DSC Notice: 17/2009 V1.1
Date of Issue: August 2009

Information Standards Board for Health and Social Care

Sponsoring Organisation:	Implementation Date:	01 December 2009
Department of Health	Subject: **Referral to Treatment Clock Stop Administrative Event**	

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:

Strategic reporting of 18 weeks will be undertaken by the Secondary Uses Service using data obtained via the Commissioning Data Sets (CDS). The Referral To Treatment data items defined in DSCN 18/2006 are enabled to flow in Commissioning Data Set version 6-0, 6-1, and will continue to flow in subsequent versions.

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

This Data Set Change Notice introduces the ability to carry Referral to Treatment Clock Stop Administrative Events in the Commissioning Data Set Type 020 Out-patient record type. They are differentiated from PATIENT contact activity by the FIRST ATTENDANCE value carried within them. An additional value for FIRST ATTENDANCE (national code 5 "Referral to treatment clock stop administrative event") is introduced by this Data Set Change Notice, which signifies that an ACTIVITY has taken place during a Referral To Treatment Period included in 18 weeks target, that has ended the REFERRAL TO TREATMENT PERIOD and changed the REFERRAL TO TREATMENT PERIOD STATUS to one of the following:

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

Referral To Treatment Clock Stop Administrative Events only require a sub-set of the data elements contained in the Commissioning Data Set Version 6 Type 020 Outpatient record, to be submitted to the Secondary Uses Service. All other data elements not listed should be omitted from the XML submission of the type 020 Commissioning Data Set record to the Secondary Uses Service.

The ability to carry additional value 5 within the FIRST ATTENDANCE field within the Commissioning Data Set XML Schema, and hence the ability to flow a Referral To Treatment Clock Stop Administrative Event, is available in Commissioning Data Set schema version 6-1 and will continue in subsequent versions.

There is no clinical impact - the change is proposed to enable improved recording of existing processes.

The administrative impact of the change is moderate. Changes to trust processes and procedures are not proposed but it may require a change in the way in which these processes are recorded within systems.

System suppliers will be impacted as they will be required to generate a subset of the data to support a Commissioning Data Set type 020 Out-patient record, from a transaction which is not a traditional Outpatient attendance.

Guidance and scenario's for use of the Referral To Treatment Clock Stop Administrative Event, are available from the 18 weeks website at :

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

Other data sets / return affected:

Commissioning Data Set Type 020 Out-Patients

Related DSCNs:

DSCN 10/2006
DSCN 18/2006
DSCN 18/2007

Impact of Change:

Service: Moderate **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/commissioning

DATA SET CHANGE NOTICE

Reference No:	DSCN 17/2009
Version No:	1.1
Subject:	Referral to Treatment Clock Stop Administrative Event
Type of Change:	Introduction of a new approved information requirement or information standard
Implementation Date:	01 December 2009
Business Justification:	To support an agreed government manifesto, Public Service Agreement (PSA) target and the NHS Operating Framework 18 weeks referral to treatment (RTT) time data collection

Introduction

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

Strategic reporting of 18 weeks will be undertaken by the Secondary Uses Service using data obtained via the Commissioning Data Sets (CDS). The new data items defined in DSCN 18/2006 are enabled to flow in Commissioning Data Set version 6-0, 6-1, and will continue to flow in subsequent versions.

These events may happen because:

- The activity ending the event does not qualify as a "patient contact" between a clinician and patient, or
- The activity occurred in a setting where IT systems cannot produce Referral To Treatment Period data items, or
- The activity would be carried in a Commissioning Data Set record type not currently processed by the Secondary Uses Service

The Secondary Uses Service currently processes the following Commissioning Data Set record types in order to build Referral To
Treatment pathways:

- 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

All other Commissioning Data Set types are not currently processed and so if they carry the REFERRAL TO TREATMENT PERIOD END DATE for a

REFERRAL TO TREATMENT PERIOD, a Referral To Treatment Clock Stop Administrative Event must also be sent in order to inform the Secondary Uses Service of the clock stop.

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

These Referral to Treatment Clock Stop Administrative Events are carried using the Commissioning Data Set Type 020 Outpatient record type. They are differentiated from PATIENT contact activity by the FIRST ATTENDANCE value carried within them. FIRST ATTENDANCE national code 5 "Referral to treatment clock stop administrative event" signifies that an ACTIVITY has taken place during a Referral To Treatment Period included in 18 weeks target, that has ended the REFERRAL TO TREATMENT PERIOD and changed the REFERRAL TO TREATMENT PERIOD STATUS to one of the following:

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

Referral To Treatment Clock Stop Administrative Events only require a sub-set of the data elements contained in the Commissioning Data Set Version 6 Type 020 Outpatient record, to be submitted to the Secondary Uses Service. All other data elements not listed should be omitted from the XML submission of the type 020 Commissioning Data Set record to the Secondary Uses Service.

Background

The ability to submit a Commissioning Data Set type 020 Outpatient record with an additional value for FIRST ATTENDANCE will enable accurate measurement and reporting of RTT times, and also ensure that the principles of 18 weeks are adhered to by all organisations concerned.

One of the priorities outlined in the NHS Improvement Plan was that by December 2008 no one will have to wait longer than 18 weeks from GP referral to hospital treatment.

This is also stated in the Department of Health's (DH) Public Service Agreement (PSA) target 13 to ensure that by 2008 no-one waits more than 18 weeks from GP referral to hospital treatment unless it is clinically appropriate or the patient chooses to do so.

The 18-week Referral To Treatment (RTT) pathway is about improving patients' experience of the NHS and ensuring all patients receive high quality elective care without any unnecessary delay.

(Reference 18 week rules suite – executive summary - http://www.18weeks.nhs.uk/Content.aspx?path=/Library-of-resources/publications/)

Details of Change

Referral To Treatment Clock Stop Administrative Events only require a sub-set of the data elements contained in the Commissioning Data Set Version 6 Type 020 Outpatient record, to be submitted to the Secondary Uses Service. All other data elements not listed should be omitted from the XML submission of the type 020 Commissioning Data Set record to the Secondary Uses Service.

The required data elements making up a Referral To Treatment Clock Stop Administrative Event are:
(Note: New text is shown with a blue background)

Data Element Required	Notes
UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) or PATIENT PATHWAY IDENTIFIER	The Commissioning Data Set Schema version 6-1 requires EITHER the PATIENT PATHWAY IDENTIFIER, or the UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) to be populated.
ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	If the UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) is used, the ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) should contain X09 (which relates to the Choose and Book system)
REFERRAL TO TREATMENT STATUS	This should contain only one of the following codes to signify that the REFERRAL TO TREATMENT PERIOD has ended: 30 Start of First Definitive Treatment 31 Start of Active Monitoring initiated by the PATIENT 32 Start of Active Monitoring initiated CARE PROFESSIONAL 34 Decision not to treat - decision not to treat made or no further contact required 35 PATIENT declined offered treatment 36 PATIENT died before treatment
REFERRAL TO TREATMENT PERIOD START DATE	
REFERRAL TO TREATMENT PERIOD END DATE	
NHS NUMBER	
NHS NUMBER STATUS INDICATOR	
POSTCODE OF USUAL ADDRESS	
ORGANISATION CODE (PCT OF RESIDENCE)	
FIRST ATTENDANCE	This should always hold the National code 5 - "Referral to Treatment Period Clock Stop Administrative Event"
APPOINTMENT DATE	This field is XML mandatory in Commissioning Data Set Schema version 6-1 for Type 020 Outpatients, and for the purposes of the Referral To Treatment Clock Stop Administrative Event, should hold the same date as the REFERRAL TO TREATMENT PERIOD END DATE
AGE AT CDS ACTIVITY DATE	This field is XML mandatory in the Commissioning Data Set Schema version 6-1 for Type 020 Outpatients, and should hold the PATIENTS age at REFERRAL TO TREATMENT PERIOD END DATE
ORGANISATION CODE (CODE OF PROVIDER)	This field is not XML mandatory in the Commissioning Data Set version 6-1 schema but is required by the Secondary Uses Service for processing of all records
ORGANISATION CODE (CODE OF COMMISSIONER)	This field is not XML mandatory in the Commissioning Data Set version 6-1 schema but is required by the Secondary Uses Service for processing of all records

Implications to stakeholders

There is no clinical impact - the change is proposed to allow accurate recording of existing processes.

The administrative impact of the change is moderate. Changes to trust processes and procedures are not proposed but it may require a change in the way in which these processes are recorded within systems.

System suppliers will be impacted as they will be required to generate a subset of the data to support a Commissioning Data Set type 020 Outpatient record, from a transaction which is not a traditional Outpatient attendance.

This will have no impact on existing confidentiality and security, or legal and professional rules relating to the transfer of patient information.

Timescales for Implementation / Change

FRAMEWORK		Health and Social Care Personnel	Organisation[1]	IT Suppliers[2]
Effective Date[3] "may use"		**12 August 2009**		
Implementation Date[4] "must use"	***Collection Start Date[5]***	**1 December 2009**		
	First Submission Date[6]	**1 December 2009**		
	Reporting Period / Submission Cycle[7]	Weekly - monthly*	Weekly - monthly*	
Conformance Date[8] "must be used effectively and assessed for use"		**1 February 2010**		
Superseded Date (of prior standard)[9] "stop using prior standard"		**Not applicable**		

Effects on Other Information Standards

None

Sponsor Details

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

Further Information and Support

The following links provide additional guidance:

• 18 weeks rules suite "How to Measure" guide
www.18weeks.nhs.uk/Asset.ashx?path=/Rules%20suite/18weeksRulesSuite_HowToMeasure_280208.doc

• The 18 weeks rules suite - 'How to apply' guide:
www.18weeks.nhs.uk/Asset.ashx?path=/Rules%20suite/18weeksRulesSuite_HowToApply_280208.pdf

• For further advice and scenarios for the use of the Referral To Treatment Clock Stop Administrative Event visit the 18 weeks website at:
http://www.18weeks.nhs.uk/Content.aspx?path=/

Further information is available by e-mail to: data18weeks@dh.gsi.gov.uk

For enquiries about the Change Request, please email datastandards@nhs.net

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 1045
Version No:	1.0
Subject:	Referral to Treatment Clock Stop Administrative Event
Effective Date:	1 December 2009
Reason for Change:	Introduction of Referral to Treatment Clock Stop Administrative Event to support a Public Service Agreement (PSA) target and the NHS Operating Framework
Publication Date:	6 August 2009

Background:

DSCN 18/2006 published in December 2006, defined essential new data items required to support the measurement of 18 week Referral To Treatment Periods (monitoring of DH PSA target 13 - "By 2008, no one will have to wait longer than 18 weeks from GP referral to hospital treatment"). In particular, the 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 STATUS

Strategic reporting of 18 weeks will be undertaken by the Secondary Uses Service using data obtained via the Commissioning Data Sets (CDS). The new data items defined in DSCN 18/2006 are enabled to flow in Commissioning Data Set version 6-0, 6-1, and will continue to flow in subsequent versions.

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

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

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- 35 PATIENT declined offered treatment
- 36 PATIENT died before treatment

Referral To Treatment Clock Stop Administrative Events only require a sub-set of the data elements contained in the Commissioning Data Set Version 6-1 Type 020 Outpatient record, to be submitted to the Secondary Uses Service. All other data elements not listed should be omitted from the XML submission of the type 020 Commissioning Data Set record carrying the administrative event. The submission of Referral to Treatment Clock Stop Administrative Events is not reliant on the use of the Net Change Commissioning Data Set Submission Protocol to the Secondary Uses Service, however this is strongly recommended. Referral to Treatment Clock Stop Administrative Events are not processed by the Secondary Uses Service for Payment by Results purposes. The facility to submit Referral To Treatment Clock Stop Administrative Events is available in the Commissioning Data Set XML Schema version 6.1, and is not supported by Commissioning Data Set XML Schema version 6-0.

Further guidance and scenarios of when to use the Referral to Treatment Clock Stop Administrative Events can be found on the Department of Health 18 Weeks Website at www.18weeks.nhs.uk.

Summary of changes:

Data Set	
CDS V6 TYPE 020	Changed Description
Supporting Information	
COMMISSIONING DATA SET OVERVIEW	Changed Description
COMMISSIONING DATA SETS MENU	Changed Description
REFERRAL TO TREATMENT CLOCK STOP ADMINISTRATIVE EVENT	New Supporting Information
Attribute Definitions	
FIRST ATTENDANCE	Changed Description
Data Elements	
APPOINTMENT DATE	Changed Description
CDS TYPE	Changed Description
FIRST ATTENDANCE	Changed Description

Date: 6 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.

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

This Commissioning Data Set Type may also be used to submit Referral To Treatment Clock Stop Administrative Events.

The CDS consists of the following CDS Data Groups:

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

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

CDS V6 TYPE 020 - THE OUTPATIENT CDS (Known in the Schema as the Care Activity CDS)

CDS DATA GROUP: PATIENT PATHWAY: To carry the details of the Patient Pathway. One optional occurrence of this Group is permitted.		
Opt	**CDS Data Element**	
O	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	
O	PATIENT PATHWAY IDENTIFIER	
O	ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	
O	REFERRAL TO TREATMENT STATUS	
O	REFERRAL TO TREATMENT PERIOD START DATE	
O	REFERRAL TO TREATMENT PERIOD END DATE	
*	LEAD CARE ACTIVITY INDICATOR (Not defined or approved by the Information Standards Board 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.

COMMISSIONING DATA SET OVERVIEW

Change to Supporting Information: Changed Description

The primary purpose of national data sets is to enable conformant health information to be generated across the country, independent of the ORGANISATION or system that maintains it. In achieving this, the Health and Social Care Information Centre will enable healthcare professionals to measure and compare the delivery and quality of care provided and to support them in sharing information with other health professionals and ORGANISATIONS.

Information Requirements

- monitor and manage Service Agreements;
- develop commissioning plans;
- support the Payment By Results processes;
- support NHS Comparators;
- monitor Health Improvement Programmes;
- underpin clinical governance;
- understand the health needs of the population.
- support reporting against 18 week wait targets

Information on care provided for all PATIENTS by NHS Hospitals and Primary Care Trusts and Independent Sector Providers (for NHS PATIENTS only) is specified in the Commissioning Data Sets and must be submitted to the Secondary Uses Service according to issued guidelines.

Commissioners need access to data to monitor Non-Contract Activity as part of the management of their Service Agreements. Primary Care Trusts also need to monitor in-year referrals to investigate the sources and reasons for Non-Contract Activity.

Independent Sector Treatment Centres (TC) are responsible for providing Admitted Patient Care and Out-Patient Attendance

Commissioning Data Sets and may submit this data on their own behalf or via a third party. Other Independent Sector activity for NHS PATIENTS is the responsibility of the NHS commissioning body for the provision of the appropriate central returns and data sets.

The Department of Health requires accurate data of all PATIENTS admitted to or treated as out-patients, or treated as an Accident And Emergency Attendance by NHS Hospital Providers and Primary Care Trusts, including PATIENTS receiving private treatment. The data also includes NHS PATIENTS treated electively in the independent sector and overseas. These Hospital Episode Statistics (HES) are derived from the Admitted Patient Care, Out-Patient Attendance and Accident and Emergency Attendance Commissioning Data Sets as stored in the Secondary Uses Service. This data provides information about hospital and PATIENT management, epidemiological data on PATIENT DIAGNOSES and OPERATIVE PROCEDURES.

Referral To Treatment Clock Stop Administrative Events may also flow using the CDS V6 TYPE 020 - OUTPATIENT CDS. This allows the Secondary Uses Service to build accurate PATIENT PATHWAYS for the reporting of 18 weeks activity.

Commissioning Data Set Data Flow Definitions

CDS TYPES

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

Commissioning Data Set Messages have been defined in specific components known as a CDS TYPE. Each Commissioning Data Set Type as configured into the Commissioning Data Set Message carries only one specific Commissioning Data Set Type, an examples being the Finished Consultant Episode Commissioning Data Set Type etc.

COMMISSIONING DATA SETS MENU

Change to Supporting Information: Changed Description

- Commissioning Data Set Overview
- Commissioning Data Set Versions
- CDS Mandated Data Flows
- CDS Submission Protocol
- CDS Addressing Grid
- Commissioning Data Set Validation Table
- Security Issues and Patient Confidentiality
- CDS Submission and PCT Mergers
- CDS Data Duplication
- Hospital Episode Statistics
- Hospital Episode Statistics Cross Reference Tables
- Referral To Treatment Clock Stop Administrative Event

The CDS-XML Message

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REFERRAL TO TREATMENT CLOCK STOP ADMINISTRATIVE EVENT

Change to Supporting Information: New Supporting Information

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

Strategic reporting of 18 weeks will be undertaken by the Secondary Uses Service using data obtained via the Commissioning Data Sets . The new data items defined in DSCN 18/2006 are enabled to flow in Commissioning Data Set version 6-0, 6-1, and will continue to flow in subsequent versions.

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

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

30 Start of First Definitive Treatment

31 Start of Active Monitoring initiated by the PATIENT

32 Start of Active Monitoring initiated by the CARE PROFESSIONAL

34 Decision not to treat - decision not to treat made or no further contact required

35 PATIENT declined offered treatment

36 PATIENT died before treatment

When to Use Referral To Treatment Clock Stop Administrative Events

These events may happen because:

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

Secondary Uses Service Processing

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

- CDS V6 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

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

Note that future versions of the Secondary Uses Service will also process:

- CDS V6 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

The dates when ORGANISATIONS submitting REFERRAL TO TREATMENT PERIOD data to the Secondary Uses Service can cease having to also send a Referral To Treatment Clock Stop Administrative Event when a clock stop is carried in one of the Elective Admission List Commissioning Data Set Types, will be notified as part of the Secondary Uses Service release documentation. It is also anticipated that CDS V6 TYPE 021 - FUTURE OUTPATIENT CDS will be processed once piloting is complete and its use is approved by the Information Standards Board for Health and Social Care. A cancelled future Appointment record could carry a REFERRAL TO TREATMENT PERIOD Clock Stop. Again the timescales will be notified as part of the Secondary Uses Service release documentation.

There are no current plans for the Secondary Uses Service to process the remaining Commissioning Data Set Types:

- CDS V6 TYPE 010 - ACCIDENT AND EMERGENCY CDS
- CDS V6 TYPE 040 - EAL - END OF PERIOD CENSUS OLD CDS
- CDS V6 TYPE 050 - EAL - END OF PERIOD CENSUS NEW CDS
- CDS V6 TYPE 090 - EAL - EVENT DURING PERIOD - AVAILABLE / UNAVAILABLE CDS
- CDS V6 TYPE 100 - EAL - EVENT DURING PERIOD - OLD SERVICE AGREEMENT CDS
- CDS V6 TYPE 110 - EAL - EVENT DURING PERIOD - NEW SERVICE AGREEMENT CDS
- CDS V6 TYPE 120 - ADMITTED PATIENT CARE - FINISHED BIRTH EPISODE CDS
- CDS V6 TYPE 140 - ADMITTED PATIENT CARE - FINISHED DELIVERY EPISODE CDS
- CDS V6 TYPE 150 - ADMITTED PATIENT CARE - OTHER BIRTH EVENT CDS
- CDS V6 TYPE 160 - ADMITTED PATIENT CARE - OTHER DELIVERY EVENT CDS
- CDS V6 TYPE 170 - ADMITTED PATIENT CARE - DETAINED AND/OR LONG TERM PSYCHIATRIC CENSUS CDS
- CDS V6 TYPE 180 - ADMITTED PATIENT CARE - UNFINISHED BIRTH EPISODE CDS
- CDS V6 TYPE 200 - ADMITTED PATIENT CARE - UNFINISHED DELIVERY EPISODE CDS

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

When NOT to Use a Referral To Treatment Clock Stop Administrative Event

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

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

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

Referral To Treatment Clock Stop Administrative Events only require a sub-set of the data elements contained in the CDS V6 TYPE 020 - OUTPATIENT CDS record, to be submitted to the Secondary Uses Service. All other data elements not listed should be omitted from the XML submission of the CDS V6 TYPE 020 - OUTPATIENT CDS record to the Secondary Uses Service. The submission of a Referral To Treatment Clock Stop Administrative Event is not reliant on the use of the Net Changes Commissioning Data Set Submision Protocol to the Secondary Uses Service

The required data elements making up a Referral To Treatment Clock Stop Administrative Event are:

Data Element Required	Notes
UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) or PATIENT PATHWAY	The Commissioning Data Set Schema version 6-1 requires EITHER the PATIENT PATHWAY IDENTIFIER, or the UNIQUE BOOKING REFERENCE NUMBER

IDENTIFIER	(CONVERTED) to be populated.
ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	If the UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) is used, the ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) should contain X09 (which relates to the Choose and Book system)
REFERRAL TO TREATMENT STATUS	This should contain only one of the following codes to signify that the REFERRAL TO TREATMENT PERIOD has ended: 30 Start of First Definitive Treatment 31 Start of Active Monitoring initiated by the PATIENT 32 Start of Active Monitoring initiated CARE PROFESSIONAL 34 Decision not to treat - decision not to treat made or no further contact required 35 PATIENT declined offered treatment 36 PATIENT died before treatment
REFERRAL TO TREATMENT PERIOD START DATE	
REFERRAL TO TREATMENT PERIOD END DATE	
NHS NUMBER	
NHS NUMBER STATUS INDICATOR	
POSTCODE OF USUAL ADDRESS	
ORGANISATION CODE (PCT OF RESIDENCE)	
FIRST ATTENDANCE	This should always hold the National code 5 - "Referral to Treatment Period Clock Stop Administrative Event"
APPOINTMENT DATE	This field is XML mandatory in Commissioning Data Set Schema version 6-1 for Type 020 Outpatients, and for the purposes of the Referral To Treatment Clock Stop Administrative Event, should hold the same date as the REFERRAL TO TREATMENT PERIOD END DATE
AGE AT CDS ACTIVITY DATE	This field is XML mandatory in the Commissioning Data Set Schema version 6-1 for Type 020 Outpatients, and should hold the PATIENTS age at REFERRAL TO TREATMENT PERIOD END DATE
ORGANISATION CODE (CODE OF PROVIDER)	This field is not XML mandatory in the Commissioning Data Set version 6-1 schema but is required by the Secondary Uses Service for processing of all records
ORGANISATION CODE (CODE OF COMMISSIONER)	This field is not XML mandatory in the Commissioning Data Set version 6-1 schema but is required by the Secondary Uses Service for processing of all records

FIRST ATTENDANCE

Change to Attribute: Changed Description

This indicates whether a PATIENT is making a first attendance or contact; or a follow-up attendance or contact.

National Codes:

1 First attendance face to face
2 Follow-up attendance face to face
3 First telephone or telemedicine consultation
4 Follow-up telephone or telemedicine consultation
5 Referral To Treatment Clock Stop Administrative Event*

*Referral to Treatment Clock Stop Administrative Event allows the Secondary Uses Service to build accurate PATIENT PATHWAYS for the reporting of 18 weeks activity. It flows through the CDS V6 TYPE 020 - OUTPATIENT CDS structure. See Referral To Treatment Clock Stop Administrative Event.

APPOINTMENT DATE

Change to Data Element: Changed Description

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

Notes:
APPOINTMENT DATE is the same as APPOINTMENT DATE.

Usage in the CDS:
The Outpatient and Future Outpatient CDS Types use the APPOINTMENT DATE as the "CDS ORIGINATING DATE" as a mandatory requirement of the CDS Exchange Protocol, see CDS ACTIVITY DATE.

For the Future Outpatient CDS where no APPOINTMENT DATE is available from the healthcare system, a default date value of 2999-12-31 may be applied.

Care must be taken to generate the correct CDS Exchange Protocol when using this default value.

When submitting a Referral To Treatment Clock Stop Administrative Event via the CDS V6 TYPE 020 - OUTPATIENT CDS, APPOINTMENT DATE is equivalent to the REFERRAL TO TREATMENT PERIOD END DATE carried in the record.

CDS TYPE

Change to Data Element: Changed Description

Format/length:	n3
HES item:	
National Codes:	
Default Codes:	

Notes:

Definition:
A code to identify the specific type of Commissioning Data Set data.

Permitted values are:

CODE	CLASSIFICATION
010	Accident and Emergency Attendance
~~020~~	~~Outpatient~~ ~~*(Known in the Schema as Care Activity from CDS v6)*~~
~~021~~	~~Future Outpatient~~ ~~*(Introduced in CDS Version 6 - known in the Schema as Future Care Activity)*~~
020	Outpatient *(Known in the Schema as Care Activity from CDS v6)* May also be used to submit a Referral To Treatment Clock Stop Administrative Event
021	Future Outpatient *(Introduced in CDS Version 6 - known in the Schema as Future Care Activity)*
030	Elective Admission List End of Period Census (Standard)
040	Elective Admission List End of Period Census (Old)
050	Elective Admission List End of Period Census (New)
060	Elective Admission List Event During Period (Add)
070	Elective Admission List Event During Period (Remove)
080	Elective Admission List Event During Period (Offer)
090	Elective Admission List Event During Period (Available/Unavailable)
100	Elective Admission List Event During Period (Old Service Agreement)
110	Elective Admission List Event During Period (New Service Agreement)
120	Finished Birth Episode

130	Finished General Episode
140	Finished Delivery Episode
150	Other Birth
160	Other Delivery
170	Detained and/or Long-Term Psychiatric Census
180	Unfinished Birth Episode
190	Unfinished General Episode
200	Unfinished Delivery Episode

Usage:
This is a mandatory data element for the processing of Commissioning Data Set data.

FIRST ATTENDANCE

Change to Data Element: Changed Description

Format/length:	n1
HES item:	
National Codes:	Click on the attribute tab to display the attribute that contains the National Codes.
Default Codes:	

Notes:
This indicates whether a PATIENT is making a FIRST ATTENDANCE or follow-up attendance or contact and whether the CONSULTATION MEDIUM USED was a face to face contact or telephone/telemedicine consultation.

A FIRST ATTENDANCE is the first in a series, or only attendance of an APPOINTMENT which took place regardless of how many previous APPOINTMENTS were made which did not take place for whatever reason. All subsequent attendances in the series which take place should be recorded as follow-up.

FIRST ATTENDANCE National Code 5 - "Referral to Treatment Clock Stop Administrative Event" allows the Secondary Uses Service to build accurate PATIENT PATHWAYS for the reporting of 18 weeks activity. It flows through the CDS V6 TYPE 020 - OUTPATIENT CDS structure. See Referral To Treatment Clock Stop Administrative Event.

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