Information Standards Board for Health and Social Care

Sponsoring Organisation:	Implementation Date:	1 December 2009
Department of Health	Subject: **Commissioning Data Sets: Mandation of 18 Week Referral To Treatment Data Items**	

DATA SET CHANGE NOTICE

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

This was approved by ISB on 06 August 2009.

The burden of collection has been agreed by the Review of Central Returns Steering Committee (ROCR) -ROCR No: ROCR/09/0017/FT6.

Summary:

This DSCN informs providers of NHS funded care and its systems suppliers of changes to information standards to mandate the population of the 18 Week Referral To Treatment (RTT) data items in the Commissioning Data Sets (CDSs).

The following data items will be mandated for a subset of the CDS types that contain the Patient Pathway Data Group according to the existing schema validation rules:

UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)
PATIENT PATHWAY IDENTIFIER
ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER
REFERRAL TO TREATMENT PERIOD START DATE
REFERRAL TO TREATMENT PERIOD END DATE
REFERRAL TO TREATMENT PERIOD STATUS

This means that where the CDS currently flows into SUS for the CDS types listed below (and as new CDS flows of these types are established), the RTT data items should be populated for pathways subject to the 18 Week target, where available.

The following CDS types are mandatory and are currently processed by SUS for 18 Weeks:

- CDS Type 020 – Outpatient CDS
- CDS Type 130 – Admitted Patient Care – Finished General Episode CDS
- CDS Type 190 – Admitted Patient Care – Unfinished General Episode CDS

The following CDS types are optional and are not yet processed by SUS for 18 Weeks. Where they do flow into SUS, however, the RTT data items should be considered mandatory:

- CDS Type 030 - Elective Admission List - End of Period Census Standard CDS
- CDS Type 060 - Elective Admission List - Add CDS
- CDS Type 070 - Elective Admission List - Remove CDS
- CDS Type 080 - Elective Admission List - Offer CDS

The NHS Data Model and Dictionary description of EARLIEST REASONABLE OFFER DATE will be expanded to explain how it will be used by the Secondary Uses Service (CR1003).

Organisations are required to submit RTT data for events on 18 Week pathways that start on or after

1 December 2009 to the Secondary Uses Service.

This DSCN should be read by suppliers of Patient Administration System and other local systems suppliers; all providers of NHS funded care and commissioners of health care for patients on 18 Week pathways, and 18 Weeks leads and information departments.

Datasets / return affected:

Commissioning Data Set 6-0 (and subsequent versions)

Related DSCNs:

DSCN 18/2006 - Introduction of the RTT data items
DSCN 02/2007 - Monitoring of RTT data items for five treatment functions
DSCN 09/2007 - Earliest Reasonable Offer Date
DSCN 16/2007 - Amends and introduces additional Sources of Referral for Outpatients
DSCN 18/2007 - Commissioning Data Set version 6-0
DSCN 44/2007 - Inter-Provider Transfer Administrative Minimum Data Set
DSCN 29/2008 - Interim breach sharing

Impact of Change:

Service: Major **System Suppliers: Minor**

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

www.isb.nhs.uk/docs/cds-mandation/commissioning

DATA SET CHANGE NOTICE

Reference No:	**DSCN 16/2009**
Version No:	**1.1**
Subject:	**Commissioning Data Sets: Mandation of 18 Week Referral-to-Treatment Data Items**
Type of Change:	**Change to an approved information standard**
Implementation Date:	**1 December 2009**
Business Justification:	**The proposed information standard supports the delivery of an agreed government manifesto commitment, a PSA target and the NHS Operating Frameworks for 2008/2009 and 2009/2010.**

Introduction

The NHS Improvement Plan (June 2004) [1] set out an ambitious new commitment: 'By 2008 no one will wait longer than 18 weeks from GP referral to hospital treatment.' This aim is designed to remove hospital waiting as a concern for patients. The Operating Frameworks for 2008/09 and 2009/10 reaffirmed the goal and its national priority: "By December 2008, no-one should have to wait more than 18 weeks from the time they are referred to the start of their treatment unless it is clinically appropriate to do so or they choose to wait longer"

This is a completely new way of looking at waiting times. Previous targets focused on reducing waits for particular stages of assessment or treatment (the wait to see a consultant in outpatients; the wait for hospital admission following a decision by a consultant that admission is required). The 18 Week operational standard spans all the stages of care from referral through to the start of definitive treatment properly matching the total wait experienced by individual patients.

The supporting IT infrastructure to manage patients from referral to treatment, based on the approved information standards, is critical to delivery of the 18 Week standard. Historically, Patient Administration Systems (PASs) have not been designed to capture the status of patients at each significant event from referral to treatment. However, the NHS now needs to navigate its elective patients actively, linking events in the outpatient, diagnostic and treatment services of a hospital, and between providers for patients that need the services of more than one. Timely prospective and retrospective data is needed to manage patients and operational processes, i.e. commissioners and providers need to be able to see what is coming up, as well as what has already happened.

The Secondary Uses Service (SUS) is a national system that receives data submissions from provider organisations across England in pre-defined formats. From an 18 Week perspective, this means that the SUS is uniquely positioned to enable linkage across care settings and providers and this will support commissioners and providers to measure and monitor the progress of patients along their Referral To Treatment (RTT) pathways.

Currently, RTT data is reported to the Unify2 system for the national reporting and monitoring of 18 Weeks and for the support of a 'Breach Sharing' regime in advance of full functionality being enabled through SUS (as defined in DSCN 29/2008). It is planned that there will be controlled move over to the SUS for 18 Week reporting.

[1] *The NHS Improvement Plan : Putting people at the heart of public services* 24 June 2004 (www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084476

Users of the SUS will be able to analyse and report on how long patients waited from their referral to the point at which their treatment began. They will also be able to monitor and manage the progress of patients along their 18 Week care pathway through the SUS prospective reporting capability.

Provider organisations will inevitably continue to rely on local systems for operational management purposes, but the use of the SUS for 18 Week monitoring and measurement will ensure that consistent information is available to all users – including providers of NHS funded care, commissioners, Strategic Health Authorities and the Department of Health (DH) - more quickly than other applications may allow.

The SUS will control access so that users will only be able to access data appropriate for their job role. Users of the SUS will include the Department of Health, Strategic Health Authorities, Primary Care Trust commissioners, providers of NHS funded care (including Primary Care Trusts, Mental Health Trusts and the Independent Sector).

Commissioning Data Set version 6-0 introduced the RTT data items so the use of the CDS version 6-0 or above is a necessary though not sufficient condition for reporting on 18 Weeks through the SUS. CDS version 6-0 based flows are still being established and the RTT data items are currently not mandated. To ensure that suppliers make and implement the necessary technical changes to support the extraction of RTT data into the CDS and that providers of NHS funded care populate the CDS with RTT data it is necessary to mandate the population of the RTT data items in the CDSs.

Background

DSCN 18/2006 "Changes to the NHS Data Dictionary to support the measurement of 18 week RTT periods", published in December 2006, defined essential new data items to support monitoring of DH Patient Safety Agency target 13 - "By 2008, no one will have to wait longer than 18 weeks from GP referral to hospital treatment". In particular, DSCN 18/2006 introduced the following new data items:

- PATIENT PATHWAY IDENTIFIER
- REFERRAL TO TREATMENT PERIOD START DATE
- REFERRAL TO TREATMENT PERIOD END DATE
- REFERRAL TO TREATMENT PERIOD STATUS
- ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)

These new data items were included in the CDS version 6-0, introduced by DSCN 18/2007 "Introduction of Commissioning Data Set Version 6". This introduced the PATIENT PATHWAY CDS data group in all CDS types. This data group consists of all the data items introduced by DSCN 18/2006, plus the UNIQUE BOOKING REFERENCE NUMBER (CONVERTED), which together with the ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) of NHS Connecting for Health (X09) uniquely identifies the Patient Pathway if it started with a referral from the Choose and Book system.

Patient Pathways which do NOT start with a referral from Choose and Book, are identified by the PATIENT PATHWAY IDENTIFIER generated by the first organisation in the Pathway, and the ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) of that initiating organisation. The CDS Schema 6-0 (and subsequent releases) rules are that organisations can submit EITHER the PATIENT PATHWAY IDENTIFIER, OR the UNIQUE BOOKING REFERENCE NUMBER, not both. All the data elements in the PATIENT PATHWAY CDS DATA GROUP were introduced as Optional. In addition, DSCN 09/2007 introduced the EARLIEST REASONABLE OFFER DATE, which may also optionally flow in CDS Version 6-0 onwards.

The strategic national solution for reporting of 18 weeks performance is the SUS using data submitted by providers of NHS-funded care via the CDSs. In order to meet the NHS Operating Frameworks 2008/09 and 2009/10 requirements for using the SUS as the source for all activity reporting on the 18 weeks operational standard, including Performance Sharing, it is necessary to mandate the population of the RTT data items above in the CDSs, for all events on active 18 Week RTT pathways that are within the current mandated scope of CDSs. 18 Week pathways are defined in the 18 weeks rules suite:

http://www.18weeks.nhs.uk/Content.aspx?path=/measure-and-monitor/Rules-suite/

This intention was announced in the Advance Notification AN 0903, which was published by the ISB in March 2009.

Details of Change

The population of RTT data items in the CDSs is mandated where there are existing CDS flows into SUS for the CDS types listed below (and as new CDS flows of these types are established) if the RTT data is available.

The population of RTT data items is mandated in the CDSs for events on active 18 week RTT pathways, as defined in the 18 weeks rules suite:

http://www.18weeks.nhs.uk/Content.aspx?path=/measure-and-monitor/Rules-suite/

The following data items in the PATIENT PATHWAY CDS data group are mandated:

- UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)
- PATIENT PATHWAY IDENTIFIER
- ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER
- REFERRAL TO TREATMENT PERIOD START DATE
- REFERRAL TO TREATMENT PERIOD END DATE
- REFERRAL TO TREATMENT PERIOD STATUS

The population of RTT data items for events on active 18 week RTT pathways is only mandated in the following CDS Types:

- CDS Type 020 - Outpatient CDS
- CDS Type 130 - Admitted Patient Care - Finished General Episode CDS
- CDS Type 190 - Admitted Patient Care - Unfinished General Episode CDS

- CDS Type 030 - Elective Admission List - End of Period Census Standard CDS
- CDS Type 060 - Elective Admission List - Add CDS
- CDS Type 070 - Elective Admission List - Remove CDS
- CDS Type 080 - Elective Admission List - Offer CDS

Note that the SUS does not currently process the four Elective Admission List CDS types listed above for 18 weeks reporting. This functionality will be introduced in a later SUS release, but the DH are mandating the flow of RTT data items in these CDS types now to ensure that organisations involved in the preparation and submission of CDSs, are aware of the requirement and can implement the flow of data as soon as possible. It is important that these CDS types flow for the monitoring and measurement of 18 Weeks.

This DSCN does not change the mandation of the flow of individual CDS types - therefore it remains optional to flow the Elective Admission List CDS types; however the DH plan to submit a proposal to the ISB in the near future to mandate the flow of these CDS types.

RTT data for events on active 18 weeks RTT pathways may optionally continue to flow in other CDS Types not stated above, but are not processed by the SUS for reporting 18 week performance. Also, RTT data items may optionally continue to flow for events NOT subject to 18 weeks measurement, in all CDS types, as at present. It may prove easier to send Patient Pathway Data Group RTT data elements for all CDS records, regardless of whether the patient is on an 'active' 18 Week pathway at the time.

In order to ensure that the SUS processes patient pauses correctly:

- if a patient pause is relevant for the event which ends the RTT Period, EARLIEST REASONABLE OFFER DATE must be populated in the Admitted Patient Care General

Episode CDS record (CDS types 130 and 190) for that event. Failure to include this data item with the Admitted Patient Care General Episode CDS record, which indicates the end of a RTT Period, will mean no pause is applied to the duration of wait calculation performed by the SUS.

- If a patient pause is NOT to be applied then EARLIEST REASONABLE OFFER DATE should not be populated.

The NHS Data Model and Dictionary will be amended to show the new level of mandation for data elements in the affected CDS types, and the data element EARLIEST REASONABLE OFFER DATE will be updated to define the rules for submission to the Secondary Uses Service (CR1003).

This DSCN does not mandate the flow of initially-coded weekly CDS submissions, although this is a requirement in the NHS Operating Framework 2008/09 and is recommended by DH and the Information Centre for Health and Social Care to enable the presentation of timely activity data for organisations from the SUS. Use of the Net Change CDS Submission Protocol is also recommended for the submission of weekly initially-coded data sets to the SUS.

As part of this mandation of the submission of RTT data items in CDSs, organisations are required to submit RTT data for events on 18 Week pathways that start on or after 1 December 2009 to the SUS, to support the move to the SUS for full Performance Sharing.

Timescales for Implementation / Change

FRAMEWORK		Health and Social Care Personnel	Organisation[1]	IT Suppliers[2]
Effective Date[3] "may use"		Immediate		
Implementation Date[4] "must use"	***Collection Start Date***[5]	1 December 2009		
	First Submission Date[6]	In line with CDS submission cycles		
	Reporting Period / Submission Cycle[7]	In line with CDS submission cycles		
Conformance Date[8] "must be used effectively and assessed for use"		1 February 2010		
Superseded Date (of prior standard)[9] "stop using prior standard"		N/A		

Effects on Other Information Standards

None

Sponsor Details

Alan Robson
Deputy Director - Head of Elective Care and Diagnostics
NHS Finance, Performance and Operations - Performance Division
Department of Health

Further Information and Support

For further information on the 18 Weeks programme including the rules suite, how to measure and apply the rules and lessons learnt from the Secondary Uses Service pilot work visit:

http://www.18weeks.nhs.uk/Content.aspx?path=/

Email enquiries to data18weeks@dh.gsi.gov.uk

For further information on related DSCNs visit:

http://www.connectingforhealth.nhs.uk/dscn

For information on the NHS Data Dictionary visit:

http://www.connectingforhealth.nhs.uk/systemsandservices/data/datamodeldictionary

Email datastandards@nhs.net

For further information on the Secondary Uses Service including implementation timescales, training and access visit:

http://www.connectingforhealth.nhs.uk/systemsandservices/sus/index_html

The Secondary Uses Service Helpdesk email: bt.sus.helpdesk@bt.com or contact: 0845 600 2558

Appendices

For Human Behavioural, Organisational and Technical User Implementation Guidance visit:

http://www.18weeks.nhs.uk/Content.aspx?path=/measure-and-monitor/IT-solutions/

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:
    5. **Collection Start Date** – this is the date collection of data must begin
    6. **First Submission Date** – this is the date of first submission of data centrally
    7. **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).
8. **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
9. **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"***.

Change Request

NHS Connecting for Health

NHS Data Model and Dictionary Service

Reference:	Change Request 1003
Version No:	1.1
Subject:	Mandation of Referral to Treatment Period Data Items in Commissioning Data Sets
Effective Date:	1 December 2009
Reason for Change:	Change to Data Standards
Publication Date:	27 August 2009

Background:

Data Set Change Notice 18/2006 "Changes to the NHS Data Dictionary to support the measurement of 18 week referral to treatment periods", published in December 2006, defined essential new data items to support monitoring of Department of Health Patient Safety Agency target 13 - "By 2008, no one will have to wait longer than 18 weeks from GP referral to hospital treatment". In particular, DSCN 18/2006 introduced the following new data items:

- PATIENT PATHWAY IDENTIFIER
- REFERRAL TO TREATMENT PERIOD START DATE
- REFERRAL TO TREATMENT PERIOD END DATE
- REFERRAL TO TREATMENT PERIOD STATUS
- ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)

These new data items were included in the Commissioning Data Set version 6-0, introduced by DSCN 18/2007 "Commissioning Data Set Version 6-0". This introduced the PATIENT PATHWAY CDS Data Group in all Commissioning Data Set types. This Data Group consists of all the data items introduced by DSCN 18/2006, plus the UNIQUE BOOKING REFERENCE NUMBER (CONVERTED), which together with the ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) of NHS Connecting for Health (X09) uniquely identifies the Patient Pathway if it started with a referral from the Choose and Book system. Patient Pathways which do NOT start with a referral from Choose and Book, are identified by the PATIENT PATHWAY IDENTIFIER generated by the first organisation in the Pathway, and the ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) of that initiating organisation. The Commissioning Data Set Schema 6-0 (and subsequent releases) rules are that organisations can submit EITHER the PATIENT PATHWAY IDENTIFIER, OR the UNIQUE BOOKING REFERENCE NUMBER, not both. All the data elements in the PATIENT PATHWAY CDS Data Group were introduced as Optional. In addition, Data Set Change Notice 09/2007 introduced the EARLIEST REASONABLE OFFER DATE, which may also optionally flow in Commissioning Data Set Version 6-0 onwards.

The strategic national solution for reporting of 18 weeks performance is the Secondary Uses Service using data submitted by providers of NHS-funded care via the Commissioning Data Sets. In order to meet the NHS Operating Framework 2008/09 and 2009/10 requirements for using the Secondary Uses Service as the source for all activity reporting on the 18 weeks target, including Performance Sharing, it is necessary to mandate the flow of the Referral To Treatment data items above, for all events on active 18 week Referral To Treatment pathways, as defined in the 18 weeks rules suite (http://www.18weeks.nhs.uk/Content.aspx?path=/measure-and-monitor/Rules-suite/). Organisations will be required to submit Referral To Treatment data items for events on 18 week pathways that start on or after the 1st December 2009, to support the move to the Secondary Uses Service for full Perfomance Sharing. This intention was announced in the Advance Notification AN 0903, which was published by the Information Standards Board for Health and Social Care in March 2009.

The flow of Referral To Treatment data items for events on active 18 week Referral To Treatment pathways is only mandated in the following Commissioning Data Set Types:

- CDS Type 020 - Outpatient CDS
- CDS Type 130 - Admitted Patient Care - Finished General Episode CDS
- CDS Type 190 - Admitted Patient Care - Unfinished General Episode CDS
- CDS Type 030 - Elective Admission List - End of Period Census Standard CDS
- CDS Type 060 - Elective Admission List - Add CDS
- CDS Type 070 - Elective Admission List - Remove CDS
- CDS Type 080 - Elective Admission List - Offer CDS

Referral to Treatment data for events on active 18 weeks Referral To Treatment pathways may optionally continue to flow in other Commissioning Data Set Types not stated above, but are not processed by the Secondary Uses Services for reporting 18 week performance. Also, Referral to Treatment data items may optionally continue to flow for events NOT subject to 18 weeks measurement, in all Commissioning Data Set types, as at present.

In order to ensure that the Secondary Uses Services processes patient pauses correctly:

- if a patient pause is relevant for the event which ends the Referral To Treatment Period, EARLIEST REASONABLE OFFER DATE must be populated in the Admitted Patient Care General Episode Commissioning Data Set record (CDS types 130 and 190) for that event. Failure to include this data item with the Admitted Patient Care General Episode Commissioning Data Set record, which indicates the end of a Referral To Treatment Period, will mean no pause is applied to the duration of wait calculation performed by the Secondary Uses Service.
- If a patient pause is NOT to be applied then EARLIEST REASONABLE OFFER DATE should not be populated.

The NHS Data Model and Dictionary will be amended to show the new level of mandation for data elements in the affected Commissioning Data Set types, and data element EARLIEST REASONABLE OFFER DATE will be updated to define the rules for submission to the Secondary Uses Service.

Note that the Secondary Uses Service will not immediately process the four Elective Admission List Commissioning Data Set types listed above for 18 weeks activity reporting. This functionality will be introduced in a later Secondary Uses Service release, but the Department of Health are mandating the flow of Referral To Treatment data items in these Commissioning Data Set types now to ensure that organisations involved in the preparation and submission of Commissioning Data Sets, are aware of the requirement and can implement the flow of data as soon as possible.

There are no changes to the requirements for Mandatory submission of the individual Commissioning Data Set types. Providers of NHS-funded care are currently **required** to submit Commissioning Data Sets to the Secondary Uses Service for the following activity:

- Hospital Provider Spells with a separate episode for every consultant episode
- Consultant, Nurse and Midwife Out-Patient Attendances (Commissioning Data Set type 020 may also be used to carry data relating to Ward Attenders and Allied Health Professional activity, but these uses are not mandated)
- Accident and Emergency Attendances including those at Walk-In Centres and Minor Injuries Units

Therefore it remains optional to flow the Elective Admission List Commissioning Data Set types at present; however the Department of Health intend to mandate the flow of these Commissioning Data Set types in the near future (subject to approval from the Information Standards Board for Health and Social Care). Where the Elective Admission List Commissioning Data Sets do flow however, the Referral To Treatment data items in the PATIENT PATHWAY CDS Data Group should be present in the record if applicable.

This Data Set Change Notice also does not mandate the flow of initially-coded weekly Commissioning Data Set submissions, although this is a requirement in the NHS Operating Framework 2008/09 and is recommended by the Department of Health and the Information Centre for Health and Social Care to enable the presentation of timely activity data for organisations from the Secondary Uses Services. Use of the Net Change CDS Submission

Protocol is also recommended for the submission of weekly initially-coded data sets to the Secondary Uses Service.

Further guidance on collection and submission of Referral To Treatment activity is available from the Department of Health 18 Weeks website, at http://www.18weeks.nhs.uk/Content.aspx?path=/ .

Summary of changes:

Data Set	
CDS V6 TYPE 020	Changed Description
CDS V6 TYPE 030	Changed Description
CDS V6 TYPE 060	Changed Description
CDS V6 TYPE 070	Changed Description
CDS V6 TYPE 080	Changed Description
CDS V6 TYPE 130	Changed Description
CDS V6 TYPE 190	Changed Description
Supporting Information	
CDS MANDATED DATA FLOWS	Changed Description, Aliases
Data Elements	
EARLIEST REASONABLE OFFER DATE	Changed Description
ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	Changed Description, Aliases
PATIENT PATHWAY IDENTIFIER	Changed Description
REFERRAL TO TREATMENT PERIOD END DATE	Changed Description
REFERRAL TO TREATMENT PERIOD START DATE	Changed Description
REFERRAL TO TREATMENT STATUS	Changed Description
UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	Changed Description

Date: 5 August 2009

Sponsor: Alan Robson, Deputy Director - Head of Elective Care and Diagnostics, NHS Finance, Performance and Operations - Performance Division, Department of Health

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

CDS V6 TYPE 020

Change to Data Set: Changed Description

CDS V6 TYPE 020 - OUTPATIENT CDS

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

Where the Care Activity data relates to a Referral To Treatment Period Included In 18 Weeks Target, the CDS DATA GROUP : PATIENT PATHWAY data elements must be completed where appropriate.

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

The CDS consists of the following CDS Data Groups:

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

PATIENT IDENTITY
PATIENT CHARACTERISTICS
CARE EPISODE
ATTENDANCE OCCURRENCE
GP REGISTRATION
REFERRAL
MISSED APPOINTMENT OCCURRENCE
HEALTHCARE RESOURCE GROUP

The markers in the columns "OPT, U/A and HES" indicate the NHS recommendations for the inclusion of data:
M = Mandatory - data must be included **where** available
O = Optional - data need not be included
* = Must **Not** Be Used

CDS V6 TYPE 020 - THE OUTPATIENT CDS (Known in the Schema as the Care Activity CDS)		
~~CDS DATA GROUP: PATIENT PATHWAY: To carry the details of the Patient Pathway. One optional occurrence of this Group is permitted.~~		
CDS DATA GROUP: PATIENT PATHWAY: To carry the details of the Patient Pathway. This Group must be present if the record relates to a Referral To Treatment Period Included In 18 Weeks Target. One occurrence of this Group is permitted.		
Opt	**CDS Data Element**	
~~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~~	
M	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	
M	PATIENT PATHWAY IDENTIFIER	
M	ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	
M	REFERRAL TO TREATMENT STATUS	
M	REFERRAL TO TREATMENT PERIOD START DATE	
M	REFERRAL TO TREATMENT PERIOD END DATE	
*	LEAD CARE ACTIVITY INDICATOR (Not defined or approved by the Information Standards Board for Health and Social Care)	
CDS DATA GROUP: PATIENT IDENTITY: To carry the identity of the Patient. One occurrence of this Group is permitted.		
Opt	**CDS Data Element**	
M	LOCAL PATIENT IDENTIFIER	
M	ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	
M	NHS NUMBER	
M	NHS NUMBER STATUS INDICATOR	
O	PATIENT NAME	
O	PATIENT USUAL ADDRESS	
M	POSTCODE OF USUAL ADDRESS	

M	ORGANISATION CODE (PCT OF RESIDENCE)	
M	PERSON BIRTH DATE (From Commissioning Data Set version 6-1 onwards)	

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

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

CDS DATA GROUP: PATIENT CHARACTERISTICS: To carry the characteristics of the Patient. One occurrence of this Group is permitted.		
Opt	**CDS Data Element**	
M	PERSON BIRTH DATE (Commissioning data set version 6-0 only)	
M	PERSON GENDER CURRENT	
O	CARER SUPPORT INDICATOR	
M	ETHNIC CATEGORY (from Commissioning Data Set Version 6-1)	
CDS DATA GROUP: CARE EPISODE - Person Group (Consultant): To carry the details of the responsible Consultant. One occurrence of this Group is permitted.		
M	CONSULTANT CODE	
M	MAIN SPECIALTY CODE	
M	TREATMENT FUNCTION CODE	
CDS DATA GROUP: CARE EPISODE - CLINICAL DIAGNOSIS (ICD): To carry the details of the ICD Diagnosis Scheme and the Diagnoses.		
O	DIAGNOSIS SCHEME IN USE	
O	PRIMARY DIAGNOSIS (ICD)	
O	SECONDARY DIAGNOSIS (ICD) Multiple Secondary Diagnoses may be recorded.	
CDS DATA GROUP: CARE EPISODE - CLINICAL DIAGNOSIS (READ): To carry the details of the READ Diagnosis Scheme and the Diagnoses.		
O	DIAGNOSIS SCHEME IN USE	
O	PRIMARY DIAGNOSIS (READ)	
O	SECONDARY DIAGNOSIS (READ) Multiple Secondary Diagnoses may be recorded.	
CDS DATA GROUP: ATTENDANCE OCCURRENCE - Activity Characteristics: To carry the details of the Care Attendance or cancelled appointment.		
M	ATTENDANCE IDENTIFIER	
M	ADMINISTRATIVE CATEGORY	
M	ATTENDED OR DID NOT ATTEND	
M	FIRST ATTENDANCE	
M	MEDICAL STAFF TYPE SEEING PATIENT	
M	OPERATION STATUS (per attendance)	
M	OUTCOME OF ATTENDANCE	
M	APPOINTMENT DATE	

	This is the ***mandatory*** date used to derive the ***mandatory*** CDS ACTIVITY DATE.	
M	AGE AT CDS ACTIVITY DATE	
O	EARLIEST REASONABLE OFFER DATE	
CDS DATA GROUP: ATTENDANCE OCCURRENCE - Service Agreement Details: To carry the details of the Service Agreement for the Care Attendance.		
M	COMMISSIONING SERIAL NUMBER	
O	NHS SERVICE AGREEMENT LINE NUMBER	
O	PROVIDER REFERENCE NUMBER	
M	COMMISSIONER REFERENCE NUMBER	
M	ORGANISATION CODE (CODE OF PROVIDER)	
M	ORGANISATION CODE (CODE OF COMMISSIONER)	
CDS DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Activity Group (OPCS): To carry the details of the OPCS coded Clinical Activities undertaken.		
O	PROCEDURE SCHEME IN USE	
O O	PRIMARY PROCEDURE (OPCS) PROCEDURE DATE (of Primary Procedure)	
 O O	(Multiple Procedures may be recorded) PROCEDURE (OPCS) PROCEDURE DATE (of Secondary Procedure)	
CDS DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Activity Group (READ): To carry the details of the READ coded Clinical Activities undertaken.		
O	PROCEDURE SCHEME IN USE	
O O	PRIMARY PROCEDURE (READ) PROCEDURE DATE (of Primary Procedure)	
 O O	(Multiple Procedures may be recorded) PROCEDURE (READ) PROCEDURE DATE (of Secondary Procedure)	
CDS DATA GROUP: ATTENDANCE OCCURRENCE - Location Group of Care Attendance: To carry the details of the location and Site Code of Treatment. One occurrence of this Group is permitted.		
M	LOCATION CLASS	
M	SITE CODE (OF TREATMENT)	
*	LOCATION TYPE Definition and value list currently under review	
CDS DATA GROUP: GP REGISTRATION: To carry the Patient's General Medical Practitioner and General Practice details. One occurrence of this Group is permitted.		
O	GENERAL MEDICAL PRACTITIONER (SPECIFIED)	
M	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	
CDS DATA GROUP: REFERRAL - Activity Characteristics: To carry the details of the referral. One occurrence of this Group is permitted.		
M	PRIORITY TYPE	
M	SERVICE TYPE REQUESTED	
M	SOURCE OF REFERRAL FOR OUT-PATIENTS	
M	REFERRAL REQUEST RECEIVED DATE	
CDS DATA GROUP: REFERRAL - Person Group (Referrer): To carry the details of the referrer. One occurrence of this Group is permitted.		
M	REFERRER CODE	
M	REFERRING ORGANISATION CODE	

CDS DATA GROUP: MISSED APPOINTMENT - Occurrence: To carry the details of a missed appointment. One occurrence of this Group is permitted.		
M	LAST DNA OR PATIENT CANCELLED DATE	
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.		
O	PROCEDURE SCHEME IN USE	
O	HRG DOMINANT GROUPING VARIABLE-PROCEDURE	

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

CDS V6 TYPE 030

Change to Data Set: Changed Description

CDS V6 TYPE 030 - EAL - END OF PERIOD CENSUS STANDARD CDS

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

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

Three derivations are permitted:
1) CDS Type 030 - The End Of Period Census (STANDARD)
2) CDS Type 040 - The End Of Period Census (OLD)
3) CDS Type 050 - The End Of Period Census (NEW)

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

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

Where the Elective Admission List data relates to a Referral To Treatment Period Included In 18 Weeks Target, the CDS DATA GROUP : PATIENT PATHWAY data elements must be completed where appropriate.

The CDS TYPE 030 consists of the following CDS Data Groups:
INTERCHANGE, MESSAGE and CDS TRANSACTION HEADERS and TRAILERS (defined independently)
PATIENT PATHWAY
PATIENT IDENTITY
PATIENT CHARACTERISTICS

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

The markers in the columns "OPT, U/A and HES" indicate the NHS recommendations for the inclusion of data:
M = Mandatory - data must be included **where** available
O = Optional - data need not be included
* = Must **Not** Be Used

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

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

CDS DATA GROUP: PATIENT PATHWAY:
To carry the details of the Patient's Pathway. This Group must be present if the record relates to a Referral To Treatment Period Included In 18 Weeks Target.
One occurrence of this Group is permitted.

Opt	CDS Data Element	
~~O~~	~~UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)~~	
~~O~~	~~PATIENT PATHWAY IDENTIFIER~~	
~~O~~	~~ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)~~	
~~O~~	~~REFERRAL TO TREATMENT STATUS~~ ~~(intended status of the anticipated admission)~~	
~~O~~	~~REFERRAL TO TREATMENT PERIOD START DATE~~	
~~O~~	~~REFERRAL TO TREATMENT PERIOD END DATE~~	
M	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	
M	PATIENT PATHWAY IDENTIFIER	
M	ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	
M	REFERRAL TO TREATMENT STATUS (intended status of the anticipated admission)	
M	REFERRAL TO TREATMENT PERIOD START DATE	
M	REFERRAL TO TREATMENT PERIOD END DATE	
*	LEAD CARE ACTIVITY INDICATOR (Not defined or approved by the Information Standards Board for Health and Social Care)	

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

Opt	CDS Data Element	
M	LOCAL PATIENT IDENTIFIER	
M	ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	
M	NHS NUMBER	
M	NHS NUMBER STATUS INDICATOR	
O	PATIENT NAME	
O	PATIENT USUAL ADDRESS	
M	POSTCODE OF USUAL ADDRESS	

M	ORGANISATION CODE (PCT OF RESIDENCE)	
M	PERSON BIRTH DATE (From Commissioning Data Set version 6-1 onwards)	

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

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

CDS DATA GROUP: PATIENT CHARACTERISTICS: To carry the characteristics of the Patient. One occurrence of this Group is permitted.		
Opt	**CDS Data Element**	
M	PERSON BIRTH DATE (Commissioning Data Set version 6-0 only)	
M	PERSON GENDER CURRENT	
O	CARER SUPPORT INDICATOR	
CDS DATA GROUP: COMMISSIONING OCCURRENCE - Service Agreement Details: To carry the details of the Service Agreement for the Care Attendance.		
M	COMMISSIONING SERIAL NUMBER	
O	NHS SERVICE AGREEMENT LINE NUMBER	
O	PROVIDER REFERENCE NUMBER	
M	COMMISSIONER REFERENCE NUMBER	
M	ORGANISATION CODE (CODE OF PROVIDER)	
M	ORGANISATION CODE (CODE OF COMMISSIONER)	
O	NHS SERVICE AGREEMENT CHANGE DATE	
CDS DATA GROUP: EAL ENTRY - Activity Characteristics: To carry the details of the EAL ENTRY Occurrence.		
M	ELECTIVE ADMISSION LIST ENTRY NUMBER	
M	ADMINISTRATIVE CATEGORY	
M	COUNT OF DAYS SUSPENDED	
M	ELECTIVE ADMISSION LIST STATUS	
M	ELECTIVE ADMISSION TYPE	
M	INTENDED MANAGEMENT	
M	INTENDED PROCEDURE STATUS	
M	PRIORITY TYPE	
M	DECIDED TO ADMIT DATE (for this provider) This is the ***mandatory*** date used to derive the ***mandatory*** CDS ACTIVITY DATE	
M	AGE AT CDS ACTIVITY DATE	
O	GUARANTEED ADMISSION DATE	
M	LAST DNA OR PATIENT CANCELLED DATE	
O	WAITING LIST ENTRY LAST REVIEWED DATE	
CDS DATA GROUP: EAL ENTRY - Person Group (Consultant): To carry the details of the responsible Clinician. One occurrence of this Group is permitted.		
M	CONSULTANT CODE	

M	MAIN SPECIALTY CODE	
M	TREATMENT FUNCTION CODE	
CDS DATA GROUP: INTENDED PROCEDURES - OPCS: To carry the details of the Intended OPCS Procedures.		
O	PROCEDURE SCHEME IN USE	
O O	PRIMARY PROCEDURE (OPCS) PROCEDURE DATE (of Primary Procedure)	
 O O	(Multiple Procedures may be recorded) PROCEDURE (OPCS) PROCEDURE DATE (of Secondary Procedure)	
CDS DATA GROUP: INTENDED PROCEDURES - READ: To carry the details of the Intended READ Procedures.		
O	PROCEDURE SCHEME IN USE	
O O	PRIMARY PROCEDURE (READ) PROCEDURE DATE (of Primary Procedure)	
 O O	(Multiple Procedures may be recorded) PROCEDURE (READ) PROCEDURE DATE (of Secondary Procedure)	
CDS DATA GROUP: INTENDED PROCEDURES - Location Group: To carry the details of the Intended Location.		
O	LOCATION CLASS	
O	INTENDED SITE CODE (OF TREATMENT)	
*	LOCATION TYPE Definition and value list under review	
CDS DATA GROUP: GP REGISTRATION: To carry the Patient's General Medical Practitioner and General Practice details. One occurrence of this Group is permitted.		
O	GENERAL MEDICAL PRACTITIONER (SPECIFIED)	
M	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	
CDS DATA GROUP: REFERRAL: To carry the details of the Patient's Registered GMP. One occurrence of this Group is permitted.		
M	REFERRER CODE	
M	REFERRING ORGANISATION CODE	
CDS DATA GROUP: OFFER OF ADMISSION: To carry the details of the Offer of Admission and the Outcome.		
O	ADMISSION OFFER OUTCOME	
M	OFFERED FOR ADMISSION DATE	
O	EARLIEST REASONABLE OFFER DATE	
CDS DATA GROUP: - ORIGINAL EAL ENTRY: To carry the date on which the decision to admit was made.		
M	ORIGINAL DECIDED TO ADMIT DATE	
CDS DATA GROUP: EAL ENTRY REMOVAL: To carry the details of the removal from the EAL. One occurrence of this Group is permitted.		
O	ELECTIVE ADMISSION LIST REMOVAL REASON	
O	ELECTIVE ADMISSION LIST REMOVAL DATE	
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: (HCA) Healthcare Resource Group Activity - Clinical Activity Group: To carry the details of the HRG Dominant Grouping Variable - Procedure. Note that this will not apply when no operation was carried out.		
O	PROCEDURE SCHEME IN USE	
O	HRG DOMINANT GROUPING VARIABLE-PROCEDURE	

CDS V6 TYPE 060

Change to Data Set: Changed Description

CDS V6 TYPE 060 - EAL - EVENT DURING PERIOD - ADD CDS

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

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

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

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

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

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

Where the Elective Admission List data relates to a Referral To Treatment Period Included In 18 Weeks Target, the CDS DATA GROUP : PATIENT PATHWAY data elements must be completed where appropriate.

The CDS TYPE 060 consists of the following CDS Data Groups:
INTERCHANGE, MESSAGE and CDS TRANSACTION HEADERS and TRAILERS (defined independently)
PATIENT PATHWAY
PATIENT IDENTITY
PATIENT CHARACTERISTICS
COMMISSIONING OCCURRENCE
EAL ENTRY
GP REGISTRATION
OFFER OF ADMISSION
ORIGINAL EAL ENTRY
REFERRAL
HEALTHCARE RESOURCE GROUP

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

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

O = Optional - data need not be included

* = Must **Not** Be Used

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

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

CDS DATA GROUP: PATIENT PATHWAY:
To carry the details of the Patient Pathway. This Group must be present if the record relates to a Referral To Treatment Period Included In 18 Weeks Target.
One occurrence of this Group is permitted.

Opt	CDS Data Element	
~~O~~	~~UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)~~	
~~O~~	~~PATIENT PATHWAY IDENTIFIER~~	
~~O~~	~~ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)~~	
~~O~~	~~REFERRAL TO TREATMENT STATUS~~ ~~(intended status of the anticipated admission)~~	
~~O~~	~~REFERRAL TO TREATMENT PERIOD START DATE~~	
~~O~~	~~REFERRAL TO TREATMENT PERIOD END DATE~~	
M	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	
M	PATIENT PATHWAY IDENTIFIER	
M	ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	
M	REFERRAL TO TREATMENT STATUS (intended status of the anticipated admission)	
M	REFERRAL TO TREATMENT PERIOD START DATE	
M	REFERRAL TO TREATMENT PERIOD END DATE	
*	LEAD CARE ACTIVITY INDICATOR (Not defined or approved by the Information Standards Board for Health and Social Care)	

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

Opt	CDS Data Element	
M	LOCAL PATIENT IDENTIFIER	
M	ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	
M	NHS NUMBER	
M	NHS NUMBER STATUS INDICATOR	
O	PATIENT NAME	
O	PATIENT USUAL ADDRESS	
M	POSTCODE OF USUAL ADDRESS	
M	ORGANISATION CODE (PCT OF RESIDENCE)	
M	PERSON BIRTH DATE (From Commissioning Data Set version 6-1 onwards)	

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

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

CDS DATA GROUP: PATIENT CHARACTERISTICS: To carry the characteristics of the Patient. One occurrence of this Group is permitted.		
Opt	**CDS Data Element**	
M	PERSON BIRTH DATE (Commissioning Data Set version 6-0 only)	
M	PERSON GENDER CURRENT	
O	CARER SUPPORT INDICATOR	
CDS DATA GROUP: COMMISSIONING OCCURRENCE - Service Agreement Details: To carry the details of the Service Agreement for the Care Attendance.		
M	COMMISSIONING SERIAL NUMBER	
O	NHS SERVICE AGREEMENT LINE NUMBER	
O	PROVIDER REFERENCE NUMBER	
M	COMMISSIONER REFERENCE NUMBER	
M	ORGANISATION CODE (CODE OF COMMISSIONER)	
M	ORGANISATION CODE (CODE OF PROVIDER)	
O	NHS SERVICE AGREEMENT CHANGE DATE	
CDS DATA GROUP: EAL ENTRY - Activity Characteristics: To carry the details of the EAL ENTRY Occurrence.		
M	ELECTIVE ADMISSION LIST ENTRY NUMBER	
M	ADMINISTRATIVE CATEGORY	
M	COUNT OF DAYS SUSPENDED	
M	ELECTIVE ADMISSION LIST STATUS	
M	ELECTIVE ADMISSION TYPE	
M	INTENDED MANAGEMENT	
M	INTENDED PROCEDURE STATUS	
M	PRIORITY TYPE	
M	DECIDED TO ADMIT DATE This is the ***mandatory*** date used to derive the ***mandatory*** CDS ACTIVITY DATE. for this provider)	
M	AGE AT CDS ACTIVITY DATE	
O	GUARANTEED ADMISSION DATE	
M	LAST DNA OR PATIENT CANCELLED DATE	
O	WAITING LIST ENTRY LAST REVIEWED DATE	
CDS DATA GROUP: EAL ENTRY - Person Group (Consultant): To carry the details of the responsible Clinician. One occurrence of this Group is permitted.		
M	CONSULTANT CODE	
M	MAIN SPECIALTY CODE	
M	TREATMENT FUNCTION CODE	
CDS DATA GROUP: INTENDED PROCEDURES - OPCS: To carry the details of the Intended OPCS Procedures.		
O	PROCEDURE SCHEME IN USE	
O	PRIMARY PROCEDURE (OPCS)	

O	PROCEDURE DATE (of Primary Procedure)	
O O	(Multiple Procedures may be recorded) PROCEDURE (OPCS) PROCEDURE DATE (of Secondary Procedure)	
CDS DATA GROUP: INTENDED PROCEDURES - READ: To carry the details of the Intended READ Procedures.		
O	PROCEDURE SCHEME IN USE	
O O	PRIMARY PROCEDURE (READ) PROCEDURE DATE (of Primary Procedure)	
O O	(Multiple Procedures may be recorded) PROCEDURE (READ) PROCEDURE DATE (of Secondary Procedure)	
CDS DATA GROUP: INTENDED PROCEDURES - Location Group: To carry the details of the Intended Location.		
O	LOCATION CLASS	
O	INTENDED SITE CODE (OF TREATMENT)	
*	LOCATION TYPE Definition and value list under review	
CDS DATA GROUP: GP REGISTRATION: To carry the Patient's General Medical Practitioner and General Practice details. One occurrence of this Group is permitted.		
O	GENERAL MEDICAL PRACTITIONER (SPECIFIED)	
M	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	
CDS DATA GROUP: REFERRAL: To carry the details of the referral. One occurrence of this Group is permitted.		
M	REFERRER CODE	
M	REFERRING ORGANISATION CODE	
CDS DATA GROUP: OFFER OF ADMISSION: To carry the details of the Offer of Admission and the Outcome.		
O	ADMISSION OFFER OUTCOME	
M	OFFERED FOR ADMISSION DATE	
O	EARLIEST REASONABLE OFFER DATE	
CDS DATA GROUP: - ORIGINAL EAL ENTRY: To carry the date on which the decision to admit was made.		
M	ORIGINAL DECIDED TO ADMIT DATE	
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: (HCA) Healthcare Resource Group Activity - Clinical Activity Group: To carry the details of the HRG Dominant Grouping Variable - Procedure. Note that this will not apply when no operation was carried out.		
O	PROCEDURE SCHEME IN USE	
O	HRG DOMINANT GROUPING VARIABLE-PROCEDURE	

CDS V6 TYPE 070

Change to Data Set: Changed Description

CDS V6 TYPE 070 - EAL - EVENT DURING PERIOD - REMOVE CDS

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

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

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

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

This derivation, CDS Type = 070, is the Event During Period (REMOVE) and is used to report that the EAL entry has been removed from the Provider's Elective Admission List.

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

Where the Elective Admission List data relates to a Referral To Treatment Period Included In 18 Weeks Target, the CDS DATA GROUP : PATIENT PATHWAY data elements must be completed where appropriate.

The CDS TYPE 070 consists of the following CDS Data Groups:
INTERCHANGE, MESSAGE and CDS TRANSACTION HEADERS and TRAILERS (defined independently)
PATIENT PATHWAY
EAL ENTRY REMOVAL

The markers in the columns "OPT, U/A and HES" indicate the NHS recommendations for the inclusion of data:
M = Mandatory - data must be included **where** available
O = Optional - data need not be included
* = Must **Not** Be Used

CDS V6 TYPE 070 - THE ELECTIVE ADMISSION LIST EVENT DURING PERIOD - REMOVE CDS		
~~CDS DATA GROUP: PATIENT PATHWAY:~~ ~~To carry the details of the Patient Pathway.~~ ~~One optional occurrence of this Group is permitted.~~		
CDS DATA GROUP: PATIENT PATHWAY: **To carry the details of the Patient Pathway. This Group must be present if the record relates to a Referral To Treatment Period Included In 18 Weeks Target.** **One occurrence of this Group is permitted.**		
Opt	**CDS Data Element**	
~~O~~	~~UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)~~	
~~O~~	~~PATIENT PATHWAY IDENTIFIER~~	
~~O~~	~~ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)~~	

~~O~~	~~REFERRAL TO TREATMENT STATUS (intended status of the anticipated admission)~~	
~~O~~	~~REFERRAL TO TREATMENT PERIOD START DATE~~	
~~O~~	~~REFERRAL TO TREATMENT PERIOD END DATE~~	
M	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	
M	PATIENT PATHWAY IDENTIFIER	
M	ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	
M	REFERRAL TO TREATMENT STATUS (intended status of the anticipated admission)	
M	REFERRAL TO TREATMENT PERIOD START DATE	
M	REFERRAL TO TREATMENT PERIOD END DATE	
*	LEAD CARE ACTIVITY INDICATOR (Not defined or approved by the Information Standards Board for Health and Social Care)	
CDS DATA GROUP: EAL ENTRY REMOVAL: To carry the details of the removal from the EAL. One occurrence of this Group is permitted.		
M	ELECTIVE ADMISSION LIST REMOVAL REASON	
M	ELECTIVE ADMISSION LIST REMOVAL DATE This is the ***mandatory*** date used to derive the ***mandatory*** CDS ACTIVITY DATE.	

CDS V6 TYPE 080

Change to Data Set: Changed Description

CDS V6 TYPE 080 - EAL - EVENT DURING PERIOD - OFFER CDS

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

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

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

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

This derivation, CDS Type = 080, is the Event During Period (OFFER) and is used to report that an offer of admission has been made to the patient.

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

Where the Elective Admission List data relates to a Referral To Treatment Period Included In 18 Weeks Target, the CDS DATA GROUP : PATIENT PATHWAY data elements must be completed where appropriate.

The CDS TYPE 080 consists of the following CDS Data Groups:
INTERCHANGE, MESSAGE and CDS TRANSACTION HEADERS and TRAILERS (defined independently)
PATIENT PATHWAY
EAL OFFER OF ADMISSION

The markers in the columns "OPT, U/A and HES" indicate the NHS recommendations for the inclusion of data:
M = Mandatory - data must be included **where** available
O = Optional - data need not be included
* = Must **Not** Be Used

CDS V6 TYPE 080 - THE ELECTIVE ADMISSION LIST EVENT DURING PERIOD - OFFER CDS		
~~**CDS DATA GROUP: PATIENT PATHWAY:**~~ ~~**To carry the details of the Patient Pathway.**~~ ~~**One optional occurrence of this Group is permitted.**~~		
CDS DATA GROUP: PATIENT PATHWAY: **To carry the details of the Patient Pathway. This Group must be present if the record relates to a Referral To Treatment Period Included In 18 Weeks Target.** **One optional occurrence of this Group is permitted.**		
Opt	**CDS Data Element**	
~~O~~	~~UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)~~	
~~O~~	~~PATIENT PATHWAY IDENTIFIER~~	
~~O~~	~~ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)~~	
~~O~~	~~REFERRAL TO TREATMENT STATUS~~ ~~(intended status of the anticipated admission)~~	
~~O~~	~~REFERRAL TO TREATMENT PERIOD START DATE~~	
~~O~~	~~REFERRAL TO TREATMENT PERIOD END DATE~~	
M	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	
M	PATIENT PATHWAY IDENTIFIER	
M	ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	
M	REFERRAL TO TREATMENT STATUS (intended status of the anticipated admission)	
M	REFERRAL TO TREATMENT PERIOD START DATE	
M	REFERRAL TO TREATMENT PERIOD END DATE	
*	LEAD CARE ACTIVITY INDICATOR (Not defined or approved by the Information Standards Board for Health and Social Care)	
CDS DATA GROUP: EAL OFFER OF ADMISSION: **To carry the details of the Offer of Admission and the Outcome.** **One occurrence of this Group is permitted.**		
O	ADMISSION OFFER OUTCOME	
M	OFFERED FOR ADMISSION DATE This is the ***mandatory*** date used to derive the ***mandatory*** CDS ACTIVITY DATE.	
O	EARLIEST REASONABLE OFFER DATE	

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.

Where the Admitted Patient Care data relates to a Referral To Treatment Period Included In 18 Weeks Target, the CDS DATA GROUP : PATIENT PATHWAY data elements must be completed where appropriate.

In addition to Finished General Episodes an Unfinished General Episode Commissioning Data Set record is required for all Unfinished General Episodes at midnight on 31 March each year. Unfinished General Episode Commissioning Data Set 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 Hospital Episode Statistics 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.~~			
CDS DATA GROUP: PATIENT PATHWAY: **To carry the details of the Patient Pathway. This Group must be present if the record relates to a Referral To Treatment Period Included In 18 Weeks Target.** **One 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~~		
M	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)		
M	PATIENT PATHWAY IDENTIFIER		
M	ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)		
M	REFERRAL TO TREATMENT STATUS		
M	REFERRAL TO TREATMENT PERIOD START DATE		
M	REFERRAL TO TREATMENT PERIOD END DATE		
*	LEAD CARE ACTIVITY INDICATOR (Not defined or approved by the Information Standards Board for Health and Social Care)		

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 version 6-1 onwards)	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 version 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 admission 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 for Health and Social Care)	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 for Health and Social Care) (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		•
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 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.

Where the Admitted Patient Care data relates to a Referral To Treatment Period Included In 18 Weeks Target, the CDS DATA GROUP : PATIENT PATHWAY data elements must be completed where appropriate.

An Unfinished General Episode Commissioning Data Set record is required for all Unfinished General Episodes at midnight on 31 March each year. Unfinished General Episode Commissioning Data Set 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 Hospital Episode Statistics 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.~~			
CDS DATA GROUP: PATIENT PATHWAY: **To carry the details of the Patient Pathway. This Group must be present if the record relates to a Referral To Treatment Period Included In 18 Weeks Target.** **One 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~~		
M	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)		
M	PATIENT PATHWAY IDENTIFIER		
M	ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)		
M	REFERRAL TO TREATMENT STATUS		
M	REFERRAL TO TREATMENT PERIOD START DATE		
M	REFERRAL TO TREATMENT PERIOD END DATE		
*	LEAD CARE ACTIVITY INDICATOR (Not defined or approved by the Information Standards Board for Health and Social Care)		

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 version 6-1 onwards)	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 version 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) (Not defined or approved by the Information Standards Board for Health and Social Care)	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 for Health and Social Care) (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		•
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 MANDATED DATA FLOWS

Change to Supporting Information: Changed Description, Aliases

~~The strategic direction originally set out within *Information for Health* is to develop comprehensive and consistent electronic health records for PATIENTS from clinical information flows.~~The minimum Commissioning Data Set information flow requirement to enable Hospital Episode Statistics, 18 weeks activity reporting, and Payment by Results to be supported by the Secondary Uses Service is shown in the table below.

~~Where Commissioning Data Set information is maintained, it should be submitted via the Secondary Uses Service which supports every CDS TYPE but only a subset is mandated to flow. The analysis of CDS TYPEs will remain important, and the submission of these data sets should continue on an at least a monthly basis.~~The Secondary Uses Service supports every CDS TYPE but only a subset is mandated to flow.

~~The minimum Commissioning Data Set information flow requirement to enable Hospital Episode Statistics and Payment by Results to be supported by the Secondary Uses Service is shown in the table below, however it is strongly advised that all NHS Trusts should, as a minimum, commence migration to use the CDS XML Version 6 Message for weekly Net Change submissions by March 2009 as this is the date mandated by the **"NHS Operating Framework".**~~Commissioning Data Sets may flow to the Secondary Uses Service using either Net Change or Bulk Replacement Commissioning Data Set Submission Protocols. Many Standard NHS Contracts between Health Care Providers and the commissioners of their SERVICES, now specify weekly submission of initially-coded data sets to the Secondary Uses Service. The use of Net Change Commissioning Data Set Submission Protocols is recommended for submissions of this frequency.

CDS TYPE	DESCRIPTION	MIN FREQ	DIRECTIVE	DATA FLOW
CDS 010	Accident And Emergency	Monthly	Accident And Emergency Attendances were mandated to flow nationally from 1st April 2005, see DSCN 32/2004	All Accident And Emergency Attendances occurring during the time period being reported and defined by the Commissioning Data Set Submission Protocol being used.
~~CDS 020~~	~~Out-Patient~~	~~Monthly~~	~~Out-Patient Attendance Commissioning Data Sets (including Ward Attenders) were mandated to be submitted to the Secondary Uses Service from 1st October 2001, see DSCN 05/2001.~~ ~~NURSE and MIDWIFE attendances and Attendances for nursing care were enabled to be carried in the Out-Patient Attendance CDS from 1 April 2005, DSCN 32/2004.~~ ~~Other CARE PROFESSIONAL Attendances where an appropriate TREATMENT FUNCTION exists may also be submitted.~~	~~Due to the high volumes involved, these are often submitted on a weekly basis.~~
CDS 020	Out-Patient	Monthly	Out-Patient Attendance Commissioning Data Sets (including Ward Attenders) were	Due to the high volumes involved, these are often submitted on a weekly basis.

			mandated to be submitted to the Secondary Uses Service from 1st October 2001, see DSCN 05/2001. Out-Patient Attendance CDS records where the activity relates to a Referral To Treatment Period Included In 18 Weeks Target must include the PATIENT PATHWAY data group items, from 1st October 2009. Nurse and Midwife attendances and Attendances for nursing care were enabled to be carried in the Out-Patient Attendance CDS from 1 April 2005, DSCN 32/2004. Other Care Professional Attendances where an appropriate Treatment Function exists may also be submitted.	
CDS 021	Future Out-Patients	As Required for piloting	From 01/01/2008, submissions to support local activities and commissioning will be supported for piloting purposes only.	.
~~CDS 030~~	~~Elective Admission List End of Period (Standard)~~	~~Monthly if used~~	~~All Providers should endeavour to support this data flow~~	~~All entries where at the end of the time period being reported and defined by the Commissioning Data Set Submission Protocol, the PATIENT remains on the ELECTIVE ADMISSION LIST. Optionally and by local agreement with commissioners, entries relating to the PATIENTS that have been removed from the ELECTIVE ADMISSION LIST may be included.~~
CDS 030	Elective Admission List End of Period (Standard)	Monthly if used	All Providers should endeavour to support this data flow. Elective Admission List End of Period Census (Standard)CDS records where the activity relates to a Referral To Treatment Period Included In 18 Weeks Target must include the PATIENT PATHWAY data group items, from 1st October 2009.	All entries where at the end of the time period being reported and defined by the Commissioning Data Set Submission Protocol, the PATIENT remains on the ELECTIVE ADMISSION LIST. Optionally and by local agreement with commissioners, entries relating to the PATIENTS that have been removed from the ELECTIVE ADMISSION LIST may be included.
CDS 040	Elective Admission List End of Period (New)	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
CDS 050	Elective Admission List End of Period (Old)	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
~~CDS 060~~	~~Elective Admission List Event During Period (Add)~~	~~Monthly if used~~	~~Optional~~	~~May be submitted where an entry has been added to the ELECTIVE ADMISSION LIST during the time period reported.~~
~~CDS 070~~	~~Elective Admission List Event During Period (Remove)~~	~~Monthly if used~~	~~Optional~~	~~May be submitted where an entry has been removed from the ELECTIVE ADMISSION LIST during the time period reported.~~
~~CDS~~	~~Elective Admission List~~	~~Monthly~~	~~Optional~~	~~May be submitted where an offer~~

~~080~~	~~Event During Period (Offer)~~	~~if used~~		~~has been made during the time period reported.~~
CDS 060	Elective Admission List Event During Period (Add)	Monthly if used	Optional Elective Admission List Event During Period (Add) CDS records where the activity relates to a Referral To Treatment Period Included In 18 Weeks Target must include the PATIENT PATHWAY data group items, from 1st October 2009.	May be submitted where an entry has been added to the ELECTIVE ADMISSION LIST during the time period reported.
CDS 070	Elective Admission List Event During Period (Remove)	Monthly if used	Optional Elective Admission List Event During Period (Remove) CDS records where the activity relates to a Referral To Treatment Period Included In 18 Weeks Target must include the PATIENT PATHWAY data group items, from 1st October 2009.	May be submitted where an entry has been removed from the ELECTIVE ADMISSION LIST during the time period reported.
CDS 080	Elective Admission List Event During Period (Offer)	Monthly if used	Optional Elective Admission List Event During Period (Offer) CDS records where the activity relates to a Referral To Treatment Period Included In 18 Weeks Target must include the PATIENT PATHWAY data group items, from 1st October 2009.	May be submitted where an offer has been made during the time period reported.
CDS 090	Elective Admission List Event During Period (Available / Unavailable)	Monthly if used	Optional	May be submitted where a patient becomes Available or Unavailable during the time period reported.
CDS 100	Elective Admission List Event During Period (Old Service Agreement)	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
CDS 110	Elective Admission List Event During Period (New Service Agreement)	Monthly if used	Optional	May be submitted where the Commissioner has been changed during the time period reported.
CDS 120	Finished Birth Episode	Monthly	All finished Admitted Patient Care data must be submitted "at least monthly" (EL - Dec 1995). This includes Out Of Area Treatments.	All Episodes that have finished relevant to the time period defined by the Commissioning Data Set Submission Protocol being used.
~~CDS 130~~	~~Finished General Episode~~	~~Monthly~~	~~All finished Admitted Patient Care data must be submitted "at least monthly" (EL - Dec 1995).~~ ~~This includes Non-Contract Activity.~~	~~All Episodes that have finished relevant to the time period defined by the Commissioning Data Set Submission Protocol being used.~~
CDS 130	Finished General Episode	Monthly	All finished Admitted Patient Care data must be submitted "at least monthly" (EL - Dec 1995).This includes Non-Contract Activity.	All Episodes that have finished relevant to the time period defined by the Commissioning Data Set Submission Protocol being used.

			Finished General Episode CDS records where the activity relates to a Referral To Treatment Period Included In 18 Weeks Target must include the PATIENT PATHWAY data group items, from 1st October 2009.	
CDS 140	Finished Delivery Episode	Monthly	All finished Admitted Patient Care data must be submitted ***at least monthly*** (EL - Dec 1995). This includes Non-Contract Activity.	All Episodes that have finished relevant to the time period defined by the Commissioning Data Set Submission Protocol being used.
CDS 150	Other Birth	Monthly	This includes Home Birth.	All Episodes that have finished relevant to the time period defined by the Commissioning Data Set Submission Protocol being used.
CDS 160	Other Delivery	Monthly	This includes Home Delivery.	All Episodes that have finished relevant to the time period defined by the Commissioning Data Set Submission Protocol being used.
CDS 170	The Detained and/or Long Term Psychiatric Census	Annually	Required by the Health and Social Care Information Centre. May *optionally* be sent more regularly, usually monthly.	Reflects data as at the 31st March each year. All Episodes that are relevant to the time period defined by the Commissioning Data Set Submission Protocol being used.
CDS 180	Unfinished Birth Episode	Annually	The Annual Census / Unfinished Census. Required by the Health and Social Care Information Centre. May optionally be sent more regularly, usually monthly.	Data relating to episodes that were unfinished as at midnight on 31st March and have not been included in the Detained and/or Long Term Psychiatric Census, and have not been submitted to the Secondary Uses Service in either Finished or Unfinished Commissioning Data Set data, must be submitted to the Secondary Uses Service.
~~CDS 190~~	~~Unfinished General Episode~~	~~Annually~~	~~The Annual Census / Unfinished Census. Required by the Health and Social Care Information Centre.~~ ~~May optionally be sent more regularly, usually monthly.~~	~~Data relating to episodes that were unfinished as at midnight on 31st March and have not been included in the Detained and/or Long Term Psychiatric Census, and have not been submitted to the Secondary Uses Service in either Finished or Unfinished Commissioning Data Set data, must be submitted to the Secondary Uses Service.~~
CDS 190	Unfinished General Episode	Annually	The Annual Census / Unfinished Census. Required by the Health and Social Care Information Centre. May optionally be sent more regularly, usually monthly. Unfinished General Episode CDS records where the activity relates to a Referral To Treatment Period Included In 18 Weeks Target must include the PATIENT PATHWAY data group items, from 1st October 2009.	Data relating to episodes that were unfinished as at midnight on 31st March and have not been included in the Detained and/or Long Term Psychiatric Census, and have not been submitted to the Secondary Uses Service in either Finished or Unfinished Commissioning Data Set data, must be submitted to the Secondary Uses Service.

CDS 200	Unfinished Delivery Episode	Annually	The Annual Census / Unfinished Census. Required by the Health and Social Care Information Centre. May optionally be sent more regularly, usually monthly.	Data relating to episodes that were unfinished as at midnight on 31st March and have not been included in the Detained and/or Long Term Psychiatric Census, and have not been submitted to the Secondary Uses Service in either Finished or Unfinished Commissioning Data Set data, must be submitted to the Secondary Uses Service.

In the above data flows, the validation criteria for each data element is shown in the Commissioning Data Set Validation Table.

CDS MANDATED DATA FLOWS

Change to Supporting Information: Changed Description, Aliases

- Changed Description
- Alias Changes

Name	Old Value	New Value
shortname	Commissioning Data Set Mandated Data Flow	
fullname	Commissioning Data Set Mandated Data Flows	
plural		CDS Mandated Data Flows

EARLIEST REASONABLE OFFER DATE

Change to Data Element: Changed Description

Format/length:	see DATE
National Codes:	
Default Codes:	

Notes:
It is the date of the earliest of the Reasonable Offers made to a PATIENT for an APPOINTMENT or Elective Admission. ~~It should only be included on the Commissioning Data Sets where the PATIENT has declined at least two Reasonable Offers.~~ It should only be included on the Commissioning Data Sets where the PATIENT has declined at least two Reasonable Offers, and a Patient Pause is to be applied to the length of wait calculation performed by the Secondary Uses Service.

For an APPOINTMENT this is the earliest of the APPOINTMENT DATES OFFERED where the REASONABLE OFFER INDICATOR of the APPOINTMENT OFFER is National code 1 - *Reasonable Offer*.

For an OFFER OF ADMISSION this is the earliest of the OFFERED FOR ADMISSION DATES where the REASONABLE OFFER INDICATOR of the OFFER OF ADMISSION is National code 1 - *Reasonable Offer*.

Patient Cancellations
Where, for any reason, a PATIENT cancels or does not attend an APPOINTMENT or an OFFER OF ADMISSION the EARLIEST REASONABLE OFFER DATE for the rearranged APPOINTMENT or OFFER OF ADMISSION will be the EARLIEST REASONABLE OFFER DATE of the cancelled APPOINTMENT or OFFER OF ADMISSION.

Provider Cancellations
Where, for any reason, any Health Care Provider cancels and re-arranges an APPOINTMENT or an OFFER OF ADMISSION, the EARLIEST REASONABLE OFFER DATE for the re-arranged APPOINTMENT or OFFER OF

ADMISSION will be the date of the earliest Reasonable Offer made following the cancellation.

Patients who are unavailable
Where a PATIENT makes themself unavailable for a longer period of time, for example a PATIENT who is a teacher who wishes to delay their admission until the summer holidays, making a Reasonable Offer may be inappropriate.

In these circumstances, so long as the Health Care Provider could have made at least two Reasonable Offers, the EARLIEST REASONABLE OFFER DATE will be the date of the earliest Reasonable Offer that the provider could have offered the PATIENT. This must be communicated to the PATIENT.

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record:

relates to a Referral To Treatment Period Included In 18 Weeks Target

and

includes the REFERRAL TO TREATMENT PERIOD END DATE of the REFERRAL TO TREATMENT PERIOD

and

is of the following Commissioning Data Set Types:

- CDS V6 TYPE 130 - ADMITTED PATIENT CARE - FINISHED GENERAL EPISODE CDS
- CDS V6 TYPE 190 - ADMITTED PATIENT CARE - UNFINISHED GENERAL EPISODE CDS

then EARLIEST REASONABLE OFFER DATE must be populated in the Commissioning Data Set record if a Patient Pause (the PATIENT is paused on the ELECTIVE ADMISSION LIST because they have made themselves unavailable for treatment for a specified period (for non-clinical reasons)) is to be applied to a REFERRAL TO TREATMENT PERIOD by the Secondary Uses Service.

Failure to include EARLIEST REASONABLE OFFER DATE in the Admitted Patient Care General Episode Commissioning Data Set record carrying the REFERRAL TO TREATMENT PERIOD END DATE, will mean no Patient Pause is applied to the duration of wait calculation for the REFERRAL TO TREATMENT PERIOD performed by the Secondary Uses Service.

ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)

Change to Data Element: Changed Description, Aliases

Format/length:	an5
National Codes:	
Default Codes:	

Notes:
This is the ORGANISATION CODE of the ORGANISATION issuing the PATIENT PATHWAY IDENTIFIER.

Where Choose and Book has been used, the ORGANISATION CODE for NHS Connecting For Health (X09) should be used.

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a Referral To Treatment Period Included In 18 Weeks Target, and is of the following Commissioning Data Set Types:

- CDS V6 TYPE 020 - OUTPATIENT CDS
- CDS V6 TYPE 130 - ADMITTED PATIENT CARE - FINISHED GENERAL EPISODE CDS
- CDS V6 TYPE 190 - ADMITTED PATIENT CARE - UNFINISHED GENERAL EPISODE CDS
- CDS V6 TYPE 030 - EAL - END OF PERIOD CENSUS STANDARD CDS
- CDS V6 TYPE 060 - EAL - EVENT DURING PERIOD - ADD CDS
- CDS V6 TYPE 070 - EAL - EVENT DURING PERIOD - REMOVE CDS
- CDS V6 TYPE 080 - EAL - EVENT DURING PERIOD - OFFER CDS

then ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)

Change to Data Element: Changed Description, Aliases

- Changed Description
- Alias Changes

Name	Old Value	New Val
plural	ORGANISATION CODES (PATIENT PATHWAY IDENTIFIER ISSUER)	

PATIENT PATHWAY IDENTIFIER

Change to Data Element: Changed Description

Format/length:	an20
National Codes:	
Default Codes:	

Notes:
~~PATIENT PATHWAY IDENTIFIER is the same as attribute PATIENT PATHWAY IDENTIFIER.~~PATIENT PATHWAY IDENTIFIER is the same as PATIENT PATHWAY IDENTIFIER.

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a Referral To Treatment Period Included In 18 Weeks Target, and is of the following Commissioning Data Set Types:

- CDS V6 TYPE 020 - OUTPATIENT CDS
- CDS V6 TYPE 130 - ADMITTED PATIENT CARE - FINISHED GENERAL EPISODE CDS
- CDS V6 TYPE 190 - ADMITTED PATIENT CARE - UNFINISHED GENERAL EPISODE CDS
- CDS V6 TYPE 030 - EAL - END OF PERIOD CENSUS STANDARD CDS
- CDS V6 TYPE 060 - EAL - EVENT DURING PERIOD - ADD CDS
- CDS V6 TYPE 070 - EAL - EVENT DURING PERIOD - REMOVE CDS
- CDS V6 TYPE 080 - EAL - EVENT DURING PERIOD - OFFER CDS

then either UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) or PATIENT PATHWAY IDENTIFIER must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

REFERRAL TO TREATMENT PERIOD END DATE

Change to Data Element: Changed Description

Format/length:	see DATE
HES item:	
National Codes:	
Default Codes:	

Notes:
This is the same as attribute REFERRAL TO TREATMENT PERIOD END DATE.

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a Referral To Treatment Period Included In 18 Weeks Target, and is of the following Commissioning Data Set Types:

- CDS V6 TYPE 020 - OUTPATIENT CDS
- CDS V6 TYPE 130 - ADMITTED PATIENT CARE - FINISHED GENERAL EPISODE CDS
- CDS V6 TYPE 190 - ADMITTED PATIENT CARE - UNFINISHED GENERAL EPISODE CDS
- CDS V6 TYPE 030 - EAL - END OF PERIOD CENSUS STANDARD CDS
- CDS V6 TYPE 060 - EAL - EVENT DURING PERIOD - ADD CDS
- CDS V6 TYPE 070 - EAL - EVENT DURING PERIOD - REMOVE CDS
- CDS V6 TYPE 080 - EAL - EVENT DURING PERIOD - OFFER CDS

then REFERRAL TO TREATMENT PERIOD END DATE must be present in the Commissioning Data Set PATIENT PATHWAY Data Group, where the REFERRAL TO TREATMENT PERIOD has ended.

REFERRAL TO TREATMENT PERIOD START DATE

Change to Data Element: Changed Description

Format/length:	see DATE
HES item:	
National Codes:	
Default Codes:	

Notes:
This is the same as attribute REFERRAL TO TREATMENT PERIOD START DATE.

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a Referral To Treatment Period Included In 18 Weeks Target, and is of the following Commissioning Data Set Types:

- CDS V6 TYPE 020 - OUTPATIENT CDS
- CDS V6 TYPE 130 - ADMITTED PATIENT CARE - FINISHED GENERAL EPISODE CDS
- CDS V6 TYPE 190 - ADMITTED PATIENT CARE - UNFINISHED GENERAL EPISODE CDS
- CDS V6 TYPE 030 - EAL - END OF PERIOD CENSUS STANDARD CDS
- CDS V6 TYPE 060 - EAL - EVENT DURING PERIOD - ADD CDS

- CDS V6 TYPE 070 - EAL - EVENT DURING PERIOD - REMOVE CDS
- CDS V6 TYPE 080 - EAL - EVENT DURING PERIOD - OFFER CDS

then REFERRAL TO TREATMENT PERIOD START DATE must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

REFERRAL TO TREATMENT STATUS

Change to Data Element: Changed Description

Format/length:	n2
HES item:	
National Codes:	Click on the attribute tab to display the attribute that contains the National Codes
Default Codes:	

Notes:
This is the same as attribute REFERRAL TO TREATMENT PERIOD STATUS.

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a Referral To Treatment Period Included In 18 Weeks Target, and is of the following Commissioning Data Set Types:

- CDS V6 TYPE 020 - OUTPATIENT CDS
- CDS V6 TYPE 130 - ADMITTED PATIENT CARE - FINISHED GENERAL EPISODE CDS
- CDS V6 TYPE 190 - ADMITTED PATIENT CARE - UNFINISHED GENERAL EPISODE CDS
- CDS V6 TYPE 030 - EAL - END OF PERIOD CENSUS STANDARD CDS
- CDS V6 TYPE 060 - EAL - EVENT DURING PERIOD - ADD CDS
- CDS V6 TYPE 070 - EAL - EVENT DURING PERIOD - REMOVE CDS
- CDS V6 TYPE 080 - EAL - EVENT DURING PERIOD - OFFER CDS

then REFERRAL TO TREATMENT STATUS must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)

Change to Data Element: Changed Description

Format/length:	n12
HES item:	
National Codes:	
Default Codes:	

Notes:
This is the same as attribute UNIQUE BOOKING REFERENCE NUMBER (CONVERTED).

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a Referral To Treatment Period Included In 18 Weeks Target,

and is of the following Commissioning Data Set Types:

- CDS V6 TYPE 020 - OUTPATIENT CDS
- CDS V6 TYPE 130 - ADMITTED PATIENT CARE - FINISHED GENERAL EPISODE CDS
- CDS V6 TYPE 190 - ADMITTED PATIENT CARE - UNFINISHED GENERAL EPISODE CDS
- CDS V6 TYPE 030 - EAL - END OF PERIOD CENSUS STANDARD CDS
- CDS V6 TYPE 060 - EAL - EVENT DURING PERIOD - ADD CDS
- CDS V6 TYPE 070 - EAL - EVENT DURING PERIOD - REMOVE CDS
- CDS V6 TYPE 080 - EAL - EVENT DURING PERIOD - OFFER CDS

then either UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) or PATIENT PATHWAY IDENTIFIER must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

For enquiries about this Data Set Change Notice, please email datastandards@nhs.net