Support. Indicated by:~~
~~Acute renal replacement therapy (e.g. haemodialysis, haemofiltration etc.)~~

05 Renal Support. Indicated by:
Acute renal replacement therapy (e.g. haemodialysis, haemofiltration etc.) or the provision of renal replacement therapy to a chronic renal failure patient who is requiring other acute organ support in a critical care situation.

~~06~~ ~~Neurological Support. Indicated by one or more of the following:~~
~~Central nervous system depression sufficient to prejudice the airway and protective reflexes, excepting that caused by therapeutic sedation prescribed to facilitate mechanical ventilation.~~
~~Invasive neurological monitoring e.g. ICP, jugular bulb sampling.~~
~~Severely agitated or epileptic patients requiring constant nursing attention and/or heavy sedation.~~

06 Neurological Support. Indicated by one or more of the following:
Central nervous system depression sufficient to prejudice the airway and protective reflexes, excepting that caused by sedation prescribed to facilitate mechanical ventilation or poisoning (e.g. self administered overdose, alcohol, drugs, etc.)
Invasive neurological monitoring e.g. intracranial pressure, jugular bulb sampling, external ventricular drain.
Severely agitated or epileptic patients requiring constant nursing attention and/or heavy sedation.
Continuous intravenous medication to control seizures and/or continous cerebral monitoring.
Therapeutic hypothermia using cooling protocols or devices.

~~07~~ ~~Gastrotintestinal Support. Indicated by:~~
~~Feeding with parenteral or enteral nutrition.~~

07 Gastrointestinal Support. Indicated by:
Feeding with parenteral or enteral nutrition.

~~08~~ ~~Dermatological Support. Indicated by one or more of the following:~~
~~Patients with major skin rashes, exfoliation or burns (eg greater than 30% body surface area affected).~~
~~Use of multiple trauma dressings (eg multiple limb or limb and head dressings).~~
~~Use of complex dressings (e.g. open abdomen or large skin area greater than 30% body surface area).~~

08 Dermatological Support. Indicated by one or more of the following:
Patients with major skin rashes, exfoliation or burns (eg greater than 30% body surface area affected).
Use of multiple trauma dressings (eg multiple limb or limb and head dressings).
Use of complex dressings (e.g. large skin area greater than 30% body surface area, open abdomen, vacuum dressings or large trauma such as multiple limb or limb and head dressings).

~~09~~ ~~Liver Support. Indicated by:~~
~~Extracorporeal liver replacement device (e.g.. MARS as manufactured by Teraklin, Rostock, Germany), bioartificial liver or charcoal haemoperfusion.~~

09 Liver Support. Indicated by:
Extracorporeal liver replacement device, bioartificial liver or charcoal haemoperfusion.

UNIT BED CONFIGURATION

Change to Attribute: Changed Description

The main composition of critical care bed types for the WARD.

National Codes:

02 Level 2 beds only where patients require more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care

~~03~~ ~~Level 3 beds only where patients require advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. This level includes beds for all complex patients requiring support for multi-organ failure~~

03 Level 3 beds only. Level 3 care is defined as patients needing advanced respiratory support alone or support of at least two organ systems. Note basic respiratory and basic cardiovascular support occurring on one day count as one organ. This level includes beds for all complex patients requiring support for multi-organ failure.

05 Flexible critical care beds where there is a mix of level 2 and level 3 beds

90 Temporary use of non critical care bed

CRITICAL CARE DISCHARGE DATE

Change to Data Element: Changed Description

Format/length:	see DATE
National Codes:	

Notes:
The end date of a CRITICAL CARE PERIOD. This may be the date the PATIENT is discharged from the critical care unit, the date the PATIENT died or the date of declaration of brainstem death.

This is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TIME TYPE is National Code 11 *'End Date'* for the CRITICAL CARE PERIOD.

For queries regarding this Data Set Change Notice please email datastandards@nhs.net